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REPORT ON THE ACHIEVEMENTS OF PAHO'S WOMEN, HEALTH, AND DEVELOPMENT PROGRAM, 1999 – 2000

This document covers the 1999–2000 achievements of PAHO's Women, Health, and Development Program (HDW). Since the 18th Session of the Subcommittee of Women, Health, and Development, the Program and its national counterparts have consolidated the integrated model for addressing intrafamily violence which has been institutionalized in over 100 communities, in the health and other sectors, as well as in policies and legislation in 10 countries. HDW is taking a leading role within the "Lives Free from Violence" Group of UN agencies and regional women's networks in organizing the Symposium 2001: Gender Violence, Health, and Rights, to mobilize the health sector in addressing gender violence.

As a follow-up of the 18th Session, the Program developed, received funding for, and is launching a project to address gender equity in health sector reform, by developing materials and operationalizing these with stakeholders in Chile and Peru. It has also spearheaded research on this issue in six countries.

HDW continues to collaborate with PAHO divisions and Member States to incorporate gender equity in research, projects, and policies: male involvement in reproductive health, gender and quality of care, involving indigenous women's groups in health promotion and care, and addressing the needs of women with their participation in environmental, and occupational health projects.

The Women, Health, and Development Program counts on the support of the Subcommittee to strengthen PAHO's and Member States' commitment to implement the integrated model for addressing gender violence, to participate in and implement the plans and recommendations of the Symposium 2001, to include stakeholder participation and gender in health analysis and monitoring of health sector reform processes, to form alliances with local, national and regional women's groups, and to disseminate its tools, research results and publications throughout the Region.

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1. Introduction

The 1999–2000 biennium saw a surge of interest in health equity and the negative health consequences of widespread inequities. While poverty's effects on mortality and life expectancy received the limelight, gender inequities continue to receive little attention. Most countries still do not disaggregate by sex their health data on which much planning and resource allocation is based, while women and their single-headed households continue to feminize the poverty ranks. These poor family members make up most of the persistent numbers of communicable diseases, maternal mortality, and malnutrition.

While our populations age, chronic diseases predominate in terms of morbidity and causes of death in developed and developing countries of the Americas. But poverty plays a role in these diseases as well, as does gender. According to the United Nations *World's Women 2000* women live an average of six more years than men. While women have longer life expectancy in most regions of our world, they do not have equal health expectancy—or life expectancy in good health—compared to men. Women suffer more disease and disability throughout their life span, with increased disability in their older years. During these years women are more likely than men to be widowed, and a majority live in poverty and are not insured, which deteriorates their health, limits their access to care, and diminishes the quality of their lives.

Cardiovascular diseases are the main killer that in some developing countries result in greater mortality among poor women than poor men. Cancer mortality in most countries is higher among women than men, mostly due to breast and cervical cancer. Increasingly, studies show that these diseases affect women and men differently and that with the exception of some cancers, the poor are disproportionately at risk. Most of these diseases are preventable and have well-known risk factors that are adopted during youth and are trans-generational, such as cigarette smoking, substance and alcohol abuse, unhealthy diet, and lack of exercise. Their prevention, therefore, should target changing the behaviors that are determined in a large part by social constructs such as class and gender and are influenced by social policy.

There is some evidence that on-going health sector reform processes in many countries increase gender inequities in access, financing, and care, and ultimately in health status. This information is derived from isolated studies, since few countries monitor these effects of their health sector reform. As a result of reforms, many governments have reduced basic health care packages to essential obstetric and prenatal services, excluding other reproductive services that were so stridently fought for during the last decades. Promotion and prevention services, so important for strengthening healthy behavior throughout the life cycle, were too often reduced or eliminated in favor of curative care. Whereas at one time most of

these services were free, now even the most austere packages are subsidized and have a price that is too often beyond the reach of the poorest, many of whom are women. There is some evidence that among the poorest strata, women use public services even less than men and, despite these women's increased need, their use is certainly less than women and men who are better off.

Health sector reform promotes privatization and decentralization of services. Again, the poor usually cannot afford these private services, and since most women spend their productive lives in unpaid work and the informal sector, few have access to insurance policies that cover these services. While women have advocated hard to sensitize and be represented among national policymakers, most local leaders continue to be men who are not gender-sensitized and, often formulate programs and policies that do not take the different needs of women in their communities into consideration.

But there have been advances. Gender violence is no longer invisible in our Region, and the role of men in improving their own health, as well as that of their families, is gaining recognition. Most countries have ratified the international conventions condemning violence against women and passed laws penalizing and addressing the problem. Some countries now are including gender violence indicators in health surveillance systems. Prevalence data are still scarce throughout the Region, but there are a number of national surveys and an increased recognition of the need for data to improve strategies for violence prevention. However, while women's organizations have mobilized the judicial sector and police to address gender violence, the health sector still lags behind. This is of special concern, given that most women bruised by gender violence request health services more often, without the providers' awareness or the ability to deal with the problem.

Efforts to prevent gender violence have called attention to the need for men to become more active in improving their own and women's health. In the Region there is a budding movement of men who work closely with women's and reproductive health advocates in changing men's role in their societies and in health decisions. In some countries public and private programs have reinforced these efforts by supporting men's participation and in developing materials.

Galvanized by its women's organizations allies and an increasing interest of ministries of health, PAHO colleagues and donors, PAHO's Women, Health, and Development Program (HDW) has scored some remarkable achievements in addressing gender inequities during the last two years.

2. Addressing Gender Violence

2.1 *The Integrated Model*

Since 1995, HDW, in collaboration with its national counterparts and with support from the Governments of Sweden, Norway, and the Netherlands, has developed an integrated model to address gender violence at the community, sector and policy levels. PAHO has implemented this model in 10 countries (seven Central American countries and Bolivia, Ecuador, and Peru), and the Inter-American Development Bank has replicated it in six others. In these countries, the model has resulted in over 100 intersectorial community networks that support, refer, and care for women and families living in violent situations and mount education and media campaigns for prevention. Counterparts have developed and implemented training modules, procedures, and surveillance systems for health providers in all these countries. They have strengthened national coalitions that advocate for better laws and the institutionalization of the projects' achievements.

Achievements:

- Inclusion of gender violence prevention and the integrated model in regional and subregional policy fora: RESSCAD, Parlatino, First Lady meetings, and regional summits.
- 100 community networks made up of health, education, and judicial sectors, police, churches, community leaders, women's organizations etc., addressing the problem at the local level.
- At the national level, 10 coalitions in six countries.
- Legislation passed in 10 countries and monitoring bodies set up in six Central American countries.
- Critical Route research in countries. Prevalence study on violence affecting women and on the male role in promoting violence in Bolivia, and knowledge, attitudes and practice study in Peru.
- Development and application of training modules in nine countries: more than 13,000 representatives from health and other sectors trained.
- Community support groups trained and functioning in eight countries.
- Masculinity education and support groups in five countries.
- Violence included in curricula of primary schools in Belize and Peru, and in college curricula in three countries.

- Norms and protocols developed and applied in 10 countries.
- Surveillance systems in five countries.
- Prevention campaigns in 10 countries.
- Incorporation of model in health sector reform processes in five countries.

2.2 *Publications and Tools for Preventing Gender Violence*

HDW published the English and Spanish version of the Protocol: *The Critical Route that Women Take in Dealing with Violence* (Ruta crítica), as well as its shorter *Rapid Assessment Version* (RAP), and an analytical comparison of the Critical Route Studies results of the 10 countries; the Spanish versions are available on HDW's website. Prototype training modules for health providers and the norms and protocols can also be obtained on the website.

2.3 *Technical Collaboration*

To facilitate the sharing of experiences, HDW promoted the technical exchange of gender violence prevention experiences between six countries on topics ranging from policy promotion to training of health providers and the setting up of community networks and support groups.

HDW staff and focal points collaborated with WHO on the multicenter study on gender violence prevalence in Brazil, Chile, and Peru. The Program translated and disseminated WHO's Ethical Guide for carrying out this and other gender violence studies.

2.4 *Symposium 2001: Gender Violence, Health, and Rights*

As part of the interagency "Lives Free from Violence" Group, PAHO/HDW played a leading role in organizing the Symposium aimed at mobilizing the health sector in addressing gender violence. Intersectorial and interagency groups from 30 countries submitted reports on the health sector's experiences, from which model approaches were selected for presentation during the Symposium. Agencies are collaborating in sponsoring participants from more than 30 countries, representing ministries of health and of women, and leading violence prevention NGOs. During the Symposium, national participants will develop subregional plans and are committed to implementing these plans and replicating the presented experiences in their countries. PAHO and its sister agencies will support the national coalitions that will facilitate this process.

3. Including Gender Equity in Health Sector Reform

HDW and women's organizations have recognized the growing gender inequities resulting from health sector reform processes. In 1998 HDW convened a group of experts to identify strategies to address this issue. During the 18th Session of the Subcommittee on Women, Health, and Development in 1999, members presented country reports on gender equity and health sector reform and drafted recommendations for the Executive Committee's consideration. As a result of these meetings, HDW launched an initiative to develop, validate, and implement analysis, advocacy, and planning instruments to incorporate gender equity criteria in national health situation analysis and policymaking. The strategy was presented in a proposal that was funded by the Ford and Rockefeller Foundations.

3.1 *Mainstreaming Gender Equity at the National Level*

The proposal also includes the implementation of these instruments in three countries. With Ford Foundation support, HDW is launching the project in Chile, followed by Peru. The Program is seeking support for a third country in Central America.

The country projects include the active participation of government and civil society stakeholders throughout their implementation and components. The main project components are: (1) production and analysis of information on gender inequities in health and care; (2) strategic communication of results to key audiences; and (3) monitoring of policy implementation and reform processes. While these activities are usually mentioned in health sector reform recommendations, the project provides an opportunity to implement these recommendations within a process that fosters stakeholder ownership.

3.2 *Mainstreaming Gender Equity at the Regional Level*

HDW advocated for including gender in health sector reform in regional and international fora: two regional meetings of the Latin American Association for Social Medicine (ALAMES), ECLAC Regional Women's Status Meetings, an International Meeting on Equity and Reform in South Africa, a meeting with the Latin American and Caribbean Women's Health Network (RSMLAC) during two regional gender and health training workshops, and with the UN Statistical Bureau training workshop for CARICOM statisticians.

During 2001 and in collaboration with PAHO and UN agency colleagues, HDW plans to use its tools to train regional and national counterparts in mainstreaming gender in health situation analysis and policymaking. Such training will take place in regional

workshops, as well as in two countries per year, where HDW will follow up with technical collaboration to complete gender and health situation analysis.

3.3 *Research on Gender Equity and Access to Health*

In collaboration with PAHO's Research Coordination Program, HDW obtained funding to call for proposals regarding gender inequities in access to and financing of health services within the context of health sector reform. Of 74 proposals submitted, six were selected from the subregions of the Americas. To assure that results translate into policy, HDW held an initial workshop with researchers to incorporate a policy component into the study. Results are expected in March of 2001 and will be integrated into HDW workshops and training on mainstreaming gender equity and health sector reform throughout the Region.

4. *Gender Equity in Quality of Care*

With the support of the Swedish Government, HDW implemented four gender and quality of care operations research projects in four Central American countries (El Salvador, Guatemala, Honduras, and Nicaragua). Using the protocol developed for a similar study in Argentina and Peru, the project coordinator and national researchers again observed gender differences in the way men and women perceived their disease status, how this affected their seeking of care and adherence to treatment, and how providers perceived their men and women patients. Tracer conditions used in the study were diabetes in El Salvador and Nicaragua, and tuberculosis in Guatemala and Honduras.

Even though study samples were small, results from all six countries were remarkably similar. They showed, among others, that men took responsibility for contracting and managing their diseases, and that their partners and families supported them with treatment. Women, on the other hand, generally felt that the disease was just another imposition in a difficult life, and that they received little or no support from their families. Their only possible support came from health care providers, who were often unsympathetic and rude, and who had unrealistic expectations for their treatment.

These results were disseminated in reports and meetings with policymakers in three countries and were incorporated in training of health care providers using the WHO manual *Health Workers for Change* (translated into Spanish and made available through PAHO's subsidized resources, PALTEX). In Nicaragua the process resulted in the forming of diabetes support groups for women; in Honduras the National Tuberculosis Program incorporated gender approach in its national policy.

5. Involving Indigenous Women in Health Promotion, Care, and Training

During 1995–1999, the Program, together with its indigenous and ministry of health counterparts, with support from Sweden, developed a model to include women's groups in the health services and to promote it in nine predominantly indigenous communities in Guatemala. Councils organized by women of these communities participated in health care and promotion training with their health service providers, in order to promote modern and traditional care and prevention practices within their health centers and communities. The model also involves referrals to traditional and modern practitioners and the dispensing of traditional remedies in health centers. The Councils play an active role in promoting such modern preventive measures as breast and cervical exams and child vaccinations.

The model serves as the basis for a four-year project presented to Norwegian donors for promoting intercultural and gender equity in health sector reform in all Central American countries. The project proposal was developed and amply consulted with the participation of national indigenous groups and the health sector of these countries. HDW and its counterparts hope to launch this project in 2001.

6. Involving Men in Reproductive Health Programs

The German Government is providing support for an operations research project to be implemented in four Central American countries. The project, which will be launched in 2001, consists of participative studies of men's knowledge, attitudes, and practices regarding their and their family's reproductive health. Based on this information, HDW will coordinate with ministry of health, men's groups and other partners to develop male involvement models in a health center and a recreation place or sports center.

In preparation for the project and to raise awareness of PAHO colleagues, HDW has published an article on "Men's Participation in Reproductive Health Programs" in the *Revista Panamericana de Salud Pública/Pan American Journal of Public Health*, and distributed an annotated bibliography, relevant materials, and fact sheets to its focal points and through its listserv.

7. Incorporating Gender Equity in PAHO

The primary mandate of HDW is to incorporate gender equity in all of PAHO's technical collaboration, activities, and policies. The Subcommittee on Women, Health, and Development meets biennially to inform PAHO's Director, colleagues, and the Executive Committee of ministers of Member States about key issues concerning gender equity in

health; it drafts resolutions and advocates for their approval by PAHO's Executive Committee.

HDW collaborates with most divisions in meeting these recommendations. Within the last two years HDW has incorporated gender indicators within PAHO's health sector reform monitoring tools, as well as in violence surveillance systems; it has mainstreamed gender in the training, activities, and policies of the Central American Project on Pesticide and Health; it is collaborating on a participative project to develop health standards for women and men working in export industries and is working with PAHO's Mental Health Program to identify and implement community approaches dealing with gender and mental health, with a particular focus on depression.

8. Providing Information on Gender Equity

One of the key objectives of HDW is to provide current information to its network of focal points, counterparts, stakeholders, and gender and health advocates throughout the Region. The Program provides this information in hard copy and through electronic channels, such as its webpage where most publications, training materials, and fact sheets are made available, its listserve GENSALUD (gensalud@paho.org) and through linking partner information centers, such as ISIS in Chile and SIMUS in Costa Rica, to PAHO's Virtual Library.

Publications available on the Web and in all PAHO's documentation centers in the Region include: the *HDW Training Guide on Gender, Health, and Development* (Spanish and English), publications of the Intrafamily Violence Project; the Spanish translation of the *Ethical Guide for Research on Domestic Violence, Smoking, and Adolescent Women* (Spanish and English), as well as the instruments developed by the Intrafamily Violence project coordinators and their national counterparts. In addition, several publications are made available through PAHO's Publications Program: *Domestic Violence: Women's Way Out* (English translation of the *Ruta Crítica*), and a Spanish translation of the Harvard series on *Gender Equity in Health*.

GENSALUD currently has more than 300 subscribers and provides information on websites, publications, conferences, and other relevant information, as well as monthly factsheets.

9. Strengthening Gender Equity in Health and Development: the Subcommittee's Role

- Draft and advocate for recommendations to mainstream gender in PAHO's and Member States' programs, research, policies and health situation analysis and monitoring.
- Strengthen and replicate the integrated model for addressing gender violence and implement the recommendations of the Symposium 2001: Gender Violence, Health, and Rights, throughout the Region.
- Include stakeholder participation, especially women and their local, national, and regional organizations in health situation analysis and research, dissemination of results, and monitoring of related policies.
- Disseminate HDW tools, research results, and training programs.

10. Conclusion

With the globalization of the world's economies and social agendas, assuring health for all provides new challenges and opportunities. While there is a general recognition that social, as well as biological, determinants affect health, gender continues to be an afterthought for most analysts and policy planners. However, there is a beginning recognition that:

- poverty is increasingly feminized;
- gender violence affects one-third to one-half of women in almost all countries;
- unlike plummeting infant mortality rates, maternal mortality rates change slowly and reflect even larger inequities between countries and provinces;
- women are less often covered by health insurance, which is increasingly determining access to health services;
- globalization and sector reform have not always delivered more equitable systems and policies.

Gender indicators should be included in health situation analysis that provides the basis for planning and policy-making. This information should be made widely available to women's groups and other stakeholders so they may use it to monitor reform processes and participate in the decision-making processes that affect their health condition and access to health care.