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***GENDER EQUITY IN HEALTH CARE REFORM***

This document proposes the creation of an electronic discussion network on equity in health and social security policies, with particular emphasis on gender equity, to promote an exchange of information, knowledge, and skills in analysis and advocacy in this area. This strategy would respond to the recommendations at the 16th Meeting of the Special Subcommittee on Women, Health, and Development on (a) the development of mechanisms by the Program on Women, Health, and Development (HDW) to promote the sharing of experiences at the national and international level regarding the impact of the reforms on gender inequities; (b) the incorporation of the gender perspective in the discussions on reform in the countries and at Headquarters; and (c) promotion of research to support the formulation of gender-sensitive policies and monitor their implementation.

The document points out the presence of gender biases in the health and social security systems of the Region, notes the potential impact of health care reforms on the patterns of gender inequities, and suggests priority areas for research and advocacy in this field.

The electronic discussion network on gender equity in public health and social security policies would link individuals from government, nongovernmental organizations, universities, research centers, donors, and lobbying groups that share an interest in analyzing and promoting equity in health and social security policies. This mechanism would represent an expeditious, democratic, and economical environment for strengthening the substantive and strategic knowledge needed for effectively influencing the formulation and monitoring of sound public policies that incorporate the gender perspective.

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## 1. Institutional Framework of the Initiative

*The Search for Equity* is the title of the latest Annual Report of the Director of PAHO.

1<sup>1</sup> This title unequivocally expresses the central tenet of the Organization's mandate. Achieving the maximum possible equity, in fact, has been at the heart of PAHO's strategic and programmatic orientations. These orientations, adopted by the XXVI Pan American Sanitary Conference in 1994, emphasize that the principle challenge to overcome in the health sector during the quadrennium is the lack of equity.

One inequity found in all societies, social classes, and ethnic groups is gender inequity. Its ubiquity has been noted by the United Nations Development Fund (UNDP) in its *Human Development Report, 1996*, which asserts that no society treats its women as well as its men.

2<sup>2</sup> PAHO has officially stated its commitment to reducing this type of inequity in health and, for this purpose, has explicitly stated that:

Gender should be one of the categories of analysis in the planning and programming of activities in all sectors and this focus should have repercussions for public health programs in all countries. 3<sup>3</sup>

Concerning the topic of gender equity in health care reform, the Director of PAHO has noted the following:

PAHO has *particularly*<sup>4</sup> *emphasized attaining gender equality within the health reform process. Throughout their lives, women become ill more than men do, and social mores assign to them the duty of caring for others. These factors cause women to have specific health needs that must be identified and addressed, if health resources are to be distributed equitably across gender lines.*<sup>5</sup>

## 2. Background

In March 1996, the 16th Meeting of the Special Subcommittee on Women, Health, and Development discussed the impact of health sector reform on the differential access of women to health services. Based on the experience of Chile, presented by that country's National Women's Service, and on other evidence revealed during the discussion, the Subcommittee noted the urgent need to examine systematically the effects that structural adjustment measures, with the consequent cutbacks in the financing of public health services and the privatization of these services, have had on women's health.

The Subcommittee emphasized the need for:

. . . greater communication among those involved in health reform efforts around the Region, so that they could learn from one another's experiences.<sup>66</sup>

and noted that:

HDW had a crucial role to play in drawing attention to the need to incorporate a gender perspective into discussion of health reform, both within the Organization and in the countries.<sup>77</sup>

In this regard the Subcommittee suggested that HDW cooperate with the countries in developing a methodology that would facilitate analysis of how health reform measures, such as privatization or changes in resource allocation for health promotion and protection, were affecting women. <sup>88</sup>

The Subcommittee concluded with a recommendation to the Member States that they:

Actively pursue ways of incorporating a gender perspective in analysis and discussion of health reform, and ensure that assessment of the impact on women and women's health is included whenever health sector reform is taken up by the Governing Bodies or other fora. <sup>99</sup>

## 3. Dimensions of the Problem

The macroeconomic structural adjustment policies adopted by the governments of the Region to alleviate the debt crisis of the 1980s have been associated, inter alia, with cutbacks in public social services (among these, health services); the elimination of subsidies for basic goods (food and fuel); higher prices for drugs, transportation, housing, water, and electricity; the privatization of public services; and the liberalization of trade.

The impact of these changes, of course, has not fallen equally on all households, nor have all household members been equally affected. There is a general consensus that the heaviest burden of the impact of cutbacks in health services and food subsidies has fallen on the sectors with the lowest income. <sup>1010</sup> In addition, numerous authors have pointed out that, within these sectors, women have been seriously affected by these measures <sup>1111</sup> due to: (a) their

disproportionate representation in the population living in poverty; (b) their comparatively greater need for care, associated with their biological role in reproduction; and (c) the additional burden of providing care once offered by the public services, a responsibility that women have been forced to assume as part of their social role as caretakers of their family's health and nutrition.

Beyond the negative impact of these changes, however, are the economic pressures of the 1980s, together with the mass integration of women into the work force and their active role in developing new forms of community organization, such as community kitchens, to collectively meet the nutritional needs of their families. The mass explosion of women onto the public stage and into community power structures during this period set in motion irreversible processes of citizen participation, <sup>12</sup><sub>12</sub> in which health protection played a leading role.

Assessing the impact of the crisis and macroeconomic policies on the health of populations is a methodologically complex task, due to the time required to measure the morbidity/mortality process and the difficulties in controlling for the effects of other secular trends. Thus, given the rate at which reforms are being introduced into the health and social security systems, it is becoming urgent to strengthen the countries' capacity to estimate the past and future impact of such measures on the health and health care of the various population groups. Here, it must be underscored that, just as it is indispensable to examine the effects of the adjustment policies on the different socioeconomic, geographic, and occupational sectors in order to take corrective action, it is also necessary to recognize that, within these groups, a differential impact by sex will probably be observed.

The present proposal emphasizes the importance of differentiating the impact of reform policies by sex, in order to shed light on a ubiquitous historical variation that usually passes unobserved, buried beneath other socioeconomic differences. Far from responding to a reductionist vision of the problems, this approach starts with a global concept of reality that recognizes the multidimensionality of both the determinants and the responses to such problems.

Macroeconomic trends and policies are normally analyzed in a language that affects to be gender-neutral; attention is directed to average indicators of productivity or efficiency, with no specific mention of sex. However, this appearance of neutrality conceals a profound gender bias, for it ignores the process involved in the reproduction and maintenance of human resources and the contribution of this process to the economy. The economy has been defined chiefly in terms of the market for goods and services. Essential activities that are unremunerated, such as childrearing, the transportation of water and fuel, the processing and preparation of food, cleaning and household administration, and the care of elderly, sick, and disabled family members do not appear in the national accounts; and, as it is well known, in most societies this is "women's work."

This division of labor by gender has meant that the primary responsibility for the domestic work necessary for social reproduction, not only in the home but also, by extension, in the labor market, falls to women. It is no accident that the female work force is concentrated in secretarial positions in offices and jobs related to the processing of food products, the preparation and sale of food, garment-making, cleaning and laundry services, primary education, domestic

services, and, of course, health care. It is also no accident that these types of activities are found on the lowest rungs of the occupational scale, with the lowest pay and the least prestige.

This division of labor by gender is central to an examination of equity in access to medical and social security services by any population group, particularly the lower-income group, because in the majority of the countries of the Region, eligibility for social security coverage derives from an individual's employment status, present or past. In addition, the possibility of obtaining private health insurance, and of keeping that insurance, depends to a large extent on the employment and remuneration of the potential subscriber.

Hence, the association between labor affiliation and access to medical services and other benefits means that if there is a significant difference in the work and remuneration profile of women and men, their access to public and private health resources and social security benefits will also differ.

Social security systems are designed basically for wage earners and their families; they generally include coverage for disease, disability and death, and occupational safety; they also provide maternity benefits, unemployment insurance, pensions, and other benefits, depending on the country. As a rule, subscribers work in the formal sector of the economy, usually in relatively large enterprises. The implication of this type of affiliation is that such systems tend to marginalize most of the workers in the informal sector, agriculture, low-paying temporary jobs, and households (where the work is unremunerated). Although the regulations do not formally or explicitly exclude such activities, in practice, the people who engage in them can rarely meet the eligibility requirements; they are simply invisible under the law.

The social division of labor by gender is marked by profound differences in the quantity and quality of participation differences that inevitably give rise to gender inequities in access to the social security system. This division implies that a considerable, though ever-decreasing, proportion of women devote themselves exclusively to unremunerated domestic chores. In no country in the Region is the percentage of women in the so-called "economically active population" equal to that of men.

If we take female participation as a proportion of male participation, we find that it ranges from 19% in the Dominican Republic to 82% in Jamaica. On average, there are three men for every "economically active" woman in the Region.<sup>13</sup> These figures imply that, due to their exclusive devotion to domestic occupations, more than half of all women do not have access in their own right to social security benefits; this is probably true for private health insurance as well. In cases involving family coverage, access by housewives to such benefits will depend on whether their relationship with the male subscriber continues indefinitely; that is, that it is not dissolved by death, divorce, or desertion. It is common knowledge that this type of stable conjugal relationship is not the norm in the Region; statistics show, for example, that the proportion of households headed by women is already over 30% and even 40%

<sup>14</sup> in a significant proportion of the countries of Latin America and the Caribbean.

Women's disadvantage on the economic front is not limited to their lower levels of participation in the labor force but extends, even decisively, to the terms of their participation. The critical problem in the division of labor by gender is that so-called "women's work" is severely undervalued; domestic work performed in the home is not remunerated, and the work performed in the labor market is consistently poorly paid and lacking in prestige. This type of segmentation and differential valuation of the type of work performed leads to a situation in which women as a group are systematically placed at a disadvantage in terms of the remuneration they receive from their work.

According to World Bank figures, <sup>15</sup> the average wage of women in the Latin American labor market is 71% of the wage received by men, and only 20 percentage points of this differential can be explained by differences in human capital. The same source indicates that in Ecuador and Jamaica, for example, women have more education and experience than men, on average, but receive wages that are 20% to 30% lower than those of their male counterparts. In these countries, asserts the Bank, women would have higher wages than men if their contributions were valued equally by the labor market.

Exacerbating the problem of lower wages for women in the work force is the fact that most of the work for which women are paid is not covered by the social security system. This is the case, for example, with parttime jobs, an area in which women are over-represented as a result of their efforts to juggle their domestic responsibilities with paid work. The current evidence <sup>16</sup> reveals that women are also over-represented in the informal sector of the economy and that their participation in this sector is growing faster than that of men. A further difficulty lies in the fact that pregnancies and childrearing interrupt the work history of women, making it difficult to accumulate the time required for pension eligibility; this problem is particularly relevant in countries with high birth rates and can even be exacerbated by regulations on early retirement for women. The number of years of coverage required for pension eligibility in the Region ranges from 3 to 3.5 (in Jamaica and Costa Rica, respectively) to 30 in Uruguay; the average for the Region of the Americas is 14.<sup>17</sup>

In sum, the work pattern of women in the labor market has three characteristics that differentially affect their access to social security benefits:

- the concentration women in low-paying jobs that either have no coverage (e.g., domestic service or the informal sector) or generate a very low contribution, a very low pension, and virtually no possibility of access to private health insurance;
- the high proportion of women in part-time jobs that are excluded from the benefits regimeCwomen who frequently lack access to private insurance;
- an interrupted work history, associated with the critical work of gestation and childrearing, which reduces the time of service and affects the amount of pension that a woman receives and even her eligibility for a pension.

The cumulative effects of a lifetime of this work pattern become dramatic as women age. Old age for women, in contrast to men, is disproportionately marked by widowhood, poverty,

and a lack of social welfare benefits.

In the United States of America, for example, where the proportion of women wage earners is relatively high, the percentage of women over 65 living below the poverty line was twice that of men of the same age in 1993. The average income from social security that retired women received was 63% of the figure for retired men. Furthermore, the number of women receiving a pension was one-third that of men. 18<sup>18</sup>

The reduced access to health services and benefits by older women is exacerbated by the fact that, due in part to their greater longevity, women are frequently more subject to chronic diseases requiring specialized medical care and to disabilities that require assistance in daily living. 19<sup>19</sup> Quantitatively multiplying the problem is the fact that women's greater longevity translates naturally into their over-representation in the 65 and older age group, a phenomenon that has given rise to the expression "the feminization of old age."

It is important to point out that the parameters of the division of labor by gender are not static and are undergoing profound changes associated with the growing incorporation of women into the labor market. Attention should also be called to the fact that gender discrimination against men is also a fact: the assumption that men are "providers" and women are "dependents" leads to a situation in some countries in which widows automatically receive their husband's pension, while widowers must prove that they are unable to support themselves in order to avail themselves of the benefit.

Thus, gender neutrality in social security and pension systems is but an expression: the very foundations of these systems rest on preexisting inequities that precede the reforms, one of whose dimensions is gender discrimination. Here, it is worth reiterating that, from the standpoint of equity, the notion of discrimination encompasses sins of omission as well as deliberate acts. For this reason, ignoring the work pattern of women is tantamount to disproportionately marginalizing them from direct access to the benefits of the system. 20<sup>20</sup>

One type of benefit that covers only women and that cannot be ignored in any discussion of gender equity is maternity care. Who covers the cost of maternity care for workers in the labor market? Who pays for the obstetric care and wages of women during maternity leave? As two recent IDB and UNDP publications emphasize, 21<sup>21</sup> when employers are forced to absorb the cost of maternity benefits, it works against women, producing discrimination in hiring, promotion, remuneration, and job stability, under the rationale that women are more expensive than men. In addition, in some private health insurance systems, such as that of Chile, women of childbearing age must pay higher premiums due to their potential for pregnancy and the consequent cost of obstetric care. To reduce gender inequities in health and the workplace, it therefore becomes essential to adopt measures to protect maternity based on the notion that the reproduction of the species (gestation, breast-feeding, and the care of children) is a social function whose costs should be covered by society as a whole, rather than by women as individuals. The content of the legislation in this regard is a factor that will determine gender equity, impacting not only on women's opportunity to remain healthy during their reproductive years but on their access to employment, job security, and job stability.



Of course, national health and social security systems in the Region vary widely, as do the types of reforms that are being promoted. This variety, which reflects the cultural, economic, and political idiosyncrasies of the countries, points to the need to provide context for the research on the nature and magnitude of the impact of the new policies.

Within the different national strategies for health sector reform currently in place, certain methodologies tend to be more frequent, mainly: decentralization, cost recovery in the public sector, selective privatization, the adoption of basic packages of health care, the introduction of new forms of hiring, the targeting of public expenditures, and the control of drugs. Policies such as extending coverage to workers in the informal sector, including maternity care in the basic package of services, and targeting public subsidies to the poor tend, or at least are intended, to reduce some of the preexisting inequities. Selection of a particular policy for analytical purposes would be made on the basis of its great potential for improving the quality of life and gender equity, within the particular policies introduced in the countries targeted for the analysis.

It is worth repeating that some apparently gender-neutral formulations referring to objectives, such as “cost reduction,” “effectiveness,” and “efficiency”, frequently include a gender bias, because they imply transfers of costs from the remunerated economy to the economy based on the unpaid labor of women. Thus, the underlying premise of some adjustment measures is that governments can cut costs by cutting services—for example, shorter hospital stays, reduced care for the elderly—because most health care occurs in the home.

From the standpoint of the search for gender equity, it would be useful to pose questions about the degree to which the new policies debated and the new basic packages of services:

- are biased in favor of particular family structures;
- recognize the division of labor by gender in the home, in the labor market, and in the work in health;
- respond to the specific needs of the sexes and the differences in the epidemiological profiles of women and men;
- explicitly recognize the impact of biological and social gender determinants on the health needs of men and women;
- are based on the assumption of equal access to and control of resources inside and outside the family;
- consider women and their health outside of the maternal context;
- include and promote women’s participation as citizens in decision-making that affects the health systems;
- are implicitly or explicitly supported by the unremunerated work of women as a means of cutting costs in health care delivery;

- help to reinforce or reduce preexisting gender inequities in terms of the distribution of responsibilities and remuneration in the work in health;

In response to the suggestion of the 16th Meeting of the Subcommittee on Women, Health, and Development, this initiative would begin targeting the impact of private sector participation in the financing and delivery of health and social security services on gender equity in access to the services and benefits of these systems. These effects would be examined in terms of their links with the redefinition of the role of the State, the dynamics of society's productive base, and the changes in the living conditions of the population.

The growing importance of the private sector in health is leading to a redefinition of the roles of the public and private sector in the organization and financing of the services. Incorporating the gender perspective into this redefinition demands an analysis of the impact of the different modalities for articulating the public and private sector on the distribution of health system benefits among men and women in the different population groups.

The concept of equity, the backbone of this analysis, is based on the notion of need. This assertion implies that the distribution of the system's resources and benefits should be guided not by impartial criteria of equality but by considerations of need. <sup>22</sup><sub>22</sub> In other words, it does not matter whether women and men receive identical quotas in the distribution of resources and services; what matters is that they receive such resources differentially according to their needs. The empirical determination of the health needs (biological, psychological, and social) of men and women, the degree of correspondence between such needs, and the content of the basic package of services thus becomes a basic planning tool. <sup>23</sup><sub>23</sub>

The information obtained in industrialized and developing countries alike reaffirms the notion that women have a greater need for health services. This is because, added to the contingencies of disease, disability, and accidents common to both sexes are the natural functions of maternity (including fertility regulation, which has fallen primarily to women) and greater female longevity, associated with the chronic diseases characteristic of old age. Within this context of differences in health between the sexes, it is essential to underscore that the survival advantage of females is not associated with better health. Mortality is only one indicator of the extreme deterioration of health and cannot show the variations in the quality of life of survivors. The empirical evidence indicates that, far from enjoying better health, women tend to experience greater morbidity than men, expressed in a higher incidence of acute disorders throughout life, a higher prevalence of non-fatal chronic diseases, and higher levels of disability in the short and the long term. <sup>24</sup><sub>24</sub>

This greater need for services is not always met; services are not always available and when they are, they may not be accessible. To the extent that access to health care and to disease or disability benefits is linked to direct outlays or to membership in a benefits system based on remunerated labor, women as a group find themselves at a systematic disadvantage with respect to men. A situation, of course, that does not apply to private services alone.

The following data from the National Medical Expenditure Survey of the United States

illustrate the relationship between the needs, expenditures, and income of women and men:

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- During the reproductive years, direct outlays for health are higher for women than for men: women aged 15 to 44 pay 68% more than their male counterparts in out-of-pocket health expenditures.
- Women spend a larger proportion of their income on out-of-pocket health expenditures than men: women represent 69% of the population aged 15 to 44 and spend more than 10% of their income on out-of-pocket health expenditures.
- Spending on reproductive health services accounts for one-third of all women's health expenditures in the 15 to 44-year age group: this proportion, naturally, is significant and represents a real difference between women and men. However, it should be remembered that reproductive health is not the only area in which women have needs and that two-thirds of their health expenditures are related to other health needs.
- Lack of coverage for preventive services discourages the use of such services, particularly among lower-income women.

The preliminary results of the research on Chile<sup>26</sup> presented to this forum in 1996 indicated that the private system had an adverse effect on equitable access to health services among low-income sectors effects that fell disproportionately on women. These findings noted that women, due to their biological potential for maternity, higher morbidity, and greater longevity, were forced to pay higher rates for private insurance or they would be excluded from certain coverage. The study also indicated that certain gaps in private coverage for example, care in childbirth and care for diseases associated with old age were provided to a large extent by the public sector. This situation, together with the fact that the responsibility for promotion and prevention activities fell exclusively to the public sector, constituted a subsidy from the public system to the private system.

The experience in Chile indicates that the relationship between the State, market forces, gender equity, and social equity in general, is complex: the State does not always act in the direction of equity, and the market does not always operate at its expense. The behavior of gender inequities in health and in health care will thus depend on the structure and articulation of the particular strategies adopted by the private and public sectors to respond to the particular needs and incorporate the contributions of each sex.

#### **4. Proposed Strategy**

A key challenge for effective advocacy to promote gender equity in public policies is the construction of systematized knowledge on the differential impact of certain types of policies on the sexes. The problem does not lie simply in the lack of information or in deficiencies in the quality of the information. While the need for research to generate new information is certainly evident, in many cases important information sources exist that have still not been adequately

exploited (for example, the household surveys or surveys of living conditions conducted periodically in a number of countries). The main problem often lies in the limited ability to access pertinent information, analyze it, and translate it into appropriate policies. The primary challenge, then, is to strengthen national capabilities in the use, adaptation, and construction of the information and knowledge needed to formulate equitable, sustainable, and efficient policies adapted to local realities. A strategic method for achieving this goal is to establish dynamic and interactive communication networks that facilitate the timely dissemination, multidirectional multiplication, and synergistic expansion of the knowledge acquired locally.

In compliance with the recommendations at the 16th Special Subcommittee on Women, Health, and Development, the creation of an electronic discussion network on the topic “Gender Equity in Public Policies on Health and Social Security” is proposed. This strategy combines the suggestions of this Subcommittee with regard to: (a) the development of mechanisms to facilitate international information exchange on experiences related to the effects of health care reform on gender inequities; (b) promotion of the incorporation of the gender perspective into the debate on reform; and (c) the promotion of research to contribute to the formulation and monitoring of policies based on a body of widely validated knowledge.

#### **4.1 Nature and Scope of the Network**

The network, called the “Inter-American Conference on Gender Equity in Health Policies” (CIEGP), is proposed as an expeditious, democratic, and economical environment for promoting advancement of the substantive and strategic knowledge needed for effectively influencing the formulation and monitoring of sound public policies that incorporate the gender perspective.

The CIEGP would be modeled on the wealth of experience amassed by the Inter-American Network on Health Economics and Financing (REDEFS).<sup>2727</sup> In operation since 1994, REDEFS was established and developed with the participation of the Pan American Health Organization, together with the Human Resources Division of the World Bank (IBRD) and the Inter-American Center for Social Security Studies (CIESS). The goal of REDEFS is to foster the sharing of experiences, skills, and information among people working in the field of health economics and financing.

The CIEGP would also attempt to link specialists and institutions from the Americas who work in the field of equity in health and social security policies and who have a specific interest in gender equity. The network would serve as an international forum, linking government agencies, nongovernmental organizations, universities, research centers, advocacy and lobbying groups, academics from the different disciplines, and donors interested in sharing information, experiences, and technical knowledge on promoting gender equity in health and social security systems. The CIEGP would promote cooperation among developed and developing countries to reduce gender inequities, a key topic in the agreements reached over the past decade at the international conferences of the United Nations. Agreements to which the countries of this Region are committed.<sup>2828</sup>

## **4.2 Objectives**

The specific objectives of the CIEGP cover four major areas of activity: research, dissemination of information, training, and direct technical advisory services. In order to achieve its objectives, the CIEGP would act in close concert with the Inter-American Network on Health Economics and Financing (REDEFS).

### *4.2.1 Research*

- (a) To select and disseminate national studies and to distribute information on the research in progress.
- (b) To promote and coordinate national and multinational research projects in priority areas of the topic “gender, health, and public policies.”
- (c) To improve methodological skills through training seminars or workshops on specific analytical and measurement techniques. Special emphasis will be placed on training in impact assessment methodologies and techniques for measuring inequities.

### *4.2.2 Dissemination of Information*

To promote a wide range of information exchange through the following activities:

- (a) Creation and maintenance of a documentary and statistical database on gender, health, and public policies.
- (b) Distribution of a periodic bulletin.
- (c) Translation and reproduction of scientific and technical materials.
- (d) Publication plan for technical documents, which should include the results of national and regional research projects facilitated by the network.

### *4.2.3 Training*

- (a) To promote and support the incorporation of gender issues in the analysis of health and social security policies at the intermediate and upper levels of government agencies and in a broad range of institutions and groups involved in planning, service delivery, and advocacy in health. Priority will be given to analysis of the implications of health care and social security reform processes for equity in general and gender equity in particular. Movements toward privatization and the decentralization of services will be especially targeted.
- (b) To develop and disseminate educational materials geared toward those responsible for decision-making and planning in health and social security; these materials will serve as a guide in policy formulation and analysis.

#### 4.2.4 *Specific Technical Advisory Services*

To provide technical support to network users in the training, research, and dissemination activities promoted by the network by facilitating contacts with national or regional experts and, insofar as possible, through direct technical cooperation.

## **5. Resources**

### **5.1 *Inputs Currently Available***

The Pan American Health Organization has Representative Offices in all the countries of the Region and focal points from the Program on Women, Health, and Development in each of these offices. The focal points serve as a bridge for identifying resources and setting up local networks. It should be noted that in Central America an interagency inventory of work in the field of gender and macroeconomic policies in the subregion is currently being compiled.

The PAHOWHO Representative Office in each country has the necessary equipment and programs, as well as E-mail, which gives it access to the area in question. Of course, this is not enough to guarantee regional representativeness, but it does make it possible for each country to participate to some degree in the network.

HDW enjoys the technical backing of the PAHO Program on Public Policy and Health (HDD), both at Headquarters and in the Representative Offices in the countries.

PAHO's Research Coordination Program already has a database with profiles of public health investigators and research centers in the Region.

PAHO has a home page on the Internet and through it, the programs directly involved in this initiative: HDW and HDD. REDEFS, for example, disseminates its periodic bulletin through the HDD Web page.

In December 1996, a cooperation agreement was signed between PAHO and the Women's College Hospital and Research Center (WCH) of Toronto, Canada; one of the areas of cooperation specified was the study of the impact of health reforms on differential access by the sexes to the health services. The association with the WCH, an entity with a long and well-known history in research and health care for women, constitutes not only invaluable support for this effort but also a ready-made link to individuals and groups that have extensively analyzed the topic.

Beyond the direct access to the experience of REDEFS, which will substantially fuel the development of the new network, the possibility of the two networks operating in close concert adds considerable value to this project, reinforcing the common cause of identifying and reducing inequities. CIEGP can access the existing information sources and at the same time

open up new dimensions in the discussion of health economics and financing.

The specific documentary database on gender and public policy would expand the bibliographic database already in place in the Program on Women, Health, and Development (SIMUS), which currently boasts 3,600 titles. This database already has the human resources and installed capacity to begin entering documents on the selected topics. In addition, arrangements are being made to make the database available on the Internet.

## **5.2 Resources Available in the Medium Term**

At present PAHO has an up-to-date database on mortality by sex for all the countries of the Region. This database will soon be available through the World Wide Web. Meanwhile, this type of information is regularly published in statistical yearbooks.

PAHO is committed, in the countries and at Headquarters, to strengthening the core data in health and producing national health profiles. These will appear in the quadrennial publication, *Health Conditions in the Americas*, 1998. Some portions of that information will be disaggregated by sex for some countries. Moreover, the Program on Women, Health, and Development, in association with the Program on Health Situation Analysis (HDA), will launch an initiative to strengthen local information systems to permit analysis from a gender perspective and allow access to investigators.

## **5.3 Current Cooperation**

PAHO and CIESS cooperate in reducing gender inequities in social security systems. In September 1996 CIESS, with PAHO participation, held a training seminar entitled "Woman, Gender, Equity, and Social Security," which 44 people from seven countries of the Region attended.

In December 1996, when drawing up the current agreement between PAHO and the National Women's Service (SERNAM) of Chile, PAHO, SERNAM, and Chile's Ministry of Health agreed to collaborate on a more in-depth study of the impact of health care reform on differential access by the sexes to the health services. A year ago, during the meeting of this same Subcommittee, the preliminary findings of the research commissioned by SERNAM were presented.

## **5.4 Additional Resource Needs**

Maintaining a targeted and productive exchange and carrying out the activities necessary for meeting the objectives in research, information dissemination, and training will require a major effort to mobilize financial, human, and information resources.

## **6. Plan of Action**

### **6.1 *Creation of the Electronic Site for Information Exchange***

With the technical support of the WCH, a WHO Collaborating Center, an electronic site has already been set up that will facilitate discussion of gender, health, and social security policies. Through this medium, it will be possible to collect and disseminate quantitative and qualitative information and to analyze the impact of different health care organization and financing systems on equity in access to health resources. The focus of the analysis will be gender equity, mediated by such factors as social class, ethnicity, age, marital status, and geographical location. Priority will be given to countries that are restructuring their economic and health systems.

The electronic site that has just been set up is available in two formats: one, a conference site in the APC (Association for Progressive Communications) network, and the other, a server-type mailing list. The APC network is an international association of 22 computer networks that provides technological information, communication tools, and support to individuals or groups working in the field of social change and development. WEB Networks is the Canadian member of the APC and the network in which the discussion in this area originates. The conference site in WEB Networks (shared by sister APC networks around the world) is linked to an electronic list to make it as accessible as possible. Anyone with access to E-mail can participate in this information exchange. The address of the conference site in the APC network is “wch.health.reform,” and the name of the list is “wch-health-reform-l.”

### **6.2 *Development of the Information Exchange***

The first step in the development of this information exchange is to identify individuals, groups, and networks working in the field of gender and public policy who are already connected and familiar with the Internet. This task has already begun in Toronto, Washington, D.C., and San José (Costa Rica). The next step will be to disseminate information on how to get on the list; here, instructions will soon be ready that will be circulated by E-mail among the participants. This initial group of network members will be asked to establish contacts within their own circles to promote discussion and invite new participants to join in the exchange.

As previously noted, maintaining a work site that facilitates focused and productive information exchange requires a considerable input of human resources to stimulate, enrich, and moderate the discussion. During the start-up period, two focal points will be in charge of this facilitation: one from the WCH and the other from the Program on Women, Health, and Development at PAHO. After this initial stage, there will be a need to strengthen the human resources currently available. This will require financing.

Later on, as some key ideas begin to take hold, the first face-to-face meeting of a pilot group will be promoted to outline a development plan for the network. Based on the needs



assessment and the identification of research priorities at the country level, this group will also define the lines of research and priorities of the network.

The group's first product will be the preparation of a research proposal that reflects the interests of the countries involved. This will serve as the foundation for the mobilization of national and international resources, with support from PAHO and the WCH.

## 7. Final Observations

The proposed initiative would constitute an expeditious and effective response to the need to promote regional information exchange, foster collaborative research, and strengthen national capabilities in analysis and advocacy to promote gender equity in public policy.

Development of the electronic discussion network on this topic has had a firm start, both in technical and logistical terms. Achievement of the goals of influencing policy formulation and implementation will depend largely on the support and interest that the initiative elicits beyond research circles, in the decision-making spheres.

This initiative is being presented for the consideration of the Subcommittee, which is requested, in light of the orientations issued by this Subcommittee in 1996 and the developments here described, to support this strategy and renew the appeal to the Member States:

- to continue to actively incorporate a gender perspective in the analysis of health and social security reforms, and to continue to ensure that an assessment of their differential impact by sex is always included when such reforms are taken up by the Governing Bodies or other forums;
- to encourage and support a dialogue between investigators, planners, and activists through the CIEGP network to learn from one another and promote the concerted development of equitable, effective, and sustainable policies;
- to facilitate the presentation and discussion of relevant research findings in national and international forums.

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1 PAHO. *The Search for Equity. Annual Report of the Director, 1995*. Washington, D.C., PAHO, Official Document No. 277, 1996.

2 UNDP. *Human Development Report, 1996*. New York, Oxford University Press, 1996, p. 32.

3 PAHOWHO. *Strategic and Programmatic Orientations, 1995-1998*. Washington, D.C., PAHO, 1995, p. 26.

4 Our emphasis.

5 PAHO. *Op. cit.*, p. 17.

6 PAHO. 16th Meeting of the Special Subcommittee on Women, Health, and Development of the Executive Committee of the Directing Council. Final Report.

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Washington, D.C., 27-29 March 1996, p. 21.

7 Ibid. p. 22.

8 Ibid.

9 Ibid, p. 26.

10 PAHO. 1996, p. 1.

11 WHO. *Equity in Health and Health Care*, 1996, Geneva, p. 10.

12 López Montaña, C., and Ronderos Torres, M. *Reforma social con perspectiva de género: Aportes para la discusión*. Work presented at the Foro Latinoamericano y del Caribe: Mujer y Desarrollo [Latin American and Caribbean Forum: Women and Development]. Inter-American Development Bank. Guadalajara, Mexico, April 1994.

13 World Bank. *World Development Report, 1994*, New York, Oxford University Press, 1994; UNDP, 1995.

14 UNDP. *Human Development Report, 1996*.

Gómez and Sealey. *Women, Health and Development in the Caribbean*.

PAHO. *Health Conditions in the Caribbean* (forthcoming).

Caribbean Group for Cooperation in Economic Development. *Caribbean Regional Health Study*, Washington D.C., IDB, PAHO, 1996.

15 World Bank. 1994.

16 UNDP. 1995.

World Bank. 1994.

PAHO. 1996.

17 Banco Mundial. *Envejecimiento sin crisis*, Washington, D.C., 1994.

18 Older Women's League. "Mother's Day Report" on the Economic Status of Older Women, 1995.

19 Doty, P. "Health Status and Health Services among Older Women: an International Perspective." In: *World Health Statistics Quarterly*, 40:3, Geneva, WHO, 1987.

20 McLean S., and Burrows, N. *The Legal Relevance of Gender*. London, Macmillan Press, 1987.

21 IDB. *Women in the Americas: Bridging the Gender Gap*. Washington, D.C., 1995.

UNDP. *Human Development Report, 1995*. New York, Oxford University Press, 1995.

22 Gómez Gómez, E. "Introduction," in Gómez Gómez, E. (ed.), *Gender, Women, and Health in the Americas*. Washington, D.C., PAHOWHO Scientific Publication No. 541, 1993.

23 A fundamental discussion beyond the scope of the present work is who defines need and how. The distinction between the concepts of need, demand, and utilization of services in this context and their relationship is of key importance.

24 United States National Institutes of Health. *Opportunities for Research on Women's Health*. NIH Publication No. 92-3457A, 1992.

Verbrugge, L.M. "Pathways of Health and Death," in: Apple, R. (ed.), *Women, Health and Medicine in America*. New York, London, Garland Publishing, 1990.

25 Women's Research and Education Institute. *Women's Health Insurance Costs and Experiences*. Washington, D.C., WREI, 1994.

26 Influence of Health Services Reform on the Access of Women to Health Care. Paper presented by SERNAM, of Chile, at the 16th Meeting of the Special Subcommittee on Women, Health, and Development. Washington, D.C., March 1996.

27 PAHO:REDEFS Newsletter. PAHO Home Page, March 1996.

28 Gambach, J., and de Schutter, M. *Women, Gender and Health: Agreements and Actions Established at Six World Conferences in the Nineties*. Washington D.C., OPSHDPHDW, 1996.