



**SPECIAL SUBCOMMITTEE ON WOMEN, HEALTH,
AND DEVELOPMENT: FINAL REPORT**

OF THE EXECUTIVE COMMITTEE OF THE DIRECTING COUNCIL

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FINAL REPORT

The 17th Meeting of the Special 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 1-2 April 1997.

The meeting was attended by representatives of the following Governments elected by the Executive Committee to membership on the Subcommittee: Bahamas, Chile, Costa Rica, Saint Kitts and Nevis, and United States of America. Observers for Brazil, Canada, Cuba, and Mexico were also present. One intergovernmental organization—the Organization of American States Inter-American Commission of Women—and two nongovernmental organizations—the Latin American and Caribbean Women's Health Network and Women's College Hospital and Research Center of Toronto, Ontario, Canada (a WHO collaborating center)—were represented at the meeting.

OPENING OF THE MEETING

Dr. George A. O. Alleyne (Director of PAHO) opened the meeting and welcomed the participants. He extended a special welcome to the observers and the representatives of the intergovernmental and nongovernmental organizations, pointing out that it had long been the practice of the Subcommittee to encourage everyone—Subcommittee members and non-members alike—to participate fully in the discussions and share their advice and experience. For the benefit of those representatives who were new to the Organization, he briefly outlined the structure of the Governing Bodies and explained how the Subcommittee on Women, Health, and Development fit into that structure. He explained that the Subcommittee was a working party of the Executive Committee and reported to that body. The Executive Committee, in turn, reviewed and made recommendations concerning items to be considered by the Directing Council or, every fourth year, the Pan American Sanitary Conference. Dr. Alleyne noted that the specific functions of the Subcommittee would be discussed further under the agenda item entitled "Future Role of the Special Subcommittee on Women, Health, and Development."

Election of Officers

The following officers were elected:

Chair:	Saint Kitts and Nevis	Dr. Earl Asim Martin
Vice Chair:	Costa Rica	Ms. María Gabriela Castro Páez
Rapporteur:	Chile	Dr. Rene Castro

Dr. Alleyne served as Secretary ex officio, and Dr. Pamela Hartigan (Coordinator, Program on Women, Health, and Development) served as Technical Secretary.

Adoption of the Agenda and Program of Sessions
(Documents MSD171, Rev. 1 and MSD17WP1)

The Subcommittee approved the provisional agenda and a program of sessions.

PRESENTATION AND DISCUSSION OF THE ITEMS

Report on the Activities of the Program on Women, Health, and Development (HDW) at the Regional and Country Levels

(Documents MSD173 and PAHOHDP-HDW97-003)

Dr. Pamela Hartigan (Coordinator, Program on Women, Health, and Development) reviewed the work of the Program during 1996. She drew the Subcommittee's attention, in particular, to the Evaluation of Country Programs, 1996 (Document PAHOHDP-HDW97-003), which outlined all the work done at the country level. The work of the Program had been guided by five expected results. Some of the activities highlighted by Dr. Hartigan in each area are summarized below.

Expected result 1: Increased number of regional- and country-based initiatives to generate, produce, and disseminate research and information on gender differentials in health

Achievements included a consultation on gender and communicable diseases, with the production and circulation of a background paper; design and implementation of a protocol for a multi-country qualitative study on violence against women (this study was discussed in greater detail under Item 8 of the Subcommittee's agenda); mobilization of support from the United States National Institutes of Health for a research initiative to study the interactions between gender, adolescence, and tobacco use; and mobilization of support from the Organization of American States (OAS) for a study aimed at developing profiles of women's health at the country level. In addition, the Program had continued to enhance the information on gender, health, and development in the SIMUS database (Regional Information System on Women, Health, and Development), which currently contained more than 3,500 entries, more than 600 of which had been added in 1996.

Expected result 2: Technical staff at Headquarters and in the field increasingly able to design, execute, monitor, and evaluate projects and programs from a gender perspective

Dr. Hartigan did not give a detailed account of the Program's activities in this area, as the subject of gender sensitization and training was addressed under a separate agenda item. She reported, however, that the evaluations of the gender training workshops conducted thus far had been extremely positive.

Expected result 3: Existence of initiatives at the regional and local levels that promote and strengthen the participation of women in protecting their health and formulation of gender-sensitive policies and programs

A major objective of the Program was to ensure the participation of women in the design, implementation, and evaluation of projects and programs intended to benefit them. Accordingly, the Program had devoted considerable effort and time to the mobilization of resources to support initiatives that allowed for the full participation of women at the country level, seeking, at the same time, to ensure that involving women did not mean utilizing them as a source of low-cost or unpaid labor. Document MSD173 outlined the activities carried out in the various subregions and with various population groups toward that end.

Expected result 4: Strategies developed and made systematic to ensure continuation of interagency collaboration on WHD with organizations of the United Nations system, the inter-American system, multilateral and bilateral organizations, and NGOs that work at the global, regional, and country levels

The Program had carried out a number of activities in collaboration with WHO, in particular the programs on reproductive health, tropical disease research, health and development, and health promotion. HDW had also been instrumental in securing the designation of the Women's College Hospital and Research Center (Toronto, Ontario, Canada) as the first WHO Collaborating Center on women's health in the Western Hemisphere. The Program was collaborating with the OAS on the aforementioned project to develop women's health profiles and with the IDB on several projects to combat violence against women. A number of activities had been carried out with various academic institutions and with NGOs, including the Latin American and Caribbean Women's Health Network, the Health and Development Policy Project, and the International Coalition for Women's Health.

Expected result 5: Program management and interprogrammatic coordination strengthened so as to increase capacity to deliver, monitor, and evaluate technical cooperation in health

The Program had continued to strengthen ties between its regional staff and focal points in the countries and between HDW and other technical programs at Headquarters. The third annual meeting of HDW focal points from the countries had been held. At the regional level, the Program was collaborating with every division within the Organization. Dr. Hartigan cited, in particular, the joint initiative between HDW and the Program on Healthy Lifestyles and Mental Health (HPP) to organize an event for World Mental Health Day in September 1996.

The Program had achieved the vast majority of the objectives established for 1996. Its failure to fully achieve a few objectives had been related to shortages of resources, both financial and human, but especially the latter. The Program's major achievements in 1996 had been mobilization of extrabudgetary funding for a variety of projects, direct technical cooperation, and dissemination of information. Dr. Hartigan emphasized that the Program's overriding objective was to promote the incorporation of a gender perspective into health and human development programs and projects and that doing so meant looking at development through a "gender lens" in order to understand how the health and development of both men and women in the countries was differentially affected by gender. She concluded by thanking her colleagues and, especially, the Director of PAHO, without whose support the Program's achievements would not have been possible.

The Subcommittee commended the Program staff for accomplishing a considerable amount of work in 1996, despite serious human resource limitations. The Program's achievements in mobilizing resources and working with NGOs and other organizations were considered particularly praiseworthy. Several questions were asked about how the Program's activities had been received in the countries; about the criteria by which the Program selected activities to work on, given the extremely broad range of issues affecting women and their health; and about the extent to which the availability of funds from donors affected that selection.

A representative from the English-speaking Caribbean subregion pointed out that the Program's activities had focused mainly on Latin America and encouraged HDW to increase its efforts to help the Caribbean countries address the issues relating to gender, health, and development that were of particular concern to them. Specifically, in the area of gender training, she suggested that the Program endeavor to train a group of trainers in the Caribbean who could tailor the message to the sociocultural characteristics of each country. Another representative observed that the focus of the program seemed to have shifted from a focus on women's health needs to a focus on gender and asked how the gender perspective could be reconciled with the "women's perspective," which sought to rectify the disadvantages women faced in society.

Dr. Hartigan emphasized that the Program would never abandon the "women's perspective" and would continue to focus on women's health issues. However, by incorporating a gender perspective, the Program was seeking to identify the factors and power relationships that led to social and health inequities between men and women simply because of sex. Hence, the gender perspective represented not so much a change as an expansion in focus. With regard to the criteria for selection of activities, she said that each year the Program, in consultation with the focal points in the countries, assessed the needs of the countries and tried to determine which of those needs it could most effectively address. Because the Program depended largely on extrabudgetary resources, the availability of resources for certain activities influenced the selection, but it was by no means the sole criterion. The Program also employed a criterion of Pan Americanism*C*i.e., it selected activities, such as violence against women, in which a regional overview and a regional approach could help individual countries to deal with issues affecting women's health.

In response to the representative from the English-speaking Caribbean, she pointed out that the gender training had begun in the Caribbean and the gender training manual currently being used by the Program had initially been tested in that subregion. She acknowledged that the Program was not as actively involved in other areas in the countries of the English-speaking Caribbean, in large part because there were no focal points for WHD, due to human resource limitations in the PAHOWHO Representative Offices in those countries. She encouraged the Caribbean countries to work with the Program to determine how it could best help them to address their needs.

The Director added that, at the outset, the Program had been concerned largely with the biological determinants of women's health, but its conceptual framework had expanded to include consideration of the gender-related factors that had a negative impact on women's health and human development. The Program sought to develop tools to help the countries to deal with the latter, since the health sector had developed fairly good tools for dealing with women's

health issues that derived from biological factors, but it had very poor tools for addressing those that derived from gender constructs. With regard to the criteria that guided the selection of Program activities, he stressed that the Organization's priorities were established by the Governing Bodies and expressed in the strategic and programmatic orientations. Activities were selected on the basis of those priorities and not on the basis of the interests of external donors.

Gender Equity in Health Care Reform **(Document MSD176)**

Dr. Elsa Gómez (Advisor, HDW) described a proposal formulated by the HDW Program for the development of a regional electronic discussion network on the subject of gender equity in health and social security policies. The proposal was made in response to a recommendation of the 16th Meeting of the Special Subcommittee on Women, Health, and Development, which had encouraged the Program to develop mechanisms to promote the sharing of experiences at the national and international levels regarding the impact of health sector reform on gender inequities and to seek to incorporate a gender perspective in analysis and discussion of health reform. The main points made by Dr. Gómez in her presentation are summarized below:

- Women had been disproportionately affected by the cutbacks in health services and resources that occurred in the context of macroeconomic structural adjustment during the 1980s. This was due, inter alia, to the fact that women were also disproportionately represented among the poor, who had felt the impact of those measures most severely; women had a comparatively greater need for care because they experienced more morbidity during their lifetimes and because of their greater reproductive health needs; and women, in their social role as the caretakers of their families and communities, had been obliged to assume responsibility for providing care previously offered by public services.
- Women's access to health benefits provided under social security and private insurance systems was limited, either because they were not gainfully employed or they had low-paying or part-time jobs, with few or no benefits. Moreover, women's participation in the labor market tended to be an extension of their domestic and reproductive work (i.e., caring for others), which led to undervaluation of their activities in terms of both pay and social prestige. Hence, the gender biases that women faced in health care were a reflection of the gender biases inherent in economic systems in which only "productive" work was remunerated, while "reproductive" work, including all the activities needed to reproduce and maintain the labor force, went largely unremunerated.
- In the health reform efforts currently under way in many countries, the impact that proposed strategies might have on certain social groups was not always being critically analyzed. Some strategies, particularly those that sought to reduce costs and improve efficiency, might have an inherent gender bias.
- The proposed network would seek to detect such gender biases in existing policies and in proposals for health sector reform; identify the magnitude, trends, determinants, and consequences of gender inequities; systematize and effectively communicate relevant

information for policy-making; and develop mechanisms and methodologies for monitoring the impact of health sector reform on gender equity.

- The concept of equity in the context of health care reform did not mean equal distribution of services and resources, but rather responding to the differential needs of different population groups, with the groups that had greater needs receiving a larger proportion of services and resources.

In the Subcommittee's discussion of this item, it was noted that recognition of the social value of reproduction was lacking in many countries, as a result of which women of childbearing age were in effect penalized through higher insurance premiums and personal expenditure on health care for their reproductive potential. It was also pointed out that incorporating a gender perspective into public policies would require the collaboration of sectors other than the health sector. In addition, the need to analyze the social and economic determinants of women's health was underscored.

With regard to the proposed electronic discussion network, it was pointed out that some countries had existing databases and clearinghouses on women's health, which might be utilized in developing the network. It was also emphasized that maintenance of the network, after its initial implementation, was crucial. Questions were asked regarding the nature of the network and whether it would function more as a database or as a tool for discussion and exchange. One representative inquired who the network's interlocutors in the countries would be and suggested that one entity should be designated in each country to consolidate all the information gathered at the national level before it was disseminated on the network. Another stressed the need to build into the system mechanisms to allow for feedback from the grassroots level. Several representatives observed that access to electronic communications media was not readily accessible in many areas and emphasized the need to find alternative means of communicating with communities and groups in such areas. The possibility of obtaining donations of used computer equipment from corporations and other sources was suggested. Finally, it was pointed out that the network could be a useful instrument for raising public awareness of the commitments made by the governments in international summits on women's issues, such as those held in Cairo and Beijing, and a means of empowering women to insist that those commitments be respected.

Dr. Gómez agreed that failure to recognize the social value of reproduction was at the root of much of the gender discrimination that existed in current health systems and insurance schemes, in which most of the costs of reproduction were borne individually by women rather than collectively by society. She emphasized that the Program was quite aware that intersectoral effort would be required for the development of public policies that incorporated a gender perspective and pointed out that the interlocutors for the network would therefore have to come from different sectors, including not only the WHD focal points in the countries and contacts from other governmental sectors, but also NGOs and academic institutions.

The Program was also cognizant of the need to maintain the network and of the investment of time and money that this task would entail. In reply to the questions concerning the nature of the network, she said that it was intended to provide a broad forum for discussion

utilizing the Internet. Anyone who had access to e-mail would be able to participate in exchanges of experience and discussions on the topic of gender equity in health sector reform. Eventually, it would be desirable to bring people together physically to examine the issue, but much of the preliminary discussion leading up to such a meeting could take place through the network, which would reduce costs and allow for broader participation. The lack of hardware and access to electronic communications technology in some countries was indeed a problem, which the Program would seek to address by obtaining external funding or in-kind donations. Initially, however, it would be possible for the network to begin functioning with the equipment available in each of the PAHOWHO Representative Offices, which would allow all the countries to participate to some extent.

Responding to the comments regarding the social and economic determinants of health, Dr. Hartigan noted that analysis of the links between living conditions and health status was a major focus of the Program and of the entire Division of Health and Human Development.

The Director said that, ultimately, the purpose of the network would be to explore ways of ensuring equity in health care systems. Equity was essentially a question of fairness, which meant that those who needed more care—women, in this case—should receive it. The discussions on the network would be aimed at determining whether health sector reform, as it was being proposed in the countries, would perpetuate or ameliorate the gender discrimination inherent in current health care systems. However, in order to evaluate whether or not proposed health reform measures would promote greater gender equity, it was necessary to first collect sufficient information to reveal where the inequities in the present system lay.

Dr. Alleyne also pointed out that some health care reform proposals could be expected to decrease the burden borne by women. At present, approximately 75%-90% of all care was provided in the home, mainly by women; however, inasmuch as some reform proposals would shift responsibility for part of the care currently being given in the home to the professional realm, the burden on women might be alleviated. A separate issue from the distribution of care, however, was the value placed on that care. Care provided by women was generally less valued than that provided by health professionals, which he felt was one of the most pernicious aspects of gender discrimination.

Finally, he expressed the hope that the network would maintain a well-defined focus on how gender equity would be affected by health care reform, noting that one of the risks of an electronic network of this type was that the information input into the system might not be entirely relevant to the issue being examined, or the volume of information might be so great that it would be impossible to draw any clear conclusions from it.

Violence against Women and Girls: The Conceptual Framework being Operationalized in Ten Countries

(Document MSD177)

Dr. Hartigan introduced this item. Rather than summarizing the document, which provided an account of HDW's activities in the context of an initiative to address the problem of domestic violence against women and girls, she elected to read excerpts from an article she had

written, which described some of the experiences she and other Program staff had had in the course of the initiative. The article, entitled “He Loves Me, He Loves Me Not: Insisting that the Private Become Public in Dealing with Domestic Violence,” was to appear in *Ms.* magazine, a magazine published in the United States which deals with women’s issues. Highlights from Dr. Hartigan’s presentation are summarized below:

- Though reliable data on the prevalence of domestic violence in Latin America and the Caribbean were not readily available, nine valid population-based quantitative studies in those two subregions indicated that approximately 20%-60% of women were victims of violence by their partners or ex-partners. On average 50%-60% of women who experienced physical violence from their partners were also sexually abused by them. Still, the true extent of the problem was not known because so many cases of domestic violence went unreported.

- The aim of the HDW initiative was to create coordinated community responses to domestic violence in which all local organizations would come together to fashion and implement a community network to address the complex problem of gender-based violence within the family. Diagnostic assessments would be conducted among women who sought help from the network to determine what path women victims of violence pursued when they decided to seek help, what persons or institutions they sought out, and what response they received. This information would help to pinpoint the areas in which the institutional response needed to be strengthened.

- In the strongly patriarchal culture of most Latin American countries, violence against women tended to be socially accepted. These attitudes carried over into the health system, as a result of which violence was often not accorded the attention it deserved as a serious public health problem.

- Nevertheless, thanks to the efforts of women’s groups in Latin America and the Caribbean, domestic violence as a public health issue was gaining increasing attention. There was growing awareness among public officials and community leaders that domestic violence was a problem with serious ramifications for human development. Nevertheless, in many communities and among many women, it remained a taboo subject. The initiative had illustrated the need to move this private problem into the public arena in order to change attitudes that condoned violence against women and girls.

The Subcommittee commended Dr. Hartigan for her article, which vividly depicted the problem of domestic violence and also showed how the activities of the Program were having a direct impact on lives of women in the Region. It was pointed out that violence against women was a problem with very deep cultural roots and that bringing about a change in attitudes that considered violence socially acceptable would be a lengthy process. Several representatives described efforts underway in their countries to address the problem of violence. These included the establishment of hotlines and shelters for battered women, clearinghouses on family violence, legal reforms, and multisectoral strategies for coordinated community action. Another approach mentioned was to attempt to detect cases of battering or abuse among women in other health care settings, such as drug and alcohol treatment centers.

It was pointed out that special training was required to sensitize health care providers to the problem and enable them to recognize and diagnose it. Special training should also be provided to personnel in the legal, judicial, and law enforcement sectors who were likely to come into contact with women and girls who had been victims of violence. The potential advantages—in terms of cost and increased availability of human resources—of training para-professional or auxiliary health personnel to work with the victims of violence were noted. One representative, citing a study which had shown that a majority of physicians did not perceive violence as a health problem but as a social problem, suggested that auxiliary personnel might be in a better position to deal with women who were victims of violence because they could relate more closely to them.

Dr. Hartigan observed that one of the most depressing aspects of the problem of violence was that change seemed so slow in coming. Even in countries such as the United States and Canada, where public and private agencies had been struggling for decades to raise awareness of the issue and reduce cultural acceptance of violence against women, the problem remained alarmingly prevalent. Nevertheless, the existence of success stories at the local level constituted proof that violence against women could be stopped. The HDW initiative was therefore focusing on the local level in order to promote a gradual change in attitudes. The aim was to lower the threshold of social tolerance for violence to the point that it became absolutely unacceptable.

The Director said that he had come to the conclusion that no progress would be made toward surmounting the problem as long as it continued to be viewed as a women's issue. In fact, it was a manifestation of the power relationships that existed in society, and it was not possible to change those relationships by addressing only one side of the equation. It had to be understood that violence against women demeaned all of society. As a health agency, one of the things that PAHO could do was to attempt to determine the epidemiology of the problem and identify appropriate points of intervention. Another thing the Organization could do was to work locally, as Dr. Hartigan had said, and persuade people that tolerance of such aberrant behaviors was detrimental to the health of the community as a whole.

Future Role of the Special Subcommittee on Women, Health, and Development (Document MSD179)

Dr. Hartigan said that, in order to allow as much time as possible for discussion, she would refrain from summarizing the document, which traced the history of the Special Subcommittee on Women, Health, and Development and presented the reasons why the Secretariat believed that the time had come to review the nature and functions of the Subcommittee and consider whether its continued existence was warranted and, if so, whether the way in which it functioned should be modified. She emphasized that the Secretariat's proposal to reexamine the purposes of the Subcommittee was made in a constructive spirit which sought to find the most effective ways to meet the daunting challenge of furthering gender equity in health. The Subcommittee was asked to discuss the issues raised in the document and make a recommendation to the Executive Committee regarding what the future role of the Subcommittee, if any, should be. The document presented four possible alternatives, which were not mutually exclusive.

The Director pointed out that, since the Subcommittee was first established in 1980 to examine the World Plan of Action on Women, its terms of reference had been extremely vague. In light of the changes that had taken place since then in the Program on Women, Health, and Development and in the Organization as a whole, it had been decided that the terms of reference of the Subcommittee should be revised and more clearly delineated. Accordingly, the 16th Meeting of the Subcommittee had formulated terms of reference and submitted them to the Executive Committee for consideration and approval at its meeting in June 1996. At that time, he had raised the question of whether it continued to be necessary to have a special subcommittee of the Governing Bodies to review the activities of the Program on Women, Health, and Development. He had raised that question for several reasons, namely:

- HDW had become a regular program of technical cooperation within the Division of Health and Human Development, which reflected the fact that women's health was now seen as a development issue that concerned everyone—men and women alike. That being the case, was it necessary to have a special subcommittee to examine the activities of the Program on a yearly basis?

- Other mechanisms existed for periodically reviewing the activities of the Organization's technical cooperation programs. The Subcommittee on Planning and Programming and the Executive Committee routinely examined reports from the other technical cooperation programs, as did the Directing Council, though less frequently. In addition, the Interprogrammatic Working Group on Women, Gender, and Health had recently been created within the Secretariat to review the work of the Program and formulate recommendations to the Director concerning ways in which a gender perspective could be incorporated more effectively into the work of the various technical cooperation programs.

- In years past, one of the major areas of concern for the Subcommittee had been the status of women in PAHO. However, substantial advances had been made in recruiting women to professional posts, and the trend toward greater participation of women at all levels of the Organization was irreversible. Hence, there no longer appeared to be a need for a supervisory body to monitor the Organization's efforts in this area. Moreover, an internal advisory mechanism—the Director's Advisory Committee on Women—existed for the express purpose of expanding the role of women and promoting gender equity within PAHO.

Dr. Alleyne acknowledged that technical input might be needed in the area of women, health, and development; however, he felt that a special subcommittee of the Governing Bodies might not be the best means for providing such technical input. Rather, it might be preferable to periodically convene groups of experts to examine specific issues and make recommendations.

He concluded by emphasizing that his suggestion that the Executive Committee consider eliminating the Subcommittee had not been made lightly or without due consideration. He was simply seeking ways of helping the Organization to function more effectively.

The participants unanimously commended the Director and his administration for their willingness to adapt to changing circumstances and their desire to make the Organization more

effective, particularly in the current context of constrained resources. Nevertheless, there was clear consensus that the Subcommittee should continue to exist. It was acknowledged that the Secretariat had put in place adequate mechanisms to monitor the work of the Program on Women, Health, and Development, but oversight of the Program was not viewed as the primary function of the Subcommittee. Many of the representatives pointed out that, in addition to its technical advisory role, the Subcommittee played an important political role, inasmuch as it helped to maintain the visibility of and commitment to issues relating to women's health and gender equity at the national level. This was considered especially important in view of the frequent changes in political leadership in many countries.

Several representatives emphasized the catalytic nature of the Subcommittee's work, noting that the members continued to promote awareness of and attention to gender issues upon their return to their respective countries and subregions. It was felt that the countries' participation in the Subcommittee ensured greater political support from national authorities for activities relating to the work of the Program on Women, Health, and Development. It was also pointed out that PAHO enjoyed a great deal of respect and credibility among the countries, which looked to it for leadership in this area, and that eliminating the Subcommittee might send the incorrect message that women's health and gender equity were no longer priorities for the Organization.

Various representatives commented that, while considerable progress had been made toward achieving equity for women and meeting their specific health needs, much remained to be done. They viewed the continued existence of the Subcommittee as essential in order to both maintain the gains made thus far and continue to advance toward gender equity. The Subcommittee also provided a venue for the countries to come together to exchange views and share information and experiences. This type of face-to-face contact was considered indispensable, and for this reason most representatives rejected the idea of replacing the Subcommittee meetings with electronic discussions, as proposed in Alternative 2 in Document MSD179.

Nevertheless, it was generally agreed that the way in which the Subcommittee worked could be modified in order to make it a more dynamic forum for exchange. The majority of representatives felt that the Subcommittee could function more effectively by adopting a combination of elements from Alternatives 2, 3, and 4, described in the document. In this way, the countries and the other PAHO technical programs would have greater responsibility for selecting and preparing documents on topics related to women, gender, health, and development to be examined by the Subcommittee. Several representatives also suggested that costs could be reduced by convening Subcommittee meetings biennially instead of annually. In the interim between meetings, countries and the Program could maintain an electronic dialogue on issues of interest via the Internet, although it was again noted that access to electronic communications was not equally available in all countries.

The Director thanked the representatives for their constructive comments regarding the Subcommittee's future role. He acknowledged that the consensus was that the Subcommittee should continue and assured the representatives that their views would be transmitted faithfully to the Executive Committee. He emphasized, however, that the continuation of the

Subcommittee should not be regarded as a victory for women, as that was not the spirit in which the Organization worked in the area of women, health, and development. Rather, PAHO was committed to the achievement of gender equity because it was important to human health and human development.

In view of the consensus, the Director invited the Subcommittee to reconsider the draft terms of reference developed at the Subcommittee's 16th Meeting (Document MSD179, Annex A) and determine if they should be modified in any way before they were submitted to the Executive Committee for approval. He pointed out that changes in the Subcommittee's form of work—such as the incorporation of some elements of Alternatives 2, 3, and 4, as suggested by the Subcommittee—did not need to be included in the terms of reference.

After discussion, the Subcommittee decided to recommend that the Executive Committee adopt the revised terms of reference). The principal changes introduced by the Subcommittee are summarized below:

- Function 2.1.1, which had been to advise the Executive Committee regarding the Program on Women, Health, and Development, was broadened to include all of the Organization's technical cooperation programs. The revised draft reads: "To advise the Executive Committee regarding . . . PAHO's leadership and technical cooperation in women's health."
- It was proposed that the membership of the Subcommittee be increased from five to six in order to promote a richer dialogue through greater diversity of ideas, and Section 3.1 was changed accordingly.
- It was proposed that the Subcommittee meet every two years rather than every year, and Section 4 was changed accordingly. If this proposal is accepted by the Executive Committee, the Subcommittee would also report to the Committee every two years, rather than annually.

There was considerable discussion regarding the Spanish translation of the word "empowerment," which appears in Section 2.1.4. It was ultimately decided that the word *empoderamiento* should be retained because, although it is a neologism, it is widely used and understood among those who work in the area of women's and gender issues in Latin America.

Update on the Process of Gender Sensitization for PAHO Staff **(Documents MSD174 and PAHOHDW97-002)**

Dr. Hartigan updated the Subcommittee on the gender training workshops that had been conducted in various countries of the Region during 1996. She reported that the Program had carried out 20 workshops with very positive results, as was reflected in the participant evaluations summarized in Document PAHOHDW97-002. One of the principal aims of the workshops, in addition to helping the participants to understand how gender differentials influenced health, was to give PAHO staff a sense of how the incorporation of a gender

perspective could improve the Organization's technical cooperation and contribute to the achievement of equity in health and human development. The facilitator's manual, copies of which were distributed to the Subcommittee, therefore included a number of practical exercises, designed to give the participants hands-on experience with the application of a gender perspective in their work.

Although the Program was pleased with what had been accomplished thus far in providing gender training to PAHO staff, it recognized that there were several significant challenges to be addressed in the future. One was the need to tailor the gender training to the needs of specific program areas and to the social and cultural characteristics of different countries or subregions. Another was to adapt the training to the needs of PAHO staff at Headquarters. The current training workshops were geared toward the practical needs of staff in the countries, but the staff at Headquarters tended to be more concerned with theoretical and policy issues, so a different approach was needed to enable them to apply the gender perspective in their work. The Program also needed to train additional facilitators to meet the growing demand for gender training in the countries. To that end, a "training-of-trainers" workshop for the WHD focal points would be held in August 1997.

Dr. Hartigan concluded by acknowledging the contribution of the Inter-American Commission of Women (OAS), which had provided support for publication of the facilitator's manual.

The Subcommittee encouraged the Program to continue and to accelerate its gender training activities, as well as its efforts to develop tools to facilitate gender analysis, which was viewed as essential for the development of policies and programs that responded to the different needs of men and women. It was pointed out that incorporating the gender perspective meant recognizing the social dimension of the health/disease process, which in turn signified a profound change in the way many health professionals were accustomed to thinking. Several questions were asked about how the training might be adapted for use in health care systems to enable health care providers to apply a gender approach in their interaction with patients and to help patients understand how gender differentials affected their health and how gender biases in the health care system influenced the way they interacted with providers and affected the care they received. Other questions were asked about the content of the training workshop for WHD focal points and the way in which the Program was approaching the challenge of adapting gender training to the needs of specific program areas.

Dr. Hartigan said that, as a first step toward adapting the training to specific areas of technical cooperation, the Program was in the process of compiling a conceptual document on the links between the environment, gender, and health, with a view to helping the staff of the Division of Health and Environment to apply the gender perspective to their work. A similar effort had been undertaken in the area of communicable diseases. With regard to the application of gender training in health care systems, she noted that the Program had recently adapted and begun testing in the Region a workshop entitled "Health Workers for Change," which had been developed by the Special Program for Research and Training in Tropical Diseases of WHO. The workshop was aimed at sensitizing health care workers to gender-specific needs. More information about this initiative was available in Document MSD175. As for the training

workshop for WHD focal points, she explained that its purpose would be to discuss facilitation techniques and methodologies with the focal points and explore with them how they, as facilitators, could utilize the training manual most effectively.

The Director said that, by strengthening the focal points' ability to provide gender training, the Organization was endeavoring to create "waves" or generate a multiplier effect at the national level, so that eventually the gender approach would permeate all aspects of health sector activity in the countries. He emphasized that the facilitator's manual constituted a solid basis for gender training, although it would of course be adapted and refined over time, incorporating the experience gained in conducting the workshops. He also pointed out that one of the main reasons that the gender training workshops in the countries had been so successful was that the Program had been able to convince the participants of the usefulness of the gender approach for their work, which was essential, since people were not likely to accept new approaches if they could see no practical applications for them. Finally, he reiterated the Organization's commitment to gender sensitization for staff at all levels and to the incorporation of the gender perspective in all aspects of PAHO technical cooperation.

Update on the Quality of Care Project and Presentation of the Results of the Operational Research Phase

(Document MSD175)

Ms. Patricia Pittman (Consultant on Women, Health, and Development) reported on a study underway in Argentina and Peru, which had been presented previously to the Subcommittee at its 16th Meeting. The study sought to identify gender-specific needs of men and women health service users in the health care process and to determine how these needs were being addressed by health care workers in primary health care settings. The study had focused on patients suffering from two chronic conditions: hypertension and type-II diabetes. The research had looked at gender-based differences in four main areas: (1) the capacity for self-care, including men's and women's perceptions of the determinants of their illness and their motivations for caring for their health; (2) access to services, including factors that motivated men and women to seek care and to comply with treatment regimens; (3) communicative interaction during the medical visit, including men's and women's experience of communication with and maltreatment by health care providers; and (4) curative factors, including "missed opportunities" due to failure to take account of gender-based differences. Ms. Pittman provided numerous examples of findings from the operational phase of the study that illustrated the major differences that existed in the ways men and women interacted with health care providers and in their perceptions regarding their illnesses and the care they received.

The principal achievements of the project to date were the following:

- A new methodology had been developed and tested.
- The importance of taking account of gender in evaluations of the quality of care had been demonstrated.

- Several elements had been found that revealed the androcentric nature of the health care model.
- The study had yielded valuable information for the identification of elements of the social construct of gender that had a negative impact on prevention, protection, and self-care of health.
- The study had also yielded information that made it possible to identify gender-related problems in the quality of care and to see how the interaction of health care providers with men and with women might have a negative or positive impact on health outcomes.

Ms. Pittman cautioned that the results of the study could not be extrapolated, as they were specific to the place and time in which the research had been conducted. The second phase of the study would focus on the design and testing of a simple, rapid, low-cost assessment protocol that could be applied in other places. The final phase would utilize the information obtained from the first two phases to develop and test in-service training guidelines for health care professionals, incorporating a gender perspective.

Dr. Hartigan gave a brief account of the history of the study, which had grown out of an effort by the Program to develop a methodology that would provide solid proof of the gender inequities that were known to exist in health services. The Program had initially sought to develop indicators to measure gender inequity, but it had become apparent that those indicators measured inequality, not inequity. She emphasized that the point of the gender approach was not to achieve equal treatment for men and women but rather equitable treatment, which meant responding to their gender-specific needs. The Program had therefore directed its efforts toward the development of a qualitative methodology that would make it possible to measure gender inequities with the greatest possible degree of objectivity. Although the study did have certain limitations, she considered that the methodology and many of the findings were largely applicable to other contexts.

The Subcommittee felt that the results of the study had enormous potential value for improving the quality of the health care provided to both men and women in the Region through the application of a gender approach. Various representatives pointed out that studies of this type could make an important contribution to health reform efforts and to the education and training of health care providers. In this connection, it was also pointed out that in health services there was generally a vertical, authoritarian structure of power, in which physicians were dominant, not only in the provider-patient relationship but also in relationships with other health care personnel, the majority of whom were women. A number of questions were asked regarding specific aspects of the methodology, about the cost of the study, and about the feasibility of adapting the methodology for use in other places. One representative pointed out that body language could be very revealing of attitudes and asked whether it had been taken into account in the analysis of patient-provider interactions. Another noted that, in Ms. Pittman's presentation to the Subcommittee the previous year, she had mentioned that adolescent pregnancy was one of the conditions on which the study would focus and inquired whether that was still the case.

Ms. Pittman said that, ideally, the study would have looked at non-verbal as well verbal

language. However, in order to do so, it would have been necessary to videotape or take photographs of the interviews, which had been considered too intrusive. With regard to the question concerning adolescent pregnancy, she explained that it had been the subject of a separate study using the same protocol. The results of that study were not yet available. She agreed that one of the areas in which the study findings could be applied most effectively was in the enhancement of medical curricula and pointed out that the third phase of the study would be devoted to the development of training guidelines for health care professionals.

Dr. Hartigan said that the first phase of the study had been quite costly because it had entailed all the initial costs of developing the methodology, plus the cost of analyzing every interview, which was extremely time-consuming and therefore expensive. In the second phase, the Program planned to develop a much faster, lower-cost methodology that could be applied in a variety of settings.

At the request of Dr. Hartigan, Dr. Daniel López Acuña (Director, Division of Health Systems and Services Development) outlined some of the ways in which the findings of this type of study might be incorporated into health reform processes. He pointed out that a component of health sector reform in most countries was the development of a health care model that would better respond to the needs of all persons, including both their subjective needs and their technically defined, objective needs. Studies such as this one would be extremely helpful in identifying subjective needs and in analyzing them from the perspective of gender constructs. Another very important element of health care reform was quality of care. At present, most quality assessments focused primarily on technical quality, with little attention to perceived quality. This study provided a method for measuring perceived quality. Finally, the findings of the study would be useful for incorporating a gender perspective into the training of health workers, which was another aspect of health care reform.

Lessons Learned in Working with Indigenous Women and Health: The Experience in Guatemala

Less (Document MSD178)

Dr. Lily Caravantes (Focal Point for HDW, Guatemala) described a project being carried out among Mayan women in Guatemala. Through the application of both a gender perspective and an ethnic perspective, the project sought to achieve the following objectives: (1) to promote the participation of indigenous women in order to empower them and foster in them an awareness of the importance of caring for their health; (2) to establish a basis for interaction between indigenous women and health services; (3) to transform the services based on the experience and knowledge acquired through the project. Dr. Caravantes gave a brief account of how the project had evolved since its inception in 1991 and of the political and institutional obstacles that had been encountered. She also related a number of the lessons that had been learned regarding how gender identities and gender discrimination were manifested in the indigenous population, how both gender biases and ethnic biases conditioned health problems, how indigenous women perceived health and health needs, and how health services needed to adapt to meet the needs of these women.

Through the project, significant strides had been made toward empowering and increasing the autonomy of the indigenous women, raising their awareness of their gender status and its effects on their health, promoting self-care, and increasing their involvement in health promotion and health care activities. In addition, the project had promoted greater intercultural understanding by increasing gender identity among indigenous and non-indigenous women, and it had fostered greater acceptance of indigenous ideas and practices through the incorporation in health services of elements of traditional medicine, such as use of medicinal plants.

A number of recommendations had come out of the project. Some of those mentioned by Dr. Caravantes were:

- Indigenous women should be involved in all phases of projects designed to benefit them.
- Health projects aimed at indigenous women should include educational and occupational components, since illiteracy and unemployment are seen as determinants of health status in the indigenous population.
- Transformation of health services to better meet the needs of indigenous women should begin immediately; there is no need to wait for the results of more in-depth research, as the project has yielded sufficient information about the ethnic- and gender-based discrimination faced by indigenous women to permit the introduction of changes that will enhance the provision of health services to these women.
- The lessons learned at the local level through this project should be applied in the formulation of public policies at the national level.

Dr. Juan Antonio Casas (Director, Division of Health and Human Development and former PAHOWHO Representative in Guatemala) underscored the difficulty of the historical and political context in which the project had been carried out. The history of Guatemala was to a large extent the history of the conflict between ethnic groups, and no human development project could be carried out in the country without confronting the ethnic issue. Ethnic friction had been a serious obstacle in the case of this project, as had the country's volatile political situation. Its success was largely due to the courage and perseverance of Dr. Caravantes and her colleagues. Dr. Casas also acknowledged the invaluable support that had been provided for the project by the Nordic countries.

The Subcommittee commended Dr. Caravantes for her extremely informative presentation. The project was considered an outstanding example of PAHO's technical cooperation in the area of women, health, and development. Several representatives noted that the lessons learned could be applied in other countries that had indigenous populations and inquired about the possibilities for the execution of similar projects in other countries or the exchange of experiences between countries. It was also pointed out that some of the methods used and the knowledge gained from this project might be useful in tailoring health services to the needs of migrant groups. Several questions were asked regarding future plans under the project, in particular with respect to leadership development among indigenous women and the

creation of a women's forum, which was mentioned in the document.

Dr. Caravantes said that the project team had felt that the project could be greatly enriched through exchanges with people who had similar concerns or were involved in similar projects in other countries, but because of resource limitations it had not been possible to carry out such international exchanges. Exchanges had been promoted between the two groups of Mayas involved in the project (K'iché and Kaqchikel), although this had posed a challenge because there had traditionally been a great deal of animosity between the two groups. However, by focusing on the commonalities among the women it had been possible to foster a sense of unity and persuade them to work together. The gender approach had thus been shown to be an effective vehicle for bridging the gap between women from different ethnic groups.

As for future activities, she noted that a third phase of the project was planned for the period 1998-2000. During that phase, there would be continued effort to strengthen the indigenous women's councils, which served as the liaison between indigenous women and the staff of health services, and to test methodologies being developed in the framework of the project. With regard to the women's forum, she said that, under the peace accord signed in late 1996, a forum was to be created to advance the interests of women in Guatemala. It was hoped that it would be a pluralistic forum with significant participation by indigenous women.

Dr. Hartigan observed that a crucial element in the project's success had been the willingness of Dr. Caravantes and other project personnel to incorporate into the project activities that met the needs identified by the women themselves, even when those activities fell outside the normal scope of a health project. It had meant, for example, including activities to teach reading, since illiteracy had been identified by the women as a factor that had a negative impact on their health. She also noted that discussions were under way to determine how a similar multicountry project might be developed in the framework of PAHO's Health of Indigenous Peoples (SAPIA) Initiative.

Other Matters

The Subcommittee discussed a number of topics that might be examined at its next meeting. It was decided that, in keeping with Alternative 3 presented in Document MSD179, rather than looking at a multiplicity of topics, the Subcommittee would focus on a single topic and that the Members would participate in preparing the papers on that topic.

The topic selected as the focus for the next meeting was "development of public policies that have an impact on women, health, and development." This topic was chosen because it was considered the most suitable for the presentation of case studies on the development of successful policies in the various countries.

Presentation of Recommendations of the Subcommittee to the Director of the Pan American Health

The Subcommittee presented the following recommendations to the Director:

RECOMMENDATIONS

In its capacity as an advisory subcommittee of the Executive Committee, the Subcommittee on Women, Health and Development recommends to the Executive Committee that it consider the following actions:

1. Take note of the report of the 17th Meeting of the Subcommittee on Women, Health and Development.
2. Update the terms of reference of the Subcommittee, taking into consideration the proposal submitted by the Subcommittee.
3. Formulate specific recommendations to the Member States and/or the Director of PAHO, through the Directing Council, as follows:
 - (a) To the Member States, that they:
 - Promote the incorporation of a gender perspective in the planning, programming and evaluation of health policies and programs, with particular emphasis on processes under way in health reform.
 - Support the development and execution of the Inter-American Conference on Gender Equity in Health Policies, an electronic regional discussion network.
 - Stimulate actions designed to strengthen the capacity of the health sector to detect and refer cases of domestic violence against women and promote intersectoral activities with other agencies that are involved in dealing with this social problem.
 - Incorporate a gender perspective in the evaluation of quality of health service delivery.
 - Familiarize themselves with the experience in promoting indigenous women's health in Guatemala, particularly those countries with indigenous populations, and seek mechanisms to put in place initiatives, jointly designed and carried out with indigenous groups, that improve the health situation of indigenous communities.
 - Develop and support activities designed to incorporate a gender perspective in the formation and training of human resources working in health that takes into account the socioemotional dimension of the provider-client relationship and recognizes the importance of respect for cultural diversity.
 - (b) To the Director of PAHO that he:

(b) To the Director of PAHO that he:

- Continue and expand the project on gender equity in health care services to other countries of the Region.
- Expand the project on Indigenous Women's Health in Guatemala to other countries with indigenous populations.
- Continue efforts to incorporate a gender perspective in the programs of technical cooperation of the Organization.

The Director thanked the Subcommittee for producing a set of sound recommendations that recognized which activities could be carried out by the Secretariat and which activities fell within the exclusive purview of the countries. He considered the recommendations to the Secretariat to be perfectly feasible and assured the representatives that they would be carried out to the fullest possible extent. As for the recommendations to the countries, the Organization would endeavor to encourage their implementation whenever possible as part of its technical cooperation. He urged all the representatives to also serve as advocates for action in the area of women, health, and development in their respective countries. In conclusion, he reiterated his personal commitment and that of the entire Organization to the incorporation of a gender perspective into all aspects of PAHO's work.

Annex A: AGENDA

	<i>Document No.</i>
1. Opening of the Meeting	
2. Election of the Chair, Vice Chair, and Rapporteur	
3. Adoption of the Agenda and Program of Sessions	MSD171, Rev. 1 and MSD17WP1
4. Report on the Activities of the Program on Women, Health, and Development at the Regional and Country Levels	MSD173
5. Update on the Process of Gender Sensitization for PAHO Staff	MSD174
6. Update on the Quality of Care Project and Presentation of the Results of the Operational Research Phase	MSD175
7. Gender Equity in Health Care Reform	MSD176
8. Violence against Women and Girls: The Conceptual Framework being Operationalized in Ten Countries	MSD177
9. Lessons Learned in Working with Indigenous Women and Health: The Experience in Guatemala	MSD178
10. Future Role of the Special Subcommittee on Women, Health, and Development	MSD179
	11. Other Matters

Annex B: LIST OF DOCUMENTS

Working Documents

MSD171, Rev. 1 Agenda

MSD17WP1 Provisional Program of Sessions

MSD172, Rev. 1 List of Participants

MSD173 Report on the Activities of the Program on Women, Health, and Development at the Regional and Country Levels

MSD174 Update on the Process of Gender Sensitization for PAHO Staff

MSD175 Update on the Quality of Care Project and Presentation of the Results of the Operational Research Phase

MSD176 Gender Equity in Health Care Reform

MSD177 Violence against Women and Girls: The Conceptual Framework being Operationalized in Ten Countries

MSD178 Lessons Learned in Working with Indigenous Women and Health: The Experience in Guatemala

MSD179 Future Role of the Special Subcommittee on Women, Health, and Development

PAHOHDW97-002 How were the Gender, Health and Development Training Workshops Evaluated by Participants?

PAHOHDP-HDW97-003 Evaluation of Country Programs, 1996

Annex Anexo C: LIST OF PARTICIPANTS

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