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PAHO PROGRAM ADVANCES AND STRATEGIES FOR INCORPORATING GENDER

Presented by the Special Program for Health Analysis (SHA)

In the last decade, the situation of women has gained national and international visibility. Member States continue to participate actively in international forums and support international resolutions that encourage the advancement of women as a key to progress in attaining a healthy population. The Pan American Health Organization (PAHO) concurs with the ever-growing recognition that gender plays a significant role in achieving sustainable development and agrees that gender-oriented policies, strategies, and analytical tools should be based on valid, reliable, and timely information.

In 1997, Resolution CD40.R10 of the 40th Directing Council resolved to develop the Core Health Data Regional Initiative for the purpose of promoting the use of epidemiology in health situation analysis and trends and to provide health intelligence for national and international decision-making. In 1999, this Initiative was presented to the 19th Session of the Subcommittee on Women, Health, and Development. The Subcommittee noted that the databases included key demographic, socioeconomic, mortality, morbidity, access, and resources and health services coverage variables disaggregated by sex. In 2002, Resolution CSP26.R21 on Women, Health, and Development of the 26th Pan American Sanitary Conference stated, *inter alia*, that Member States should "assign a high priority to establishing and financing information systems on gender differences in health and development; and to the collection, processing, and presentation of health information disaggregated by sex."

This document summarizes experiences and strategies for incorporating gender in Core Health Data Initiatives and documenting gender-oriented health situation analyses in technical cooperation activities with countries. It also recognizes the significant potential for improvement as well as the opportunities for applying a fully developed gender analytical framework in the assessment of the health situation and trends, particularly focused in ongoing interprogrammatic efforts to incorporate the United Nations Millennium Development Goals into PAHO technical cooperation activities, with emphasis on health and health equity issues that affect women, as well as corresponding targets.

The Subcommittee is invited to analyze and discuss the document as well as to provide comments to assist the Organization in terms of policy definition and implementation of strategies and best practices for incorporating gender perspective into its technical cooperation initiatives, linking it to the qualitative and quantitative information available in its Member States; and for following-up by monitoring and evaluating the impact of its gender-oriented technical interventions at the policy, managerial, and technical levels.

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**Incorporating Gender in PAHO Technical Cooperation Activities:
Core Health Data & Health Situation Analysis**

Overview and Context

1. The primary objective of the Special Program for Health Analysis (SHA) is to strengthen the capacity of Member States and the Secretariat of the Pan American Health Organization to generate, analyze, disseminate, and utilize strategic information to evaluate the health situation and trends in the Region of the Americas and to provide evidence aimed at influencing public health policy decisions. This encompasses identification and analysis of both health needs and the existence of health inequalities. Operationally, SHA's technical cooperation activities aim to: (1) strengthen the process of epidemiological practices; and (2) provide evidence-based health situation and trend analyses of the countries in the Americas.

2. In the period 1997-2000, the regional situation and trend analyses indicated that, on average, life expectancy at birth for women was approximately 6.3 years longer than for men. Since women continue to comprise the majority of the aging population, ensuring good health in these years will require systematic collection, analyses, interpretation, and dissemination of gender-specific information. Data from Member States for this period also indicated that women were disproportionately affected by such diseases as cancer, heart disease, diabetes, and hypertension. In this period, HIV/AIDS and domestic violence have gained priority status on the women's health agenda.

3. In the last decade, the situation of women has gained national and international visibility. Member States continue to participate actively in international forums and support international resolutions that encourage the advancement of women as a key to progress in attaining a healthy population. SHA concurs with the ever-growing recognition that gender plays a significant role in achieving sustainable development and agrees that gender-oriented policies, strategies, and analytical tools should be based on valid, reliable, and timely information. Consequently, SHA will: (1) strive to incorporate the gender perspective into its technical cooperation initiatives, linking it to the qualitative and quantitative information available in its Member States; and (2) follow-up by monitoring and evaluating the impact of its technical interventions at both the policy and managerial as well as technical levels.

4. SHA is mindful of Resolution CSP26.R21 on Women, Health, and Development of the 26th Pan American Sanitary Conference (2002) which states, *inter alia*, that Member States should "assign a high priority to establishing and financing information systems on gender differences in health and development; and to the collection,

processing, and presentation of health information disaggregated by sex." SHA has circulated the resolution to its field epidemiologists.

5. Recently, the Director has charged SHA with the responsibility of coordinating PAHO's interprogrammatic efforts to incorporate the United Nations Millennium Development Goals into its technical cooperation activities. These goals include health and health equity issues that affect women as well as corresponding targets. (For example, Goal 3 is to "promote gender equality and empower women," and Goal 5 seeks to "improve maternal health.")

SHA Experiences and Opportunities in the Selection, Collection, Analysis, and Dissemination of Information on Women's Health from a Gender Perspective

6. As regional initiatives, the Country Profiles and Core Health Data commenced in 1995 for the purpose of promoting the use of epidemiology in health situation analysis and trends to provide health intelligence for national and international decision-making. The Secretariat, PAHO/WHO Representatives, and Member States were informed about and provided data for these initiatives. In 1999, these initiatives were presented to the 19th Session of the Subcommittee on Women, Health and Development. The Subcommittee noted that the databases included the following key variables disaggregated by sex:

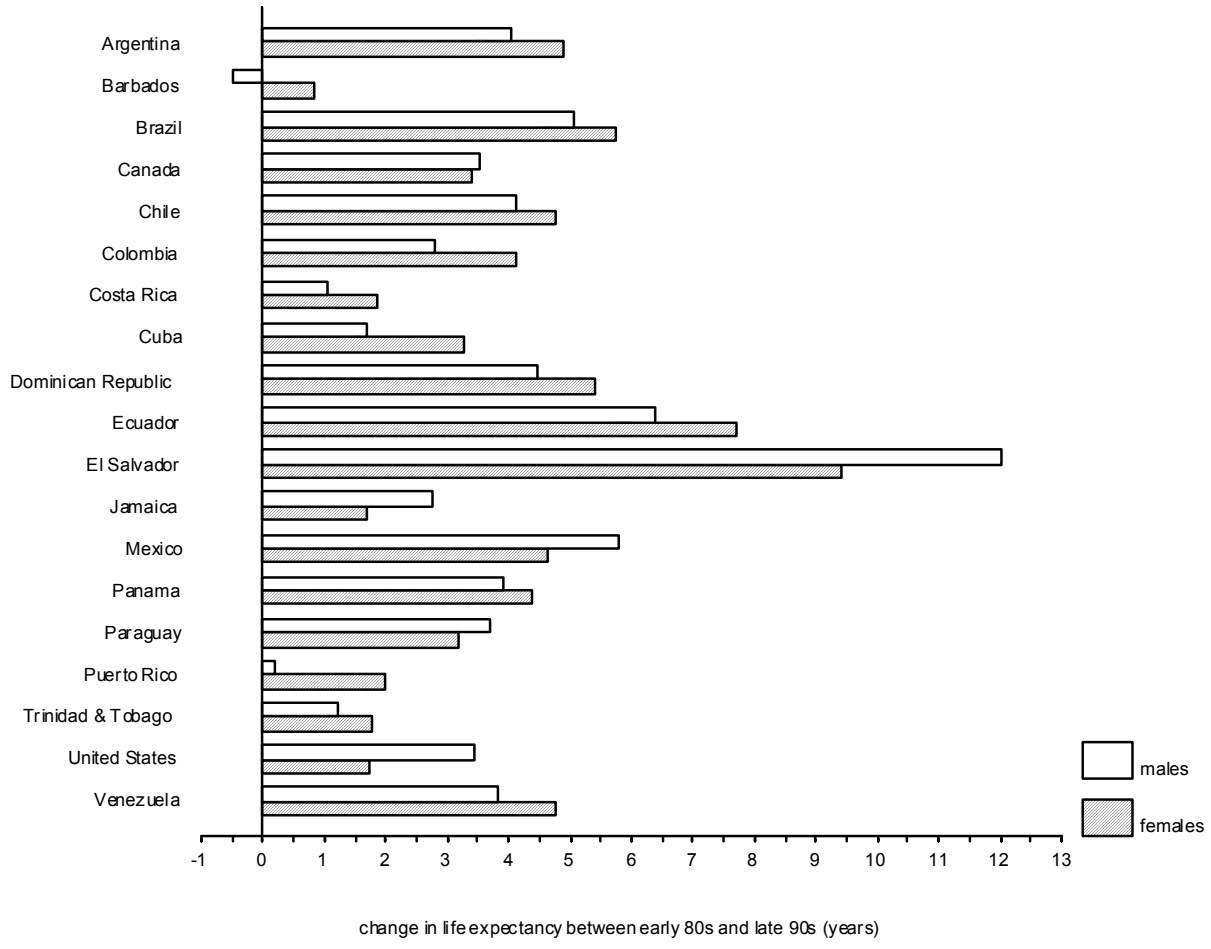
- demographic data (population, fertility rates, and life expectancy);
- socioeconomic (literacy, crude rates for school attendance, proportion of persons in the workforce);
- mortality (mortality rates in the under-5 age group, mortality rates, mortality by age groups, and mortality rates for 17 causes of death);
- morbidity (cases of AIDS); and
- access, resources, and health services coverage (proportion of pregnant women attending prenatal clinics).

7. These data and/or their inferences continue to be the framework for the analyses presented in successive editions of *Health in the Americas, the Annual Report of the Director, PAHO Epidemiological Bulletin*, and other means of dissemination of relevant public information in health.

8. With these routinely collected core health data, SHA has been able to describe, explore, analyze, and differentiate, by sex, several dimensions of the health situation and its determinants, both at the regional as well as national levels. As an illustration of these experiences, and considering the significant potential for improvement as well as the opportunities for applying a fully developed gender analytical framework in the assessment of the health situation, some evidence is summarized below.

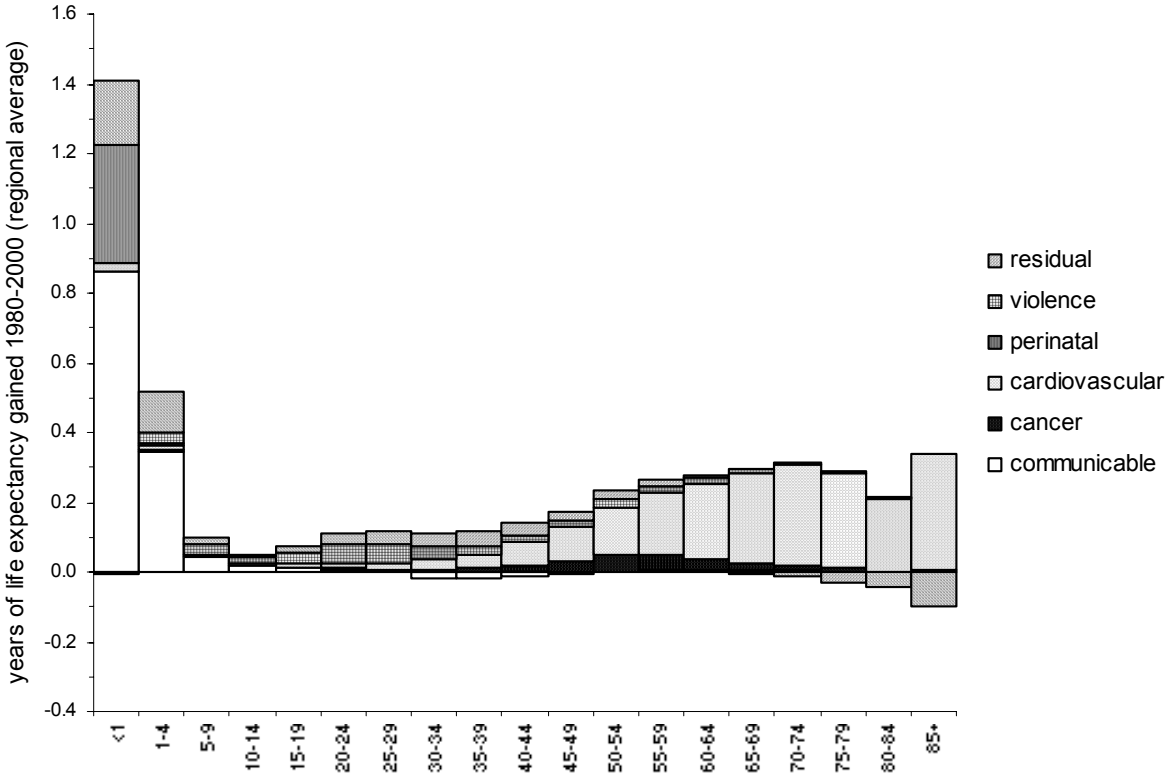
9. SHA has documented the magnitude of female life expectancy gained between the early 1980s and the late 1990s in countries of the Americas (Figure 1), in contrast to that gained by males. On a regional average, females gained 5.6 years of life expectancy during that period, 0.7 years more than males.

Figure 1. Gains in Life Expectancy in Countries of the Americas, early 1980's-late 1990's



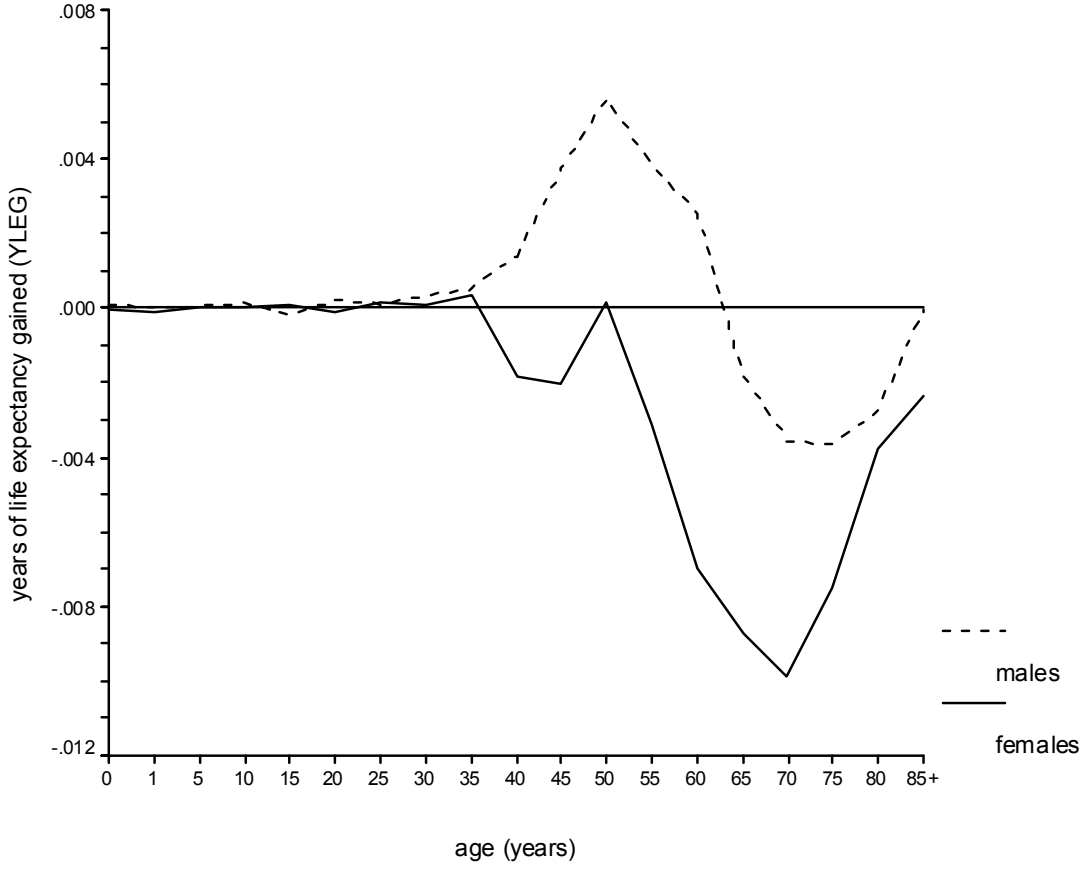
10. By means of the application of a novel methodology, SHA was able to break down the changes in female life expectancy observed between the early 1980s and late 1990s into six broad groups of risk of dying. (Figure 2). Almost 40% of the total extra amount of life expectancy gained by the female population of the Americas was due to the reduction of the risk of dying in girls under five years of age. Almost one half year was added to female life expectancy due to reductions in perinatal mortality, and one and a half year added to the reduction in communicable diseases mortality in that age group alone. As a whole, women in the Americas gained almost 2.5 years of life expectancy due to the reduction in the risk of dying from cardiovascular diseases.

Figure 2. Contribution to Change in Female Life Expectancy by Broad Disease Groups. The Americas, early 1980's-late 1990's



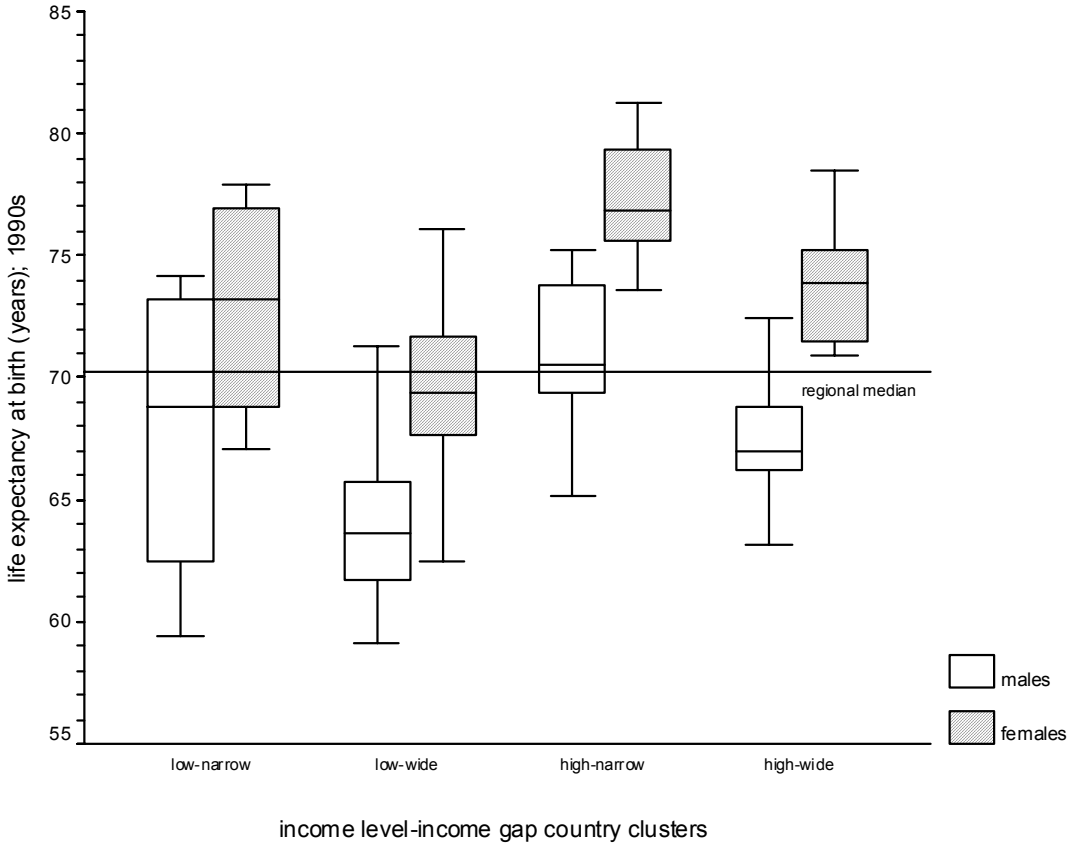
11. Further insight about changes in the female burden of mortality was obtained by extending the analysis of the years of life expectancy contributed by from 32 causes of death, by five-year age groups, differentiated by sex. Along with impressive gains in both male and female life expectancies due to reduction of the risk of dying from acute respiratory infections, diarrheal diseases, immunopreventable diseases, and nutritional deficiencies, there were conditions such as diabetes mellitus, AIDS, and lung cancer (Figure 3), among others, that contributed negatively, i.e., reducing years of life expectancy in the female population of the Americas. A more comprehensive account of those changes has been published in *Health in the Americas, 2002 Edition.*

Figure 3. Years of Life Expectancy Gained and Lost Due to Lung Cancer, by age and by sex. The Americas, early 1980's-late 1990's



12. SHA has also been committed to documenting the presence and magnitude of health inequalities in the Americas. In that respect, Figure 4 shows the unequal pattern of gains in life expectancy, both in men and women, according to four different socioeconomic country scenarios as a result of their income level and income gap. Women living in countries with low income level (i.e., with 1978-1998 median power purchase parity adjusted GNP per capita lower than the regional median), with high income gap (i.e., with 1978-1998 median 20/20 income ratio higher than the regional median), as well as those living in countries with high income level and high income gap have systematically lower life expectancies at birth during the 1990s than their male counterparts and than women living in more equitable countries with a similar income level.

Figure 4. Summary Distribution of Life Expectancy at Birth by Sex and Country Cluster of Income Level and Gap. The Americas, 1990s



13. An example of exploratory analyses delving into determinants of health inequalities is eloquently illustrated by the concentration curve of maternal deaths in the female population ranked by illiteracy level (Figure 5). More than 40% of maternal deaths are concentrated in the least literate female population quintile. Moreover, there is a marked negative interaction between low-income level plus high-income gap and level of literacy in both men and women in the Americas (Figure 6), particularly among women.

Figure 5. Concentration Curve of Inequity in Maternal Mortality by Maternal Illiteracy. The Americas, 1998

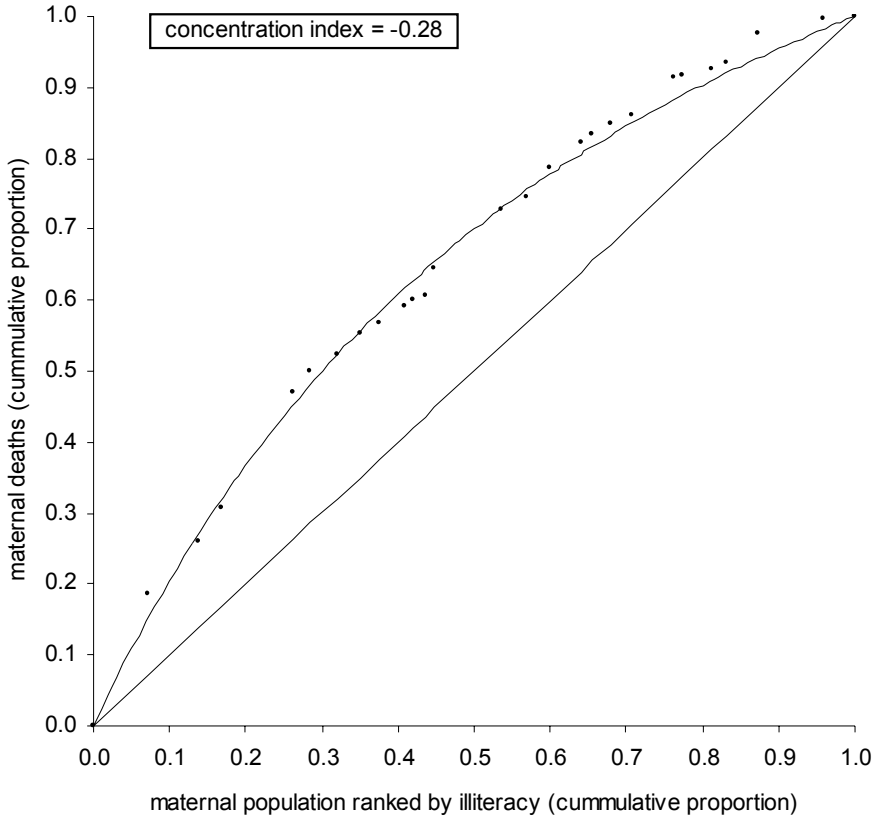
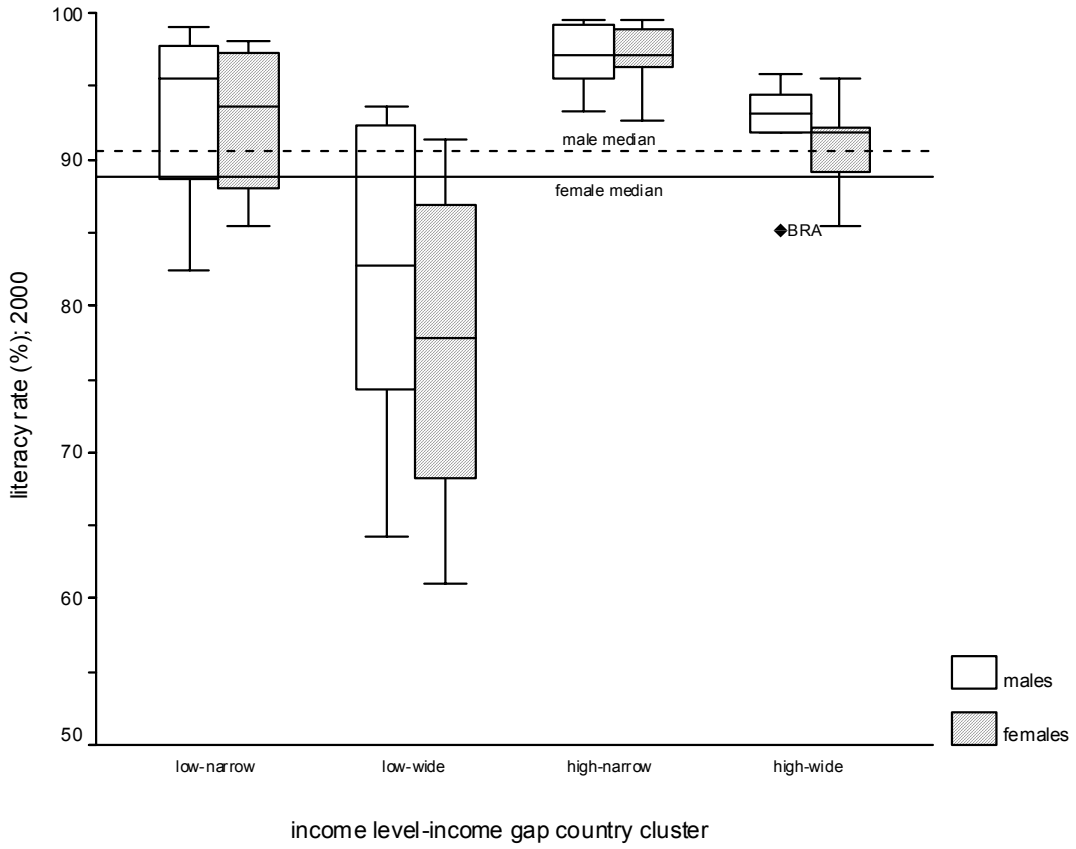
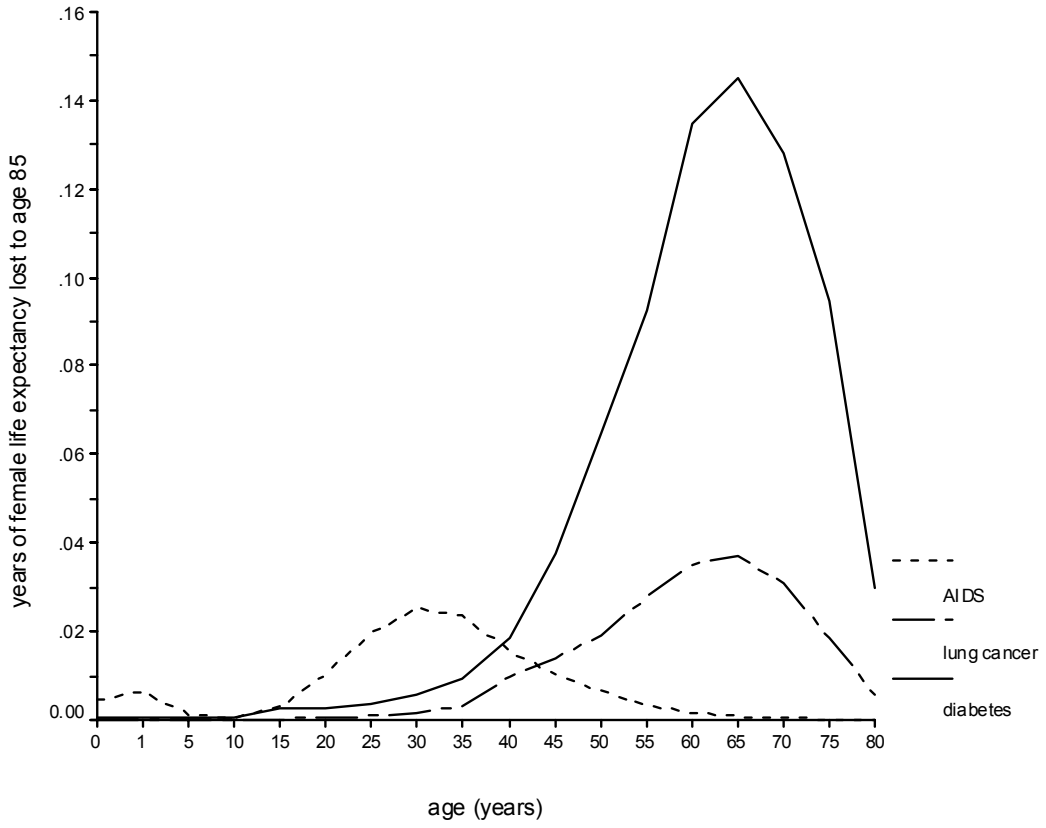


Figure 6. Summary Distribution of Literacy Rate by Sex and Country Cluster of Income Level and Gap. The Americas, 2000



14. Finally, as an analytical attempt to assess and quantify the potential impact of further reduction in the risk of dying due to particular diseases of public health importance on the current burden of mortality, SHA proposed the use of Years of Life Expectancy Lost (YLEL) to 85 years of age, which is equivalent to the number of years of life expectancy that can be added to the actual life expectancy due to further reduction in mortality risks from specific causes. Figure 7 shows the age distribution of YLEL due to three of the most important contributors to the female burden of disease in 2000 in the Americas: diabetes mellitus, AIDS, and lung cancer, highlighting the relevance of prioritizing gender-focused policies and interventions on these health outcomes.

Figure 7. Distribution of Years of Life Expectancy Lost to Age 85 in Women Due to Diabetes, AIDS, and Lung Cancer The Americas, 2000



Incorporating Gender in Core Data and Health Analyses Initiatives: A Proposal in Operational Terms

15. SHA will:

(a) Collaborate with the Program of Women, Health and Development (HDW) to identify a set of benchmarks—indicators that measure changes toward attaining stated objectives and reaching corresponding intermediate and final targets;

(b) Expand its mortality database and analytical capability to incorporate more comprehensively the gender-based perspective. The gender conceptualization and analytical approach will delineate the health situation and trends in women's

health and highlight gender inequities. SHA will integrate gender-based analysis (GBA) into one of its main activities—Surveillance of the Health Situation in the Region. Specific tasks subsumed in this area of work include coordination with the Secretariat and support to countries to establish and maintain networks and databases for the monitoring of goals and mandates at regional, subregional, and national levels. The corresponding areas of work where SHA can integrate the gender-based perspective include:

- maintaining and updating PAHO's Core Health Data System;

- supporting the periodic preparation of country health profiles using core health data;

- collaborating with other PAHO programs in monitoring of events, factors, strategies, and health mandates in countries of the Region.

(c) Introduce, in collaboration with HDW, feasible initiatives and concomitant processes to strengthen national capacities for the development of health information and monitoring systems that can include key health and health determinants indicators disaggregated by sex, age, and other gender-sensitive variables. SHA will encourage its national epidemiologists to include the gender-based perspective in their databases that support the national health situation rooms.

(d) Include indicators for monitoring gender inequity in health. SHA's current work includes a component that promotes and supports the development of comparative analyses of existing research on health situation, inequalities in health, and the identification of indicators to identify the population groups with the greatest burden of disease and levels of inequity in health.

(e) Aim, in the short term, to collaborate actively with HDW to realize the publication of the biennial series of a regional brochure containing a core set of women's health indicators. SHA will therefore request the Member States to submit individual mortality data. The analytical process will interpret mortality data by gender, age, race, ethnicity (where data is available), and causes of death. Where available, SHA will routinely contribute data on life expectancy; leading causes of death, by sex; leading causes of morbidity, by sex, including female HIV/AIDS cases; and distribution of injury-related deaths, by sex.

(f) Promote the inclusion of gender perspective in health situation and trend analyses, which is essential to guide PAHO's technical cooperation initiatives as well as to assist national governments to define health policies and plans. From the public health viewpoint, the gender perspective is essential because it leads to a more comprehensive understanding of gender roles, characteristics, responsibilities, and their link to ill-health. It also contributes to the attainment of greater equity in health and health care.

(g) Incorporate gender-based analyses in its programmatic orientation, and continue to involve its resources and technical capabilities to provide better evidence for gender-based technical cooperation priorities and public health policies. The gender-based framework is evidence-based. It will require data, which will be mostly derived from national statistical systems. It requires the availability of efficient, national statistical and health information systems. In the majority of our Member States, these systems need strengthening and trained human resources. The framework also requires institutional political will and momentum to improve and strengthen the statistical systems so that they can respond to increasing demand for diverse evidence-based statistics.

Action by the Subcommittee on Women, Health, and Development

16. The Subcommittee is invited to analyse and discuss the document as well as to provide comments to assist the Organization in terms of policy definition and implementation of strategies and best practices for incorporating the gender perspective into its technical cooperation initiatives, linking it to the qualitative and quantitative information available in its Member States; and for following up by monitoring and evaluating the impact of its gender-oriented technical interventions at both the policy and managerial as well as technical levels.

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