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COUNTRY EXPERIENCES IN MONITORING HEALTH POLICY FROM A GENDER PERSPECTIVE

Experience in Costa Rica

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Developing Health Policy through a Human Rights and Gender Approach [1]

Introduction

1. Gender inequalities—that is, inequalities between the sexes—undermine the personal fulfillment of individuals and hold back the development of countries and societies to the detriment of women and men alike. These inequalities manifest themselves in limited options or opportunities, often with disastrous consequences for health, education, and social and economic participation.

2. The right to health for women and men includes the right to greater control over matters linked with sexuality, including sexual and reproductive health, and the right to freely make decisions about these matters, without coercion, discrimination, or violence.

3. We know that public policies that ensure the right to health in general and sexual and reproductive health in particular must be geared to the development of life and personal relations and not only to counseling and care for illness, aspects of reproduction, and sexually transmitted infections. Unfortunately, however, this is not the reality for many people—especially women—who lack not only the chance to improve their sexual and reproductive health but are dying from preventable causes.

4. Health policies have been criticized for not regarding women's problems as part and parcel of social and development problems, for failing to involve women in policy-making, and for not employing a gender-sensitive perspective in policy-making. Consequently, when Costa Rica was developing its health policies, it was imperative to involve both men and women in the process.

5. What was proposed was a joint policy-making effort by the State, civil society, nongovernmental organizations, and certain cooperation agencies working toward a democratization in which social actors can influence policy-making in health. This would entail the decentralization of power and full participation in the definition and execution of strategic activities.

6. This presentation will describe health policy-making in Costa Rica, with specific emphasis on reproductive health. For greater understanding, it will delve more deeply into the health situation of women, the formulation of the National Health Policy, and experiences with the reproductive health policy.

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[1] This paper was prepared with the technical collaboration of Ms. Marielos Rojas of the Bureau of Health Development/*mrojase@racsa.co.cr* and Ms. Edda Quirós R. of the Bureau of Health Services *eddaquiros@hotmail.com* of the Ministry of Health of Costa Rica.

Health Situation of Women in Costa Rica

7. Costa Rica has a land area of 51,000 km^2. Divided politically and administratively into seven provinces and 81 cantons, it has an average population density of 75 inhabitants per km^2 (ranging from 10 to 1,000 inhabitants per km^2).[2]

8. The ninth National Population Census, conducted in June 2000, indicates that Costa Rica's population numbered 3,810,179 at the time, with 49.9% males and 50.06% females and an annual growth rate in the period between censuses (1984-2000) of 2.8% (ranging from -0.1% to 7.5%).

9. In the year 2000, 59.0% of the country's inhabitants lived in urban areas (with an annual growth rate of 3.8% for 1984-2000), and 41.0% in rural areas (with an annual growth rate of 1.7%); urban population growth during that same period was higher than both the national average (2.8%) and rural population growth.[3] The literacy rate for the population over 10 years of age was 95.2%, with similar figures for both sexes, representing a 2.1% improvement over the numbers in the 1984 census.

10. Costa Rica's population pyramid has changed dramatically over the past 50 years, as the population's rate of aging has increased. Children under 15 account for 31.9% of the population, and people 65 years and older, 5.6%. This age structure is attributable both to the decline in mortality and fertility and to international migration, which has risen over the past two decades. These changes in the age structure are substantially altering the epidemiological profile of the population, together with the demand for services.

General Mortality and Fertility Trends

11. Costa Rica's principal demographic indicators for the year 2000 are summarized in the following table:[4]

[2] Ministerio de Salud, Análisis sectorial de salud de Costa Rica, 2002 [Health Sector Análisis 2002]. San José, Costa Rica, 2003.
[3] Ibid.
[4] Ibid.

Table 1.
Demographic Indicators. Costa Rica, 2000

Indicator	Year 2000
Total population	3,810,179
Crude birth rate	19.9 per 1,000
Infant mortality rate	10.2 per 1,000 live births
Crude death rate	3.8 per 1,000
Life expectancy at birth (males)	75.4 years
Life expectancy at birth (females)	80.11 years
Total fertility rate	2.35 children
Population growth rate	annual 1.61%
Percentage of foreign population	7.8%
Estimated annual immigration balance	20,000 - 30,000 people

Source: 2000 Census. National Institute of Statistics and Censuses.

12. Infant mortality fell from 15.3 to 10.82 per 1,000 live births during the period 1990-2001. Between 1998 and 2001, the figure declined by 1.7 points, reaching the goal of a rate of less than or equal to 11 per 1,000 live births in the last year of the period.[5]

13. In the past 10 years, the maternal mortality rate has varied, with an average of 22 deaths and a rate of 2.56 per 1,000 live births. A uniform trend can be observed for the five year periods.

14. Concerning the incidence of cancer in Costa Rica, variations can be seen in the general trend for all tumors, where a decline in stomach and cervical cancer and a rise in breast and colon cancer may be linked with lifestyle, socioeconomic status, reproductive history, and other factors.

15. In the area of sexual and reproductive health, two issues are cause for special concern. The first is the rising proportion of births in women under 20 from 1900 to 2000, increasing from 15.8% to 21.2%. The second is the rise in the relative proportion of women with sexually transmitted diseases from 1995 to 1999: chancre, from 4.8% to 6.9%; gonorrhea, from 14.6% to 21.6%; and syphilis, from 40.2% to 52%. Seropositive women accounted for 12% of total HIV/AIDS cases.

[5] Ministerio de Salud, Dirección de Servicios de Salud, Análisis de mortalidad infantil y sus componentes. [Análisis of Infant Mortality and Its Components]. San José, Costa Rica, 2002.

16. The National Reproductive Health Survey shows that the use of contraceptives, especially hormone-based products, increased from 75% to 80% between 1992 and 1999, especially among young women.

17. As for violence, in the year 2000, 16 women died as a result of domestic violence and 5 more as a result of sexual violence (rape or crimes of passion). These crimes, known collectively as femicides, accounted for the majority of female homicide victims in the 1990s: 70% of those in which the circumstances surrounding the deaths are known, a figure equal to the numbers for maternal mortality and higher than the deaths from AIDS.

Raison d'être of the Policies

18. A public policy is defined within the framework of a specific development model in which the programs and policies that will affect the life of the population come together. The current development models have regarded women as the object of policies or as factors of production. Failing to view them as political actors who participate and interact is what has led to their limited representation in important areas of society.

19. The current efforts to formulate the country's National Health Policy start out with the premise that policy-making is a right and a social responsibility, since it constitutes collective acceptance of the State's legal and institutional obligation to satisfy needs and compensate for the deficits derived socially and historically from people's membership in a community.

20. The National Health Policy 2002-2006, entitled "Toward the Sustainability of Life Expectancy at Birth for the Country's Population," is an organized set of official guidelines for the period in question, designed to guide the efforts of different social actors in the organization and management of Costa Rica's strategic activities (plans, programs, projects, and specific actions) in the social production of health.[6]

21. The Bureau of Health Development was designated by the Minister of Health to draft the National Health Policy. For this purpose, it created three work teams: the Team for National Health Policy (ECPNS), the Team for Intervention Areas (ECAI), and the Expanded Team for Intervention Areas (EAAI), each with specific responsibilities.[7]

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[6] Ministerio de Salud. Dirección Desarrollo de la Salud. Metodología para la formulación de la política nacional de salud 2002-2006 [Methodology for Formulating the National Health Policy 2002-2006]. September 2002.

[7] Taken from Ministerio de Salud. Dirección de Desarrollo de la Salud. Metodología para la formulación de la política nacional de salud 2002-2006 [Methodology for Formulating the National Health Policy 2002-2006]. September 2002.

22. The guiding objectives for the formulation of Costa Rica's National Health Policy 2002-2006 are:

- To direct and manage the formulation of the National Health Policy 2002-2006, "Toward the Sustainability of Life Expectancy at Birth for the Country's Population," with the participation of the social actors involved in the social production of health.

- To develop a participatory process that draws social actors into the formulation of the National Health Policy 2002-2006 and elicits their commitment.

- To furnish the necessary procedures and instruments for the collection, analysis, and systematization of the basic information required to formulate the policy.

23. The policy for 2002-2006 is based on guiding principles and cross-cutting approaches designed to reduce social gaps and buttress the Costa Rican health system.

24. The guiding principles are as follows:

(a) *Equity*: Just distribution of the possibilities and opportunities for access to information, knowledge, resources, goods, and services in order to promote, improve, and maintain individual and collective health, providing more to those with greater needs. In this regard, the goal is to reduce disparities in health that are unnecessary, avoidable, wrong, and unjust.

(b) *Universality*: The responsibility of the State to guarantee access by the entire population, without geographic, social, economic, or cultural barriers, to a quality health system, using a rights-based approach.

(c) *Solidarity:* The principle whereby health protection for the entire population is guaranteed through a shared-financing model that gives groups with more limited resources access to the health system.

(d) *Ethics*: Ethics are the rules, standards, and mandates governing human behavior within a particular community. Ethics in health are geared to promoting respect for the dignity, integrity, and autonomy of all people and the attainment of human well-being and social justice.

(e) *Quality*: The capacity of the health system to offer comprehensive care that satisfactorily meets the needs of individuals and social groups, offering the greatest possible benefits and avoiding risks.

(f) *Social inclusion*: Situation in which the rights, responsibilities, equalities, and equities of disadvantaged and vulnerable individuals and social groups are recognized, regardless of gender, ethnicity, or ideology. An included individual or social group is one that is socially and institutionally part of the networks created by society in all dimensions: political, economic, social, and cultural.

25. The policy's cross-cutting approaches are:

(a) *The gender approach*: A process in which the differences between women and men in terms of health needs and health problems are recognized in order to plan comprehensive action suited to the special biological and social characteristics of each, guaranteeing egalitarian participation by both sexes in political, economic, and social policy-making.

(b) *The rights-based approach*: Health is a basic human right. That right is firmly enshrined in the Political Constitution of the Republic, which states that health is a public good and that it is the State's responsibility to safeguard the health of the population. In this regard, the health system recognizes that the population has rights, and it guarantees comprehensive, timely, and quality health care, with equal opportunity and respect for the whole person and the specific biological, social, and cultural characteristics and needs of individuals and the community.

(c) *Social participation*: The full exercise of citizenship, which gives all social actors the right to participate in a conscious, co-responsible, active, and informed manner in the identification, analysis, and prioritization of health needs, the development of plans and programs, and the decisions related to their execution, evaluation, and reporting to guarantee their quality, efficacy, and effectiveness.

26. Four spheres were addressed to facilitate the organization and systematization of information in the formulation of the National Health Policy; under these, different intervention areas were developed. For the purposes of the present policy, the following are the major scenarios for the social production of health, and the different intervention areas are organized under them:

- strengthening and consolidation of the National Health System;
- equity, universality, access, and quality of health activities;

- recreation and health promotion; and
- environmental health and disasters.

Methodology for Formulating Public Policies to Promote Integrated Health Care and Sexual and Reproductive Rights in Costa Rica

Creation of an Institutional Team to Facilitate the Process

27. The first step in creating this entity so key to the health policy was to search for the individual in the institution who worked most closely with health and sexual and reproductive rights from a gender and human rights approach. That person would coordinate the process and establish an institutional facilitating group.

Tackling the Problem from a Human Rights and Gender Perspective

28. Preparing the chapter on health and sexual and reproductive rights in Costa Rica's National Health Policy 2002-2006 implied not only a statistical analysis, which conceals part of the reality, but also a review of the ethical-conceptual aspects that, using a human rights and gender approach, would help the working group to identify the obstacles facing thousands of women and men in their attempts to exercise the right to sexual and reproductive health. Identifying these obstacles revealed some of the problems to consider for a preliminary definition of the critical issues that would be discussed with the different social actors to reach a consensus.

Preliminary Definition of the Critical Issues to Be Addressed by the National Health Policy

29. The Ministry of Health's facilitating group on sexual and reproductive health put together an initial list of critical issues, as follows:

- comprehensive care for adolescents;
- comprehensive care for people living with HIV/AIDS and other STI;
- comprehensive reproductive health care focusing on: prenatal care, care in childbirth, postpartum care, post-abortion care, contraceptive technologies, the climacteric, and menopause;
- comprehensive services for cervical and breast health;

- male participation in the development of sexual and reproductive health and the promotion of responsible, emotionally supportive parenthood; and

- the protection and promotion of sexual and reproductive health rights.

30. Although a comprehensive approach to domestic violence in general, and sexual violence in particular, was identified as a critical issue, it was not addressed in this chapter of the policy, because it would be dealt with in another chapter with the heading "Intrafamily Violence and Extrafamily Sexual Abuse."

31. The Ministry of Health team also identified areas for revision of the critical issues:

- the quality/equity of sexual and reproductive health care (compliance with regulations, access, information systems, quality control, network of services, etc.);

- the promotion of responsible, gratifying sexuality without violence;

- the protection and promotion of rights (education, training, information, defense);

- citizen activism in conceiving, planning, executing, and evaluating activities, and promoting participation; and

- diversity (encompassing men, women, children, disabilities, sexual orientation, and ethnic groups).

Organization of the Panel Discussion

32. The work methodology was a panel discussion that brought together the voices of different people who recounted their own experiences with the violation of their sexual and reproductive rights, in terms of the critical issues identified above. The purpose of the panel was to provide input for the subsequent work and to remind participants that they were there to develop guidelines and strategies for policies that would help citizens to exercise their sexual and reproductive rights.

33. The group consisted of a woman who had survived breast cancer, a young woman who had been the victim of institutional violence during childbirth, a pregnant woman living with HIV/AIDS and an HIV+ man, and a representative of a men's group. The group discussion was followed by a presentation on what it means to employ a gender and human rights approach in health. From there, the focus shifted to a review of the ethical/conceptual framework of the National Health Policy, the critical issues, and the

methodology to follow. The groups were divided into six working groups, one for each critical issue.

Different People with a Common Dream: Participating Social Actors

34. The representativeness of the diverse experiences, needs, ways of viewing the world and of living sexuality, as well as work experiences related to the critical issues identified, was fundamental for the designation of the 41 participating social actors. The panel discussion brought together the representatives of a wide range of interests: women's movements, a group to promote compassionate care in childbirth, men's groups, people living with HIV/AIDS, the National Women's Institute, women who had survived breast cancer, gay groups, citizen advocacy groups, young women, university women, health personnel (programs for adolescents, the elderly, treatment of HIV/AIDS, health care for women). The United Nations Population Fund (UNFPA)-Costa Rica also participated and provided assistance, supporting the work on sexual and reproductive health policies and facilitating the presence of consultant Margareth Arihna, of UNFPA-Mexico, at the event to provide input to the process.

35. The UNFPA consultant gave a presentation on her experiences in the preparation of public sexual and reproductive health policies in Latin America. She was also part of the support team that worked with the groups during the event to provide input for the discussions. The diversity of the groups facilitated a valuable reflection and discussion process that even turned into an opportunity to learn, to share experiences and knowledge, to lose the fear of differences, to recognize that people can come together through common objectives, and to forge strategies to promote partnership and cooperation.

Results of the Process

36. As an end product of the event, a document containing a series of policy guidelines and strategies [8] was prepared and turned over to an institutional committee for its review and consolidation into two policy guidelines with their respective strategies, namely:

[8] Ministerio de Salud. Política nacional de salud. Capítulo sobre "Salud y derechos sexuales y reproductivos". Documento preliminar producido en taller intersectorial. [National Health Policy. Chapter on Sexual and Reproductive Rights. Preliminary document produced in the Intersectoral Workshop] Costa Rica, October 2002. For more information, contact Edda Quirós R./ *eddaquiros@hotmail.com*

Policy guidelines

- A comprehensive sectoral and interdisciplinary approach to sexual and reproductive health in the different stages of the life cycle, employing a gender, rights, and risk approach and grounded in the principles of solidarity, universality, equality, and equity.

Policy strategies

- Promotion of sectoral and intersectoral activities that guarantee comprehensive sexual and reproductive health care for people in the different stages of the life cycle, with emphasis on population groups that are vulnerable due to their age, sex, or ethnic origin.

- Prevention and treatment of cervical, breast, and prostate cancer, from a human rights perspective.

- Promotion of safe and healthy sex in the different population groups in all stages of the life cycle.

- Promotion and respect for the sexual and reproductive rights of individuals in comprehensive care for men and women and the exercise of those rights during: preconception, pregnancy, childbirth, the postpartum period, middle age, and maturity.

- Updating of legislation and regulations governing sexual and reproductive health that guarantee equitable, safe, and quality care with dignity, and monitoring of compliance in public and private facilities.

- Promotion of research on sexual and reproductive health.

- Strengthening of the National System for the Study of Maternal Mortality.

- Activities to promote, respect, and facilitate the exercise of sexual and reproductive rights at the different stages of the life cycle—activities that respect diversity, autonomy, physical integrity, and equality.

- Strengthening of the activities of the Teen Mothers' Council.

Policy guidelines

- Comprehensive care for HIV/AIDS and STI, with emphasis on prevention and the promotion of safe and responsible sex among the different population groups, with equity, quality, respect for differences, and a human rights approach.

Policy strategies

- Evidence-based promotion of changes in knowledge and attitudes about sex and the sexual practices of the population, with special attention to children and adolescents in vulnerable groups, with social participation.

- Identification of children and adolescents who are victims of sexual and commercial exploitation or exposed to HIV/AIDS and STI, and the delivery of comprehensive health services to that group.

- Delivery of comprehensive health services to people living with HIV/AIDS or STI or who are at risk of contracting these diseases, with special attention to children and adolescents who are victims of sexual and commercial exploitation, at all levels of care.

- Intersectoral and community activities to promote a better quality of life for people living with HIV/AIDS.

- Strengthening of the National Board for the Comprehensive Treatment of HIV/AIDS (CONASIDA).

- Strengthening of epidemiological surveillance of HIV/AIDS and STI.

- Observance and dissemination of current legislation on HIV/AIDS.

Conclusions

New Paths in This Joint Effort

37. Health policy is not considered an exclusively governmental responsibility, but the outcome of an agreement involving the various social actors—governmental, nongovernmental, and civil society.

38. Participation, not planning done on the outside or by experts, is the core of the efforts to formulate health policy. Health policy-making is a joint activity that enables groups or organizations to identify their own problems and demand their rights. Thus, it

is a practical experience in democracy that, from a diversity approach, addresses individual and societal needs and determines the common good based on particular interests, with the object of improving the quality of life.

39. From an operational standpoint, the formulation of health policies fosters coordination and exchange among organizations with similar objectives and experiences. It promotes and facilitates joint action and potentiates shared resources. From a political standpoint, it encourages a social force to exert its capacity to act and builds cooperation and power networks.

40. Some 600 social actors participated in the formulation of the national policy, demonstrating the influence and credibility of the Ministry of Health in Costa Rica.

41. The National Health Policy has thus become the platform for defining the sanitary objectives of the health sector.

Follow-up

42. This work process has given rise to a number of commitments and new needs for follow-up efforts that are being organized for this year.

43. This policy-making process has not yet been shared with other agencies, because in March, the Policy and Health Agenda will be presented officially to the President of the Republic. Organizing opportunities for its dissemination will therefore be a priority; the goal will not only be to introduce it but to develop a joint strategy for monitoring compliance and providing follow-up with civil society and other actors.

44. It will also be necessary to strengthen the promotion and defense of sexual and reproductive rights and to monitor fulfillment of State responsibilities. The goal is to give priority to strengthening women's and adolescents' groups and promoting the involvement of heterosexual and homosexual men.

45. Other goals are to draft the National Plan for Sexual and Reproductive Rights, using the results of the workshop to organize a forum on men's participation in the development of sexual and reproductive health, and, finally, to develop guidelines for disease prevention and sexual and reproductive health care for men, utilizing the results of that forum.

Recommendations

46. The participation and mobilization of social actors is key to identifying their needs and priorities and developing strategies.

47. At the same time, the development of follow-up and monitoring indicators will be necessary to ensure the applicability of the strategic actions established.

48. Continued efforts should be made to thoroughly examine methodological, conceptual, and instrumental aspects to ensure state planning with a gender approach. It would be advisable to share this experience in national and international forums with a view to disseminating this knowledge and providing input for the process.

49. Although this process enjoyed financing from the Ministry of Health and several cooperation agencies, the real task will be identification of the necessary resources for monitoring and implementing the policy in the agencies responsible for its execution.

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