



Gender equality and health equity: strategic lessons from country experiences of gender mainstreaming in health

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ABSTRACT

Objectives. To analyze progress in organizational structures, mechanisms, strategies, and enabling factors and barriers towards gender mainstreaming (GM) in health in Guatemala, Guyana, and Peru, given GM's role in addressing gender inequalities in health as a key structural driver of health equity.

Methods. Data was obtained through a grey literature review of laws, policies, and/or program documents and semi-structured qualitative interviews with 37 informants. Analysis was based on a theoretical framework including 7 categories considered essential to advance GM in the health sector.

Results. Despite significant efforts and accumulated experiences of GM in health, structural barriers include: wider societal challenges of transforming gender unequal power relations; health system complexity combined with the low technical, political, and financial capacity of institutional structures tasked with GM; and limited coordination with (often weak) National Women's Machineryes (NWMs). In some contexts, barriers are compounded by limited understanding of basic concepts underlying GM (at times exacerbated by misunderstandings related to intersectionality and/or engagement with men) and the absence of indicators to measure GM's concrete results and impact.

Conclusions. Successful GM requires a more strategic and transformational agenda, developed and implemented in coordination with NWMs and civil society and with reference to external bodies (e.g. Committee on the Elimination of Discrimination against Women) to go beyond process, with clearer distinction between gender sensitivity and gender transformation, and definition of expected results and indicators to measure advances. These then could be better documented and systematized, enabling GM to be more broadly understood and operationalized as a concrete instrument towards health equity.

Keywords

Health equity; gender equality; gender mainstreaming; gender-inclusive policies; Guyana; Peru; Guatemala.

Gender inequalities constitute one of the primary underlying structural drivers of health equity, as noted by the Commission on Equity and Health Inequalities in the Americas. Their report placed greater attention than ever to 'inequities according to gender' within a conceptual framework that stressed 'political,

social, cultural, and economic structural drivers of inequities' and the need for an intersectional approach including attention to gender alongside social and economic inequities, sexuality, ethnicity, disability, and migration (1). Similarly, addressing gender inequalities through an equity and human rights lens

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is central to the ‘leave no one behind’ pledge of the Sustainable Development Goals (SDGs) (2).

This concern with gender equality is echoed in the Pan American Health Organization (PAHO) Gender Equality Policy, adopted in 2005. It also constituted a focus of the Integrated Health Systems in Latin America and the Caribbean Project, a cooperation agreement between the Government of Canada’s Department of Global Affairs and PAHO. This shared concern motivated the study that generated these findings, with the objective of investigating the degree to which, at country levels, gender mainstreaming (GM) in health is contributing to the achievement of gender equality, and hence to determine whether a new vision and strategy may be required for PAHO’s future technical cooperation.

GENDER MAINSTREAMING TO ADDRESS GENDER INEQUALITIES AND HEALTH EQUITY

Over the decades since the adoption of the Beijing Platform for Action (3) and the United Nations Economic and Social Council (ECOSOC) 1997/2 agreed conclusions (4), GM has become the primary mechanism aimed at achieving gender equality and can therefore be considered one of the key mechanisms of addressing health equity (2). GM aims to be omnipresent to demonstrate the relevance of gender considerations to all aspects of policy, programs, and plans (including in the evaluation of consequences), with public health no exception. Its inherent logic is that, without differentiated approaches addressing gender dynamics, public health interventions are unlikely to meet their objectives and that the accumulation of gender considerations across all actions will achieve gender equality in health. It also stresses that the lack of GM can produce and/or perpetuate gender inequality. GM in health examples include, amongst others, sex disaggregated reporting of health outcomes, analysis of differences in access to services between men and women, inclusion of women in decision making, and tailored responses to meet men and women’s differentiated needs, including through specific budget assignments

Whilst National Women’s Machineries or Mechanisms (NWMs)^a are identified as the primary institutions responsible for GM, their coordination role denotes a shared responsibility (3) across all policy fields, including health. Accordingly, PAHO’s Gender Equality Policy’s four strategic lines –data disaggregation, capacity building, involvement of civil society, and monitoring and evaluation– seek to operationalize GM in Ministries of Health (MOH).

CONCEPTUAL FRAMEWORK

GM is grounded in feminist theoretical frameworks that recognize deeply embedded inequalities in social norms and structures, aiming to provide a way to address them and achieve social transformation. Hence, GM was never meant to be an end in itself but a strategy to achieve gender equality. GM’s operational premise is that policymaking is not a gender-neutral process but relies on underlying gender-biased

assumptions about how society is restructured and organized. It focuses upon the process by which any action, legislation, policy, or program is evaluated in terms of its different consequences on men and women (4).

Although recent critiques have posited that, in technocratic practice, GM ‘has been depoliticized and its envisioned transformational potential weakened’ (2), the original conceptualization of GM requires a paradigm shift in the design and implementation of policy to identify and target gender-biased assumptions and to redress gender-discrimination and structures, systems and practices that were unconsciously designed with men as the model. Operationally, all actions would then be oriented, or reoriented, to ensure a positive impact on gender equality in health. The extent to which this is achieved depends upon the approach taken. GM generally takes two distinct forms at the most extreme ends of a continuum of approaches. At one end, gender sensitivity takes into account and promotes awareness of, but does not seek to change, gender inequalities and how they affect any action (5). At the other, gender transformative approaches seek to shift gendered power relations and transform harmful gender norms, roles and relations (5).

GM stands as distinct to complementary positive action measures dedicated specifically to addressing the priorities and needs of women and girls. These range from women’s health approaches that emphasize reproductive health and violence against women to specific dedicated programs emphasizing gender as a structural determinant of the health of women and men and focused on modifying unequal power and subordination relationships as well as enabling empowerment of women in access to health resources (6). More recently, actions aimed at ‘diversity mainstreaming’ or intersectionality approaches also aim to contribute to gender equality in health and thus to health equity.

OBJECTIVES OF THE STUDY

During 2018, the present study was conducted by PAHO in Guatemala, Guyana and Peru to review the experiences of GM in the health sector in order to qualitatively analyze progress in terms of organizational structures, mechanisms and strategies, and key enabling factors and barriers towards institutionalization of GM. It was anticipated that this analysis would contribute to a better understanding of whether the strategy of GM itself faces challenges to meeting its stated aims, or whether contextual factors in its implementation provide the key to its success or failure. The study built upon the findings of the complementary regional report (6), which analyzed GM definitions and institutional requirements in regional policy documents and mandates and conducted a systematic review of documented results from GM in national health policies and programs; PAHO documents, scientific publications, and information available on the web; and semi-structured interviews with regional experts. Its recommendations called for more results-based GM programs in conjunction with defined strategies for the empowerment of women and the need to continue institutional strengthening. The current study constituted a more in-depth examination of progress towards transformative or other gender equality results achieved through these mechanisms, based upon case studies.

^a Refers to national institutions that oversee women’s issues, gender equality and related issues, although variable terms are used for naming such mechanisms in different contexts.

The subsequent sections present some key results of this study, complemented by analysis of further grey literature^b to better situate them in their institutional and normative contexts.

METHODS

This multiple case study obtained information using qualitative methods: review of policy documents issued from 2015 to date, and 37 semi-structured interviews (15 in Peru, 9 in Guyana and 13 in Guatemala) involving 46 expert informants altogether. These represented national authorities (MOHs and other Ministries overseeing development, social inclusion, justice, women and gender issues); women's organizations; academia and UN agencies. All interviews were recorded with the informed consent of participants and confidentiality and anonymity agreements.

The analysis is both descriptive, with respect to experiences of GM in the health sector, and explanatory, as findings were analyzed based on a theoretical framework, including seven categories considered essential to advance GM in the health sector (Figure 1). The findings presented here are primarily drawn from analysis of the interview data, with the document review serving as context for informational purposes.

The study was not an evaluation, a good practice analysis, nor a representative study. Country selection was based on inclusion in the financing Integrated Health Systems in Latin America and the Caribbean project, representation of the three subregions (Caribbean, Central America, South America); priority countries of PAHO's 2014-2019 Strategic Plan; and government approval. Whilst the findings seek to be generally comparable, direct comparisons cannot be drawn between countries. Due to the limited number of participants and identification concerns, the analysis did not seek to expose different perspectives according to sector (e.g., UN agencies, national authorities, civil society), although this may be a useful future line of enquiry.

RESULTS

In order to aid the concise flow of the discussion in this article, the presentation of findings is not structured according to the original analytical categories but rather according to the following: institutionalization; definitions guiding GM actions; the diversity of concrete experiences in GM. These categories incorporate findings from across the seven analytical categories noted above.

Institutionalization

Given GM's focus on the process by which change occurs (4), the gender architecture to drive transformative change is considered fundamental. With reference to GM management and agenda setting, the institutionalization of GM in countries is varied and materializes at two levels: within the MOHs and within NWMs. Within the MOH, institutionalization consists of varied stand-alone dedicated advisory and coordinating institutions and structures, and gender units or focal points. These

^b In the context of this study, 'grey literature' refers to publications (official documents, publications, and research reports) by UN institutions and bodies, and governmental policy and normative documents, as detailed in the reference list.

FIGURE 1. Seven categories considered essential to advance gender mainstreaming in the health sector



are often attached to ministerial offices and can also be located at subnational levels. The different mechanisms can play a significant role in the sustainable institutionalization of GM in health. Yet, they are commonly not strategically integrated into the institutional apparatus and their structure is weak, their actions scattered, and their capacity for coordination with the different programs or divisions of the ministries is scarce.

Although the entities with which the MOH should coordinate differ in each context, the NWMs have in theory overall oversight, advisory and coordination responsibilities for GM across all policy areas, including health. In practice, the institutional consolidation of the three NWMs varies significantly, impacting their capacity to effectively advise and support health authorities. The NWM in Peru has achieved the greatest level of institutional consolidation, having evolved into a full-fledged ministry (7). However, it suffers from lack of adequate resources to carry out its mandate^c, limiting its ability to set an effective agenda for gender equality in health, in coordination with the MOH. This is particularly so regarding the needs of women and girls that face intersecting forms of discrimination, inequality and exclusion^d.

^c This was noted with concern by the Committee on the Elimination of Discrimination against Women (CEDAW) Committee in 2007 (8) and in 2014 (9), although in January 2020 (after research for this article was concluded) Peru reported, as part of its periodic submission to the CEDAW Committee, that the budget of the Ministry for Women and Vulnerable Groups had doubled between 2012 and 2017 with an average increase of almost 20% per year during that period (10).

^d The CEDAW Committee expressed its regret at the lack of "specific information on the measures to address the discrimination and violence faced by disadvantaged groups of women, facing 'multiple and intersecting forms of discrimination' and reiterating concern "that rural and indigenous women in particular continue to face barriers in the exercise of their rights" with respect to access to basic services, including health and the lack of "policy instruments to address their specificities" (9).

In Guatemala, the Presidential Women's Secretariat (SEPREM) was set up in 2000 as the advisory entity charged with coordinating public policies to promote women's advancement and gender equality, bearing in mind the sociocultural diversity of Guatemala. Despite not being a full-fledged ministry, SEPREM has always been directly attached to the office of the Presidency and its head had ministerial status until 2016 (7). Concerns over SEPREM's lack of effective coordination and unclear division of labor with other institutions and structures have been regularly noted, including in 2017 by the Committee on the Elimination of Discrimination against Women (CEDAW) Committee (11), hampering its advisory role. Calls have been made to enhance SEPREM's capacity by improving its institutional authority, human resources and sustainable financial resources (11).

In Guyana, the Gender Affairs Bureau is a low-rank NWM attached to the Ministry of Social Protection. The administrative attachment of NWMs to ministries charged with social, family, children and related affairs, is a common feature of CARICOM member states (12) conveying traditional roles of women in society, a trend that has otherwise been largely overcome in Latin America (7). Such low-profile status translates into limited authority and hampers the effective coordination required for effective GM with sectoral authorities, such as the MOH, as identified by the CEDAW in 2019 (13).

The complexity of different institutional arrangements in countries produces an overload on the gender 'units' that are forced to act proactively and reactively within a double coordination burden: with the NWM and within the MOHs. This makes coordination tasks more complex and leads to potential confusion over where the responsibility for GM lies. It creates difficulties in adopting a coherent, contextualized strategy for GM in health, further complicated by attempts to implement an intersectional approach. In Guatemala, for example, the Unit for Health Care of Indigenous Peoples and Interculturality has the task of defining strategies to mainstream responses to the specificities of indigenous populations. However, it works in isolation to the gender unit, hindering a gender approach that would be more equity sensitive in terms of consideration of the diversity of different groups of men and women.

Peru can perhaps be identified as the country with the clearest trend towards GM as a political purpose and as a normative framework. By contrast, although innovative efforts have taken place through the NWM, Guatemala's attempts are more isolated. Cooperation on specific issues predominates rather than systematic endeavors at mainstreaming more broadly in health. This indicates a relative weakness of institutionality within the MOH and continuous barriers faced by the NWM. Efforts in Guyana are yet more fragmented. The NWM has not played a central role in coordinating or advising on GM across health policy and interventions, and neither have the health authorities compensated for this weakness with strong GM structures and resources.

In all cases, institutionalization within the health sector constitutes the weakest flank in terms of mainstreaming. The efforts are fragile (in terms of human and financial resources and monitoring), discontinuous (institutional mechanism or strategy changes are common), and specific (without an action plan). This is reflected in a strong concentration on policies, laws, and regulatory frameworks, but incipient implementation within the health sector.

Challenges aside, the normative legislative and policy framework for gender has advanced, especially in Peru, followed by Guatemala, and with more recent developments in Guyana. All three countries ratified the CEDAW Convention (although only Peru and Guatemala have ratified its Optional Protocol) (14). However, only Peru has enacted specific legislation on gender equality (15), adopting a National Gender Equality Plan 2012-2017 that later informed the National Policy on Gender Equality aiming at addressing structural discrimination faced by women (16). In Guatemala, a National Policy for the Integral Promotion and Development of Women and a Plan for the Equity of Opportunities 2008-2023 have been adopted (17). In 2019, after research concluded, Guyana developed the National Gender Equality and Social Inclusion Policy as "a framework to guide the implementation of appropriate mechanisms, policies and protocols to address issues of gender inequality and social exclusion" (18).

Definitions guiding GM actions

Despite these challenges, in all three countries, there have been actions towards the goal of gender equality, with gender references in the health sector and in other areas of the state and there is, irrefutably, accumulated knowledge with regards to GM. Yet, the strongly stated commitment belies a diversity of definitions of concepts managed under the umbrella of GM.

One of the broader accepted aims is that of the 'inclusion' of the voices and needs of women, men, and/or the LGBTI population. However, understanding and operationalization of that inclusion is not uniform. For example, women's strategic needs related to sexual and reproductive health and rights are given priority in Guatemala and Peru but not in Guyana. This is in despite existing challenges in Guyana such as the need for legislative reforms to end early and forced marriage and the existence of harmful practices such as female genital mutilation, as highlighted in 2019 by the CEDAW Committee (13). GM in Guyana instead prioritizes the inclusion of positive actions to explicitly include men in policy making, with the aim of better representing their different needs and indeed work with women is referred to as being "outdated". In Guatemala, the agenda of 'gender equality' is similarly shifting with an incipient focus on sexual diversity and LGBT health.

The inclusion of these emerging themes is not inherently problematic, depending upon the guiding intention. Indeed, inclusion of LGBTI concerns is necessary to meet CEDAW demands to address competing forms of discrimination. However, it may substantiate concerns regarding diluting resources and attention to women's empowerment and/or represent a misunderstanding of the transformative aims of GM (5), especially in the context of fragility of institutionalization to appropriately guide agendas.

A diversity of concrete experiences in GM

It is in this context that concrete GM 'actions' have been developed either as national initiatives or as dispersed actions at sub-national levels and/or in other institutions outside the MOH. In general terms, actions have been implemented either as dedicated actions focused on specific issues considered strategic needs of women and linked to the SDGs, primarily including sexual and reproductive health and rights,

prevention of sexual violence and gender, contraception, and/or maternal mortality; or as fragmented and episodic process related actions that fall under the dimensions of PAHO's GM policy. This includes capacity strengthening, creation of institutional mechanisms and strengthening sex disaggregated data collection in information systems in all three countries and, in addition, gender focused budgets in Guatemala.

Capacity building efforts are notable, especially training for health personnel and for services in priority programmatic areas, especially sexual and reproductive health and rights, violence against women, or maternal mortality programs. However, these have usually not been taken up in more general and institutionalized human resource training and curricular contents do not appear to be standardized.

There have been notable advances in the inclusion of variables such as sex, in health information systems. These have often been accompanied by variables such as ethnicity or sexual identity, which are important for an intersectional analysis from a broader equity perspective. However, such intersectional analysis is not routine and often only produced for gender and health profiles supported by international cooperation. Monitoring is the most fragile component of GM. It is not carried out in a systematic or unified way within the MOHs or NWMs. Further, there is an absence of monitoring tools and practices to measure progress towards gender equality in health. The exception being areas for which indicators already exist, such as maternal mortality.

The allocation of financial resources for GM is limited in all countries, although there are few mechanisms to assess their magnitude. The most notable effort is the budget classifier tool in Guatemala to register and classify the budgetary allocations of programs, subprograms, projects, and activities aimed at the "integral development of Guatemalan women"^e.

DISCUSSION

This study identified a set of significant barriers and facilitators to advance GM, several of which can be characterized as structural in nature, thus perhaps lending weight to the depoliticization of gender in mainstreaming efforts undermining its originally stated transformative aim (2,21).

The greatest structural barrier is the persistence of societies that face wider challenges of transforming unequal power relations between women and men, and related discrimination and exclusion. The health sector is not divorced from the norms and values of broader society and these permeate providers and decision-makers. The complexity of the health system, and its multiplicity of actors, may make tackling the culture of gender inequality even more difficult than in other significant societal institutions. Again echoing the possible disconnect between feminist agendas and institutional mainstreaming (21) and/or perhaps simply the realities of competing national agendas for limited resources, the ability to genuinely tackle these complexities is not aided by the low technical, political, and financial capacity of often overly complex institutional structures tasked with the responsibility for GM.

That said, there is a broad and increasing recognition of the need for gender equality in health, formulated, at least in part, in response to priorities on the feminist agenda. Favorable aspects to advance gender equality in the region include the existence of regional and global normative standards, and the capacities at national level that have been increased directly in response to these as well as to the priorities set by civil society at national level. Guatemala benefits from a legacy of two decades of experience by several structures and institutions charged with women's rights and gender equality (7), which includes an alliance of the NWM with women's groups, including indigenous women (7) (demonstrating an attempt to strengthen rather than weaken the gender equality agenda through intersectionality by incorporation of the realities of different groups of women). Also, the recently approved health care model serves as a platform to promote GM in the sector and the work related to the gender classifier in the budget is designed to improve accountability for results.

As in Guatemala, the role of civil society in Peru and Guyana is also helping to garner attention to key issues on the feminist agenda such as violence against women and the need for greater participation of women in decision-making positions, in ways that counteract de-politicization and help gain their place within GM efforts. In the case of Peru, for example, the formulation of the new version of the gender policy on health and its implementation stand out in this regard. Similarly, in Guyana, the formulation of the National Gender Equality and Social Inclusion Policy (18) and, more specifically in response to the feminist priority of ending violence against women, the implementation of the sexual violence guide directed at medical personnel demonstrate responsiveness to transformative agendas.

Despite these advances, the barriers remain substantial. There is limited understanding of the basic concepts and expectations underlying GM, further exacerbated when intersectionality or engagement with men is brought into the arena. This illustrates a lack of a theory of change for achieving gender equality and, indeed, of clarity regarding GM's overriding aim in terms of responsiveness to feminist priorities, such as those highlighted by the CEDAW committee. GM is not consistently understood in relation to examining gender inequalities in health determinants, outcomes, and access to resources for health. The inclusion of men to sensitize them to the need to address power dynamics and to empower women is fundamental. However, their inclusion because of a misplaced concern about lack of attention to men's needs denotes neutrality rather than the need to redress the power dynamics embedded in relations between women and men, which have systematically silenced the needs and voices of women.

Similarly, the increasing focus on sexual diversity can confuse the meanings attributed to GM. Given its close relationship with heteronormativity and control of women's sexuality, addressing LGBTI discrimination is integral and transformative for the women's empowerment agenda. However, when, as in some contexts, gender is understood to primarily refer to LGBTI issues, efforts are potentially decentralized and resources diluted away from women's empowerment. This illustrates the risks of co-optation in the shift from GM to diversity mainstreaming and intersectionality approaches (19, 20) when the former is unclear, even though an intersectionality approach to address diversity (21, 22) and health equity is fundamental. The lack of tools to measure GM's concrete results, rather

^e The tool seeks to quantify the resources assigned to gender and guide the planning process and was first applied in 2018 in the health sector. 7 programs and 166 by-products were identified, corresponding to an approximate amount of 600 million Guatemalan pesos out of a total budget of the MOH of 13 billion.

than process, and especially the absence of gender indicators that exceed the vision of the program and that relate to gender equality in health itself, contribute to this confusion over the aim and vision of GM.

Conclusions

The limitations to sustainability of GM strategies represented by factors such as political instability or the lack of significant institutionalized budget allocations cannot be understated. Similarly, there is clearly a significant cultural shift needed to advance GM in a more sustainable way within the field of public health. This needs to be contextualized within wider societal efforts to shift gender norms and address inequalities. Other factors have to do with the complexity of a multi-cephalic health sector making it essential to work with areas as diverse as communication, planning, epidemiology or financing, at the same time as advancing in the various national programs or thematic areas, and at the level of prevention and care.

Coordination with NWMs, civil society and reference to external bodies, such as the CEDAW Committee, are vital for GM to prioritize a strategic transformational agenda, coherent with wider societal efforts for changes in gender norms and other initiatives to achieve equity in health. Such coordination within a more defined strategic agenda based upon a theory of change would allow GM to go beyond a focus on process, with clearer distinction between gender sensitivity and gender transformation, and towards a better definition of expected results. The inclusion of defined indicators to measure advances, would allow for results to be documented and systematized.^f

By so defining, monitoring and documenting, GM actions are likely to be better understood, institutionalized, planned, operationalized and funded as structural policies with transformational potential for impact on inequities in health on a

^f For example, PAHO has proposed "A Framework and Indicators for Monitoring Gender Equality and Health in the Americas", including an updated framework and set of core indicators for monitoring advances on gender equality in health in the Region (23).

par with other development agendas. Were this to occur, GM could be more effectively operated at all levels with a 'trickle-down' effect in which gender transformational approaches would reach the realities of peoples' lives at the level of providers and territories and be more easily understood as a concrete health equity instrument. It may also facilitate the operationalization of a contextualized, intersectional approach, going beyond a generic and mechanistic, process-orientated approach and developing 'deep dive' GM strategies to address specific aspects of gender equality in health within a broader equity framework for women living in situations of vulnerability. This is crucial as, now more than ever in the COVID-19 era, approaches to gender cannot afford to be superficial. They need to grapple in concrete ways with the profound gender inequalities that currently underlie many of the health inequities in the Region of the Americas.

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Igualdad de género y equidad en salud: lecciones estratégicas de las experiencias de los países en la incorporación de la perspectiva de género en la salud

RESUMEN

Objetivos. Analizar el progreso en las estructuras, mecanismos y estrategias organizativas, así como los factores y las barreras, que favorecen la incorporación de la perspectiva de género en la salud en Guatemala, Guyana y Perú, dado el papel que ello desempeña en el abordaje de las desigualdades de género en la salud como un motor estructural clave de la equidad en salud.

Métodos. Se obtuvieron datos a partir de la literatura gris de leyes, políticas o documentos de programas y entrevistas cualitativas semiestructuradas con 37 informantes. El análisis se basó en un marco teórico que incluía 7 categorías consideradas esenciales para avanzar la incorporación de la perspectiva de género en el sector de la salud.

Resultados. A pesar de los importantes esfuerzos y las experiencias acumuladas respecto de la incorporación de la perspectiva de género en el sector de la salud persisten obstáculos estructurales, como desafíos sociales más amplios para transformar las relaciones de poder desiguales entre los géneros; la complejidad del sistema de salud combinada con una baja capacidad técnica, política y financiera de las estructuras institucionales encargadas de abordar el tema; y la limitada coordinación con las instituciones nacionales dedicadas a la promoción de la mujer (a menudo débiles). En algunos contextos, los obstáculos se ven agravados por la limitada comprensión de los conceptos básicos subyacentes a la perspectiva de género (a veces exacerbada por una comprensión limitada de la interseccionalidad o el compromiso con los hombres) y la ausencia de indicadores para medir los resultados y el impacto concreto de la incorporación de la perspectiva de género.

Conclusiones. Para que la incorporación de la perspectiva de género en la salud sea satisfactoria se requiere una agenda más estratégica y transformadora, elaborada e implementada en coordinación con las instituciones nacionales de promoción de la mujer y la sociedad civil y vinculada a instancias externas (p. ej., el Comité para la Eliminación de la Discriminación contra la Mujer). Es necesario, asimismo, una distinción más clara entre los enfoques sensibles al género y aquellos transformativos de las relaciones desiguales de género, y una definición de los resultados previstos y los indicadores para medir los avances. Estos podrían entonces documentarse y sistematizarse mejor, lo que permitiría que la perspectiva de género se comprendiera más ampliamente y se pusiera en práctica como instrumento concreto para lograr la equidad en salud.

Palabras clave

Equidad en salud; igualdad de género; transversalidad de género; políticas inclusivas de género; Guyana; Perú; Guatemala.