



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



**20th SESSION OF THE SUBCOMMITTEE ON WOMEN,
HEALTH, AND DEVELOPMENT OF THE EXECUTIVE
COMMITTEE**

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FINAL REPORT

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FINAL REPORT

1. The 20th Session of the Subcommittee on Women, Health, and Development of the Executive Committee was held at the Headquarters of the Pan American Health Organization (PAHO) in Washington, D.C., on 25-26 March 2003.

2. The session was attended by representatives of the following Members of the Subcommittee, elected by the Executive Committee or designated by the Director in accordance with the Subcommittee's Terms of Reference: Canada, Chile, Costa Rica, Dominica, Mexico, Paraguay, and United States of America. Also present were observers for Bolivia, Cuba, Honduras, and Peru. One intergovernmental organization and one nongovernmental organization were represented.

Officers

3. The following Member Governments were elected to serve as officers of the Subcommittee during the 19th Session:

President: Costa Rica (Dr. María del Rocío Sáenz Madrigal)

Vice President: Paraguay (Dr. Roberto E. Dullak Peña)

Rapporteur: Canada (Ms. Jean Kammermayer)

4. Dr. Mirta Roses (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Marijke Velzeboer-Salcedo (Chief, Gender and Health Unit) served as Technical Secretary.

Opening of the Session

5. The Director opened the session, noting that it was the first meeting of the Governing Bodies that she had had the privilege of inaugurating since assuming the directorship of the Organization in February 2003. It seemed particularly appropriate that the first session that she—the first female Director in PAHO's history—was opening should be the body devoted to the achievement of gender equity. It was also very appropriate that the Subcommittee should be holding a joint meeting with the Subcommittee on Planning and Programming. That was the body that shaped the policies and programs of the Organization, and the Subcommittee on Women, Health, and Development could provide valuable input on how better to incorporate a gender perspective into all aspects of the Organization's policy-making, programming, and

budgeting. She looked forward to excellent discussions and a sound set of recommendations that would help guide the work of PAHO in the future.

Adoption of the Agenda and Program of Meetings (Documents MSD20/1, Rev. 1, and MSD20/WP/1)

6. In accordance with Rule 2 of its Rules of Procedure, the Subcommittee adopted the provisional agenda prepared by the Secretariat and a program of meetings.

Presentation and Discussion of the Items

Advances of PAHO's Women, Health, and Development Program (Document MSD20/3)

7. Three presentations were made under this item. First, Dr. Marijke Velzeboer-Salcedo (Chief, Gender and Health Unit, PAHO) summarized the report on the work of the Program on Women, Health, and Development contained in Document MSD20/3. Though the Program's name had changed—in February 2003, with the restructuring of PASB, it had become the Gender and Health Unit—its mandate remained the same: to mainstream gender within the programs and policies of PAHO, the PAHO/WHO country offices, and Member States in order to reduce gender inequities in health. In keeping with that mandate, the Program had focused on the following five strategic areas of activity during the period 2001–2003: (1) incorporating a gender perspective in health situation data and analysis; (2) including stakeholders in the formulation and monitoring of health policies; (3) promoting integrated models that would reduce gender inequities in health; (4) reaching out with information, education, and communication for advocacy and training; and (5) mainstreaming gender in the policies and programs of PAHO and Member States.

8. In the first and second areas, the Program had undertaken a number activities with a view to implementing Resolution CSP26.R21, which called on the Secretariat and the Member States to ensure that all health data and information were disaggregated by sex, to promote the participation of users and producers of information on gender and health issues from both government and civil society, and to incorporate gender-based analysis in the formulation and monitoring of policies. Developing gender indicators and analysis tools and strengthening national capacity to carry out gender and health analysis were important aspects of that work, as was monitoring the impact of health policies and health sector reform on gender equity in health. In carrying out those activities, the Program had been guided by the recommendations of the Subcommittee's 18th Session on including gender equity criteria and involving stakeholders in health analysis.

9. In the third strategic area, the Program, working in collaboration with numerous partners at the regional, national, and community levels, had developed an integrated

model for addressing gender inequities in health. The model had been utilized in a very successful initiative to address gender-based violence in 10 countries of the Region. An impartial outside evaluation commissioned in 2001 had identified the lessons learned from that experience, which would form the basis for a book on the integrated model to be published within the next two months. The Program was also applying the integrated model in projects to promote men's involvement in sexual and reproductive health and strengthen community-based approaches to gender equity and mental health.

10. In the area of information, education, and communication, the Program distributed information on gender and health through the PAHO website (www.paho.org/genderandhealth) and through its listserv, GenSalud (gensalud@paho.org) as well as a variety of written publications, including advocacy packets and information sheets. The Program had also begun the process of establishing a virtual information center on women, gender, health, and development (<http://genero.bvsalud.org>), which would include a virtual library of gender and health information and a virtual learning center that would be part of the Virtual Public Health Campus that PAHO was scheduled to launch in April 2003. With regard to the fifth strategic area, the Program was adapting the World Health Organization policy for integrating gender perspectives in the work of WHO. It was also collaborating with various other units within the Organization to incorporate gender indicators in various monitoring and surveillance systems and to mainstream gender in all PAHO policies and programs.

11. Document MSD20/3 contained more detailed information on the Program's activities and achievements in all five strategic areas.

12. Dr. María Isabel Matamala Vivaldi (National Coordinator for Chile, Project on Gender and Equity in Health Sector Reform, PAHO) then spoke on the application of the Program's strategy for reducing gender inequities in the framework of the Project on Gender, Equity, and Health Reform In Chile. The project's objectives were (1) to generate information and knowledge and gender inequities in health within the context of the reform in Chile; (2) to engage in advocacy to promote mainstreaming of the gender perspective in reform policies; (3) to promote institutionalization of the gender perspective in both the governmental and civil society spheres; and (4) to utilize communications to influence gender issues in health reform.

13. With respect to the first objective, a series of publications on different issues relating to gender equity and health reform had been produced. Several of those publications were made available to the Subcommittee at the 20th Session. In addition, a matrix of gender indicators had been developed to enable both government and civil society to monitor the impact of health sector reform policies, and qualitative research had been conducted as a first step towards a methodology for quantifying the

unremunerated health work performed by women and incorporating that information into national health accounts.

14. Activities in the area of advocacy included the formation of an advisory board which had enabled ongoing dialogue among stakeholders from various spheres, both governmental and nongovernmental, and organization of a series of workshops and conferences, also with a broad range of participants, to highlight issues relating to gender and health reform. Additionally, PAHO had joined forces with several other international organizations to advocate for the inclusion—as part of health sector reform—of services for victims of gender-based violence in the primary health care network.

15. As for institutionalizing the gender perspective, the third objective, progress had been made towards creating an observatory within the University of Chile for monitoring health reform policies from a gender perspective. In addition, PAHO had provided technical cooperation to the National Women's Health Service (SERNAM) and other agencies of the Ministry of Health for the application of gender analysis in the planning, execution, and evaluation of health policies. In the area of communication on gender issues and health reform, an important success had been the achievement of coverage of gender-related issues in the news media at least once every five days.

16. While considerable progress had been made in drawing public attention to gender equity concerns in health sector reform, some gender inequities in Chile's health system remained to be addressed. Those inequities were most apparent the private health care delivery system (ISAPREs), but they were also present in the public system (FONASA). For example, under FONASA, female employees were not entitled to coverage for their spouses who were unemployed, whereas male employees did receive such coverage. Rectifying those inequities would require continued advocacy to bring about legislative change. In addition, in rethinking the model of care, it was necessary to take account of the health care provided by women in the home and to ensure mechanisms for citizen participation in health sector reform and in monitoring policies from a gender perspective.

17. The third presentation on this item was given by Ms. Cathy Cuéllar (Subregional Advisor for Central America, Gender and Health Unit, PAHO), who described the implementation of the integrated model for addressing gender inequities in health, focusing in particular on how the model had been applied as part of the project to deal with the problem of gender-based violence in Central America. That project had been discussed by the Subcommittee at several of its previous sessions. The approach espoused by PAHO was a public health approach based on the principles of prevention, health promotion, detection, and, where necessary, rehabilitation. It encompassed the national, sectoral, and community levels and encouraged participation by groups of women.

18. The model for addressing gender-based violence had been developed following in-depth situation assessments conducted in all the countries of Central America. Based on that research, five objectives for the project had been established: define and consolidate uniform public health responses to the problem of gender-based violence; promote intersectoral coordination and approaches; strengthen personnel capacities and develop instruments, including materials for teaching in the health sector; build local-level networks to improve care and access to care for those experiencing violence; and conduct research and develop evidence-based interventions.

19. The successes achieved through the project on gender-based violence included the formulation of national plans and policies on gender-based violence in six countries, development of intrafamily violence norms and protocols in all seven countries, training of over 30,000 health workers and other personnel involved in addressing the problem, application of the model in more than 70 communities, enactment of legislation on gender-based violence in all seven countries, data collection and surveillance in all ministries of health, creation of over 170 local networks to respond to gender-based violence in an intersectoral manner, and research at the local and national level in all the countries to continue refining the responses to the problem. In addition, there had been numerous instances of intercountry cooperation and exchange of experiences, manuals and other educational materials had been produced, contents on gender-based violence had been introduced into the curricula of training programs for various professions, and referral and counter-referral procedures had been put in place. The latter achievement had remedied one of the major gaps identified in the initial situation assessments carried out at the national level.

20. Based on the experience in Central America, the model was considered a holistic and replicable approach which could be applied to address other types of gender inequities. It was a model that could be introduced at either the national or the local level, though the ideal was a combined approach encompassing both levels. It was also a model that facilitated the creation of alliances between the state and civil society to define national responses to gender inequities, the importance of which could not be stressed enough.

21. The Subcommittee commended the Program on its achievements to date and expressed strong support for its continued work as the Gender and Health Unit. Several delegates commented on how valuable that work had been in guiding their own countries' efforts in regard to gender and health, particularly in the areas highlighted by Ms. Cuéllar and Dr. Matamala. The Subcommittee applauded the Program's efforts to involve civil society, especially women's organizations, in its work. That involvement was considered crucial in the response to gender-based violence and in remedying gender inequities in health sector reform initiatives, as it was often civil society organizations that first drew public attention to such issues and that were in the forefront of efforts to

address them. It was pointed out, however, that many countries still lacked effective mechanisms for coordinating the work of government institutions with that of civil society. Assisting countries in developing those mechanisms was seen as an important technical cooperation role for PAHO.

22. The need for intersectoral approaches was also stressed. Problems such as gender-based violence were enormously complex and addressing them required the involvement of a broad range of actors from not only the health sector but also the judicial, law enforcement, and other sectors. Coordination within the health sector—across departments within ministries of health and between the various levels of the health system—was also essential.

23. With respect to mainstreaming of gender in the policies and programs of PAHO and Member States, a number of delegates stressed the importance of empowering women and increasing their participation in high-level decision-making in the political and economic spheres. It was pointed out that the greatest strides towards gender equity had been made in those countries where women were playing a prominent role in the various branches of government. Several delegates cited specific cases of legislative or policy-making advances that had been achieved at the initiative of female ministers and legislators. The presence of more women in senior positions within international organizations was also considered highly desirable. In that connection, many delegates welcomed the election of Dr. Roses as the first female Director of PAHO and expressed the conviction that under her leadership the Region would make great progress in redressing gender inequities.

24. The Representative of the Inter-American Commission of Women (CIM) noted that the Commission had received a mandate from a meeting of female ministers three years earlier to intensify efforts to mainstream gender in public policy. Since then, in partnership with experts in gender issues, it had formulated recommendations on the matter for ministries of labor, justice, education, science and technology, and other sectors. PAHO had collaborated in some of that work, notably with the ministries of labor. Thus far the process had been very fruitful, and significant headway had been made in incorporating a gender perspective into policies and plans of action in the various sectors.

25. The Representative of the Inter-American Commission of Women (CIM) mentioned that they had assigned some spaces for the upcoming gender-based analysis training being provided to officials at the Organization of American State (OAS) through the gender mainstreaming project of the Canadian International Development Agency (CIDA). The CIM/Executive Secretary Carmen Lomellin, also reported that, although there had been initial resistance to the OAS-CIDA Gender Mainstreaming training program, the response of participants thus far has been extremely positive. Several

remarkable initiatives have grown out of the gender training, including the formulation of a staff-driven gender policy for the OAS and the establishment of a special subcommittee of the OAS staff association to deal with gender-related workplace issues. The Delegate from Canada and a number of other delegates expressed their support to PAHO in accepting the opportunity for some of their senior staff to benefit from this training opportunity.

26. With regard to the issue of gender-based violence, several delegates described programs under way in their countries to address the problem. The need for development of indicators to measure the impact of such programs was stressed. Monitoring and evaluation were considered essential in order to determine which interventions were most effective. Several specific questions were asked regarding assessment of the effects of the gender-based violence project in Central America, in particular its impact in reducing the prevalence of the problem. Sharing of experiences was also seen as an important means of identifying best practices, and various delegates offered to share information on their countries' initiatives. PAHO's role in facilitating such exchanges and in developing impact indicators was emphasized. Delegates underscored the need for more specific attention to sexual violence and child abuse. One delegate pointed out that attitudes about violence were shaped in early childhood. Violence prevention interventions should therefore begin in primary school and should continue through adolescence. It was also important to call attention to—and condemn—the glorification of violence in the mass media.

27. The Representative of the CIM reported that the Commission had undertaken an impact assessment of the Convention of Belém do Pará on the Prevention, Punishment, and Eradication of Violence Against Women. The assessment had revealed that, while progress had been made in enacting legislation to protect victims of violence, there continued to be problems in implementing that legislation. It had also revealed, *inter alia*, the need for better training of judicial and law enforcement officials and more focused violence education and awareness programs. The results of the study could be accessed from the CIM website (www.oas.org/cim).

28. Collecting sex-disaggregated information was seen as a critical first step in addressing gender-based violence and other gender inequities. However, it was pointed out that compiling statistical information was not sufficient to rectify the inequities that affected women's health and quality of life. It was necessary to identify the root causes of those inequities and then to take action to correct them. In that connection, several delegates emphasized the need for greater attention to poverty, which was both a cause and an effect of gender inequities among women.

29. Delegates also emphasized the need to focus on gender equity issues that affected men. The Delegate of Bolivia noted that in his country, as in Chile, male spouses of female employees were not entitled to health care coverage. That was an example of gender discrimination against men that needed to be addressed.

30. The Delegate of Dominica observed that the discussion had pointed up the fact that the countries of the Region were grappling with many of the same problems. It was important to forge partnerships among all stakeholders, both governmental and nongovernmental, and work together to identify solutions to those common problems. Bodies such as the Subcommittee provided a valuable forum for doing just that.

31. Dr. Velzeboer agreed that creation of alliances and partnerships and collaboration across sectors were essential. Intersectoral collaboration was one of the guiding principles of the integrated model developed by the Program to address not just gender-based violence but other gender issues. However, such collaboration was not always easy to achieve. The involvement of women's organization, in particular, remained a challenge for many countries. As a partner and collaborator in working with countries on difficult issues such as gender-based violence, PAHO always underlined the need to involve those organizations and build upon their work, not only because they often spearheaded efforts to address gender inequity issues, but because, in many case, they had compiled the only data that existed on them. Moreover, whereas the Organization's government counterparts tended to change frequently, its partners in women's organizations often remained the same, which allowed for greater consistency and continuity of effort.

32. Several delegates had mentioned the importance of measuring impact. That continued to be a tremendous challenge, and was one of the primary reasons why the Program had identified disaggregation and improvement of information as a top priority. As other delegates had pointed out, however, it was not sufficient just to improve information; it was also necessary to improve the use of information for advocacy and action. Often, though information on gender equity issues existed, it was not available to those who could use it to improve interventions and advocate for better policies. Putting information in the hands of those who needed it was therefore another of the Program's priorities. Responding to a delegate who had noted that access to information on the Internet was limited in the Region, she said that while that was true in the case of many of the poor and vulnerable populations targeted by PAHO, most of the organizations that were working to address their needs at the national level did have Internet access, and the Organization believed that the Internet could be a valuable resource in making tools and information available to those organizations.

33. Regarding the question of data on gender-based violence, she pointed out that collection of such data was inherently difficult. The experience in Central America had

shown that, without proper training and sensitization for data collection personnel, attempting to collect information from women who were experiencing gender-based violence could do more harm than good. The situation was further complicated by the existence of multiple surveillance and information systems in various sectors, often with no linkage between them. Data collection should take place within an integrated effort to address the problem of gender-based violence that included, inter alia, training for the personnel involved, implementation of norms and protocols, and establishment of referral systems.

34. Despite the difficulties, some successful data collection initiatives had been carried out. For example, a number of countries had done population studies on gender-based violence, and WHO, in collaboration with PAHO's focal points and other intersectoral partners, had recently conducted comprehensive prevalence studies in several cities in Brazil and Peru, which had yielded a tremendous amount of data on the problem. Those studies exemplified the approach that should be taken: they had been done by interviewers trained to deal with the respondents in a sensitive manner and they had set up referral systems to assist women living in violent situations. Although such studies were quite expensive, they were enormously important because they provided information on the extent of the problem and its impact on women and girls. Such information was critical for advocacy and for influencing policy-making.

35. She agreed that education on gender-based violence and other issues related to gender, reproductive health, and equity should begin at an early age and continue throughout childhood and adolescence. Some countries, including Belize and Peru, had already begun to incorporate contents on prevention of gender-based violence in their primary education curricula. Within PAHO, the Gender and Health Unit was working with the unit that dealt with adolescent health to incorporate awareness of gender-based violence into its work.

36. With respect to gender and health sector reform, work was just beginning in that area. Four years earlier, when the Subcommittee had held its 18th Session, there had been virtually no data on the impact of health sector reforms in gender terms, and very little had been done to incorporate gender considerations into health sector reform initiatives. Significant progress had been made since then in raising awareness of the fact that certain reforms had created inequities. The next step would be to develop simple indicators for monitoring the impact of health reform processes. Again, it would be important to involve women's organizations in that effort because it would be those organizations that would be working at the national level to influence health reform policies.

37. Finally, responding to the Delegate from CIM, she said that PAHO would welcome the opportunity to participate in the gender training at the OAS and looked forward to becoming more involved in CIDA's gender mainstreaming project.

38. Alluding to the comments regarding the empowerment of women, Dr. Matamala affirmed that the presence of women in positions of authority within the government had been a decisive factor in the progress achieved in mainstreaming gender in Chile. Still, much remained to be done to mainstream gender across all ministries and sectors. Doing so was a long process which entailed not only raising awareness of gender issues, but also incorporating theoretical instruments into policy and, especially, into daily practice. Otherwise, gender mainstreaming would remain an abstract idea that produced few concrete results.

39. She also pointed out that advocacy for gender mainstreaming was a dynamic process that had to be adapted to situations that were constantly changing. It was necessary to be alert to emerging issues in order to sensitize people to them. That, in turn, meant constantly producing updated information, a need that was not always sufficiently recognized.

40. Another important matter that had not received enough attention was the inequity that affected men. As the Subcommittee had noted, the exclusion of spouses of working women from health care coverage was one example. That practice was, in reality, an example of double discrimination: it was discriminatory against men because they were excluded from coverage, but it was also discriminatory against women because they were denied a benefit to which male employees were entitled.

41. Ms. Cuéllar, replying to the questions concerning the impact of the gender-based violence project, said that one of the major accomplishments had been that gender-based violence was now recognized as a public health problem, and the health sector in the countries had assumed responsibility for addressing it. As for the concrete impact of the project in terms of reducing the problem, hard data were not yet available. Nevertheless, the qualitative evaluation had indicated that both health workers and the affected women perceived that the project had yielded positive changes, including creation of intersectoral networks to address gender-based violence, better access to care, and better training for health personnel in dealing with the problem. The next challenge would be to develop indicators to measure the project's impact in quantitative terms.

42. The experience in Central America had underscored the importance of building on work that had already been done. As much of that work in the area of gender-based violence had been done by women's organizations, it was essential to find ways to harmonize their efforts with those of governmental entities. Different strategies had been applied in the various countries, and some very creative approaches to intersectoral collaboration had emerged. For example, in some cases, the gender-based violence project had "piggybacked" on other health promotion initiatives, such as the healthy settings or healthy communities movement.

43. In reply to a question from one of the delegates about the results of the intercountry collaboration on gender-based violence, she reported that, for example, Bolivia and Nicaragua were collaborating on data collection and surveillance, while Panama and Belize were collaborating in the development of curricula for nursing schools that included topics related to gender-based violence and gender equity. There had also been technical exchanges between regions, notably between Central America and the English-speaking Caribbean. Those exchanges had, in turn, spawned additional exchanges between individual countries.

44. The Director affirmed that achieving gender equality was a priority for the Organization in general and for her in the current five- year period in particular. Substantial progress had been made towards that goal, both within the Secretariat and in the countries, but much was left to do. Two types of strategies were needed to reach the goal of gender equality: (1) gender mainstreaming in all policies, plans, programs, projects, etc., and (2) empowerment of women. The two strategies were inextricably linked.

45. As the Subcommittee had emphasized, empowering women and increasing their participation in decision-making was a crucial aspect of mainstreaming gender and addressing gender issues. The current situation in the Region in that respect was somewhat disheartening: only one country had a female head of state, and only four ministers of health were women. Nevertheless, women were playing increasingly important roles in other areas, such as foreign affairs, defense, and justice, where they had not previously been prominent.

46. The participation of women in legislative bodies was also a key factor in bringing about greater gender equality. As had been pointed out, the countries that had made the greatest strides in addressing gender issues had been those in which women were actively involved in formulating policies and laws. It was interesting to note in that regard that female legislators tended to join forces as women, often crossing party lines, to bring gender issues to the fore.

47. Mainstreaming gender was important not just from the standpoint of overcoming gender inequities but also in the context of the Millennium Development Goals, one of which concerned the promotion of gender equality. Indeed, the Secretary-General of the United Nations had identified progress towards gender equality as the sine qua non for achieving all the other goals, including the three that related directly to health. The application of a gender perspective and use of gender analysis in all planning, programming, and policy-making would reveal how men and women were affected differently by different actions and measures, which would, in turn, help foster greater understanding and appreciation of diversity. And acknowledgement of diversity—

between ethnic groups, age groups, countries, regions within countries, and elsewhere—was crucial for achieving the Millennium Development Goals.

48. She welcomed the invitation for PAHO to participate in the gender mainstreaming project at the OAS. If PAHO was to help the countries achieve gender equality, it must first bring about a transformation within the Secretariat. The training being provided as part of the CIDA project would help equip the staff to accomplish that transformation and fully mainstream gender within the Organization. She appealed to other countries in the Region that had made significant headway in mainstreaming gender to assist the Secretariat in transforming itself and achieving true gender equality. Only then could the Organization be an effective instrument for change in the Region.

49. A key element in the transformation would be ongoing monitoring and evaluation to determine whether progress towards gender equality was, in fact, being made and to identify the underlying causes that were impeding the recruitment of women and their access to senior positions. To facilitate that process and to ensure that gender equality and gender mainstreaming received the priority they deserved, in the restructuring of the Secretariat, the Gender and Health Unit had been placed within the area of Governance and Policy, which was directly linked, through the Director of Program Management, to the Office of the Director. By raising the matter of gender to that level in the organizational hierarchy, it would be possible to insert the “gender chip” into everything the Secretariat did.

50. Another of her priorities as Director was to increase interagency collaboration on gender issues, both within the inter-American system and the United Nations system. Given PAHO’s dual status, it was uniquely positioned to serve as a liaison between the two systems. In addition, it was important to foster collaboration with the nongovernmental sector, including women’s organizations, academic institutions, and other entities. A mechanism for interagency collaboration at the regional level was needed. One possibility might be to create an interagency committee, similar to those that existed at the national level in many countries. By pooling their efforts, the various agencies could make much more progress than if they worked alone, not just on gender equity, but on related issues such as poverty reduction, AIDS, and others that had been mentioned by the Subcommittee.

51. She concluded by reiterating her appeal to the Member States, as well as to nongovernmental organizations and other partners, to assist the Secretariat in transforming itself so that it would be better equipped to support the countries in meeting the challenges of mainstreaming gender and achieving gender equality.

***Country Experiences with Monitoring Health Policies with a Gender Perspective
(Documents MSD20/4, MSD20/5, MSD20/6)***

52. Presentations on this topic were made by representatives of three Member States: Canada, Costa Rica, and Mexico. In addition to the documents prepared for the Subcommittee, all three representatives distributed other publications relating to women's health and gender mainstreaming in the health sector in their countries.

Canada

53. Ms. Jean Kammermayer (Senior Policy Analyst, Women's Health Bureau, Health Canada) described Canada's approach to monitoring gender inequalities in health policies. She began with an overview of the Canadian context and the Canadian health system. Canada is a federation in which responsibility for health is shared among the federal, provincial, and territorial governments. The federal government provides leadership in developing health policy, enforcing health regulations and promoting disease prevention ensures health services for First Nations and Inuit communities, and provides financial assistance to the provinces and territories to assist them in the delivery of health care services to their residents. That financial assistance is contingent on provincial and territorial compliance with the Canada Health Act, which sets out the operating principles for the country's health insurance system. Under the Canada Health Act, provinces and territories must provide to Canadian residents universal access to physician and hospital services on uniform terms and conditions, that is, regardless of age, sex, race, financial circumstances, lifestyle, or prior health status.

54. The Women's Health Bureau within Health Canada promotes equitable health outcomes for men and women. The Bureau serves as a focal point for action with regard to women's health and provides leadership in the application and integration of gender-based analysis to legislation, policies, programs, and practices. The Bureau's work is guided by Health Canada's *Women's Health Strategy*, which has four main goals: to ensure that Health Canada's policies and programs are responsive to sex and gender differences and to women's health needs, to increase knowledge and understanding of women's health and women's health needs, to support the provision of effective health services to women, and to promote good health through preventive measures and the reduction of risk factors that most imperil the health of women.

55. Designing and monitoring policies and programs with a citizen focus involves building the capacity of citizens to engage in the process. The government seeks to engage citizens in the policy process, and also provides accountability, federally, by providing information on health activities and accomplishments through a number of different reports. One of the mechanisms for citizen participation in the process is the Women's Health Contribution Program, administered by the Women's Health Bureau. The Program, comprised of four research centers and the Canadian Women's Health Network, contributes to the development of policy options aimed at enhancing the responsiveness of healthy policy to women's health concerns through information, knowledge generation, communication, networking, and policy advice. One example of the type of research conducted is a qualitative study that sought to identify how women had been impacted by the shift from institution-based care to community-based care.

56. Canada's commitments to gender equality are codified in four documents: the Canadian Charter of Rights and Freedoms, the Federal Plan for Gender Equality, the Gender-based Analysis Policy, and the Agenda for Gender Equality. The latter is led by Status of Women Canada in partnership with three other federal departments. One of its components is acceleration of the use of gender-based analysis across the federal government. Canada also has two central data collection agencies, Statistics Canada and the Canadian Institute for Health Information. Although an increasing amount of data contained in national and provincial/territorial reports is sex disaggregated, to date, not all data is presented in a sex-disaggregated manner.

57. Gender-based reports on a number of aspects of women's lives, including health, have been produced at the federal and provincial/territorial level which are helpful in identifying issues related to the impact of health policies on women.

58. Canadians have just engaged in a dialogue on the future of health care in Canada aimed at identifying ways of improving the public health care system and making it sustainable. Subsequently, governments, in the Health Accord 2003, reaffirmed their commitment to the principles of the Canada Health Act and committed to enhancing the transparency and accountability of the health care system. That commitment to accountability will provide an opportunity for enhancing Canada's system of monitoring health policies and programs with a gender perspective. Similarly, the women's health indicators project Health Canada initiative to develop a core set of relevant indicators that took gender and diversity into account—will provide baseline data for monitoring women's health and generate information for policy-makers.

59. One of the major challenges for the future in monitoring health policies from a gender perspective includes identifying the impact of the various determinants of health, given their multidimensional and intersectoral nature. For example, with respect to care-giving, does it contribute to the progression of chronic conditions, and if so, is it through

stress, through isolation, through financial impact, and which were the strongest mediating factors? Another challenge is monitoring and addressing the combined effect of gender and the other factors that contribute to health.

Costa Rica

60. Dr. Rocío Sáenz Madrigal (Minister of Health, Costa Rica) spoke on the topic “Developing a Public Health Policy from a Human Rights and Gender Perspective.” She began by noting that Costa Rica had been working on issues relating to gender equality and gender-based violence for more than 15 years. Those issues were now being widely discussed in numerous forums throughout the country, and great progress had been made. Nevertheless, several major challenges remained to be overcome.

61. In Costa Rica, the priority task identified for public health was to confront inequalities and inequities, satisfy needs, reduce deprivation and want, and advance towards a society that recognized the similarities, diversity, and specific characteristics of its population in constructing public health. Accordingly, the guiding principles for the formulation of the country’s National Health Policy 2002–2006 had been equity, social inclusion, ethics, universality, solidarity, and quality. The process had also been guided by three cross-cutting concepts: gender and application of the gender perspective, human rights, and social participation.

62. The first step in formulating the policy had been to create an institutional team to facilitate the process and designate a coordinator with experience in working on the issue of sexual and reproductive health from a gender and human rights perspective. The second step had been to undertake an ethical-conceptual analysis, applying the gender and human rights perspectives, in order to identify the critical issues to be addressed. Those issues were: comprehensive care for adolescents; comprehensive care for HIV/AIDS and other STIs; 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. It had been determined that those issues should be analyzed from the standpoint of the quality and equity of sexual and reproductive health services; disease prevention and promotion of responsible, gratifying sexuality without violence; protection and promotion of rights; citizen involvement in conceiving, planning, executing, and evaluating activities, and in promoting participation; and diversity (encompassing men, women, children, disabilities, sexual orientation, and ethnic groups).

63. The next step in the process had been the organization of a panel discussion that brought together a broad range of stakeholders to talk about their experiences with violation of sexual and reproductive rights. Participants were also divided into groups to discuss each of the critical issues. The participants included representatives of the women's movement, persons living with HIV/AIDS, gays and lesbians, and breast and cervical cancer survivors, as well as representatives of government and academic institutions and international organizations. Constructing the policy had thus been a process of bringing together different people with common dreams.

64. What had emerged from the consultation process had been two major policy orientations, each accompanied by its own set of policy strategies. The first policy orientation was 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. The second policy orientation was comprehensive care for HIV/AIDS and other STIs, 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.

65. The policy formulation process had created several new commitments and monitoring needs, notably, the need to develop a strategy for monitoring compliance, with the involvement of civil society and other stakeholders, and the need to strengthen the promotion and defense of sexual and reproductive health rights, ensuring that the responsibilities of the State were fulfilled. The process had also given rise to several recommendations for future policy-making exercises. First, promotion of the participation and mobilization of social actors was key to identifying their needs and priorities and developing strategies. In addition, the process had shown that it was necessary to develop follow-up and monitoring indicators that would ensure the applicability of the strategic actions identified. Methodological, conceptual, and instrumental aspects should be examined carefully to ensure that the gender perspective was being applied in state planning. And lastly, it was important to discuss the different stages of the experience in national and international forums with a view to sharing experiences and obtaining feedback.

Mexico

66. Dr. Blanca Rico (Coordinator, Women and Health Program, Mexico) outlined the work and accomplishments of the Women and Health Program, a program of the Mexico's Secretariat of Health, whose basic objective was to mainstream gender throughout the health sector. She noted that it had recently been decided that the Program would become a directorate within the Health Secretariat: the Directorate for Gender Equity in Health. The Program had originated to address the factors that had hindered

progress under public policies relating to women's health. Those factors included a narrow focus on women's reproductive functions, failure to adopt a life cycle approach, discrimination in care for women, lack of sex-disaggregated data, and deficient quality of care. In addition, while the concept of gender was present in discourse, it had not really been incorporated into health policies.

67. For the period 2001-2006, the Secretariat of Health had identified three main challenges as the focus of its work: equity, quality, and financial protection. Critical gender issues existed in all three areas. For example, there were clear differences in the care received by men and women for health problems that affected both sexes, and the quality of care for health problems that affected women exclusively was deficient. The most visible manifestation of that deficiency was maternal mortality, which remained unacceptably high in Mexico, despite the relatively high level of development the country had attained and despite the fact that the vast majority of maternal deaths were preventable. At the same time, however, women had less access to and paid more for insurance, owing to their reproductive health needs.

68. The work of the Women and Health Program was concentrated under five components. The first was institutionalization of the gender perspective throughout the health sector, involving other key sectors, and introducing innovations in the design and execution of institutional strategies that would facilitate a cross-cutting multisectoral approach. Another crucial aspect of the first component was incorporation of the gender perspective in budgeting, since as Dr. Guillermo Soberón, former Secretary of Health and a prominent figure in the public health community in Mexico, had observed, priorities that were not reflected in budgets were merely demagoguery. A number of initiatives were under way to sensitize decision-makers in the financial sphere to the existence of gender inequities in public budgets and to analyze how to make future planning and budgeting more equitable.

69. The Program's second component was women's health. It was carried out in coordination with the Reproductive Health Directorate and its focus was on aspects of women's health that did *not* relate to reproductive health. The component targeted problems that affected women exclusively or more seriously and that had not received sufficient attention, including family violence, mental health, and substance abuse, as well as health gaps and emerging problems. It sought to guarantee access to equitable, high-quality care and reduce inequities between different social groups and regions in the country. The Program had designed an integrated model for addressing gender-based violence through coordinated intersectoral action, with a focus on especially vulnerable populations, including indigenous women, agricultural workers, and others.

70. The third component, information and research, was aimed at generating statistics disaggregated by age and sex, developing gender indicators, incorporating satellite accounts into national accounts to reflect the value of women's unpaid work in the health sector—a topic that had been discussed at length by the Subcommittee on previous occasions—and analyzing the health research in progress to identify the topics being studied. The overarching objective of this component was to generate evidence of gender inequities in health and reveal the causes and effects of those inequities.

71. The fourth component focused on female health workers. It sought to address the historical gaps that existed between male and female workers and redress the inequities in working conditions in the health sector, promote gender equity in decision-making and in the working environment in health services, and evaluate training programs in medicine, nursing, and social work, as well as other technical careers in health. The fifth component, home and community health, was geared towards addressing the changes arising from health sector reform and from the demographic and epidemiological transition, many of which had placed an additional burden on women, who were responsible for most of the health care provided in the home. Under this component, the Program sought to design policies to encourage greater involvement of other family members, especially men, in home health care; support daycare facilities and design options for intermediate care for chronic patients; and apply a gender perspective in community care programs.

72. To ensure broad stakeholder participation in designing health policies and programs with a gender perspective and in monitoring their impact in reducing gender inequities, the National Consortium on Women and Health had been created. The Consortium included a broad range of participants from government, academia, and civil society.

73. The Subcommittee found the presentations and the accompanying documents extremely informative and instructive, and reaffirmed the value of such exchanges of experience as a means for countries to learn from one another and work together to address common problems. The Subcommittee also welcomed the emphasis in the presentations on aspects of women's health other than those related to their reproductive and maternal roles, such as mental health and substance abuse, and the effort to understand the many determinants of women's health status. The effort to involve men to a greater extent in sexual and reproductive health and in family life, including caregiving for ill family members, was also applauded.

74. It was pointed out that the three presentations had contained several common themes. One was the issue of gender-based violence, a problem all three countries were grappling with. The Director pointed out that there might well be a relationship between gender-based violence and certain economic and social trends. She had noted, for

example, when she was stationed in the Dominican Republic, that violence against women seemed to increase in places where the maquila (export assembly) industry had become the dominant employer, and she had witnessed the same phenomenon in some cities on the Mexico–United States border. The maquiladora plants hired mainly young women, leaving many men unemployed and unable to provide an income for their families. The result was a loss of self-esteem among men and a rise in violence against women. That pointed up the need to take account of factors such as employment patterns in devising a response to gender-based violence.

75. Dr. Rico observed that the problem was not limited to the maquila industry. Increased participation of women in the labor force in general had changed the nature of relations between men and women, both in the home and in the workplace, and one of the results had been more violence against women. Another delegate agreed with that view, remarking that, to a certain extent, increased violence against women seemed to be a cost of the changes that had occurred in male-female power relationships and of women's greater participation in decision-making roles. Dr. Rico said that, indeed, her country had found that to be true in communities in which a large proportion of the males had emigrated in search of work. In those communities, the women had taken over many of the responsibilities formerly reserved to men, such that, when the men returned, the balance of power had shifted and their role in community life had changed. Again, one of the consequences had been an increase in violence against women.

76. Another common theme that emerged in the Subcommittee's discussion was that of the increased demands being placed on women as a result of health sector reforms that had transferred responsibility for care from institutions to households. It was pointed out that such reforms were being introduced with little consideration of their consequences for families and, especially, women, who made up the majority of home caregivers. The Delegate of Chile reported that a survey on health and quality of life conducted in her country in 2002 had confirmed something which everyone suspected but which had not been well documented: assuming the responsibility of caring for a disabled or chronically ill family member had a negative impact on families' quality of life. The Subcommittee agreed that more such research, incorporating a gender perspective, was essential in order to provide the evidence needed to design policies that would effectively support families who were providing health care in the home.

77. The Subcommittee saw income replacement and other means of financial assistance as a crucial aspect of the support that needed to be furnished to home caregivers, many of whom were forced to leave their jobs or take extended unpaid leave. Nevertheless, it was recognized that, even in countries that had made some provision in their health sector reforms for dealing with the phenomenon of home health care, addressing that need was extremely complex and difficult. The Delegate of Canada mentioned her country had made a commitment to modify existing programs to ensure

that Canadians can provide care for a gravely ill or dying child, parent or spouse without putting their jobs or incomes at risk. This support would help a portion of those who provide care in the home and benefits would be geared to those who meet certain eligibility criteria linked to employment. Women who are not in the workforce, however, would not be able to gain access to this provision given its linkages to the employment insurance system.

78. Several specific issues were raised in regard to points mentioned by the presenters or in the documents. One delegate inquired about the impact of Canada's Family Violence Initiative in reducing the problem of gender-based violence. Another participant called attention to the gender inequities present in many aspects of reproductive health care for women and wondered how the gender perspective was being incorporated into Mexico's Directorate for Reproductive Health, given that the Women and Health Program was focusing on aspects of women's health other than reproductive health. The Delegate of the United States noted that many countries in the Region, including her own, had sizeable indigenous populations, and suggested that efforts to improve health care for women should incorporate midwives, herbalists, and other practitioners of traditional medicine. Referring to information presented by the Delegate of Mexico regarding medical school enrollment and employment patterns in the medical profession, she also pointed out that increasing the number of women working in the health sector would not necessarily lead to more gender-sensitive health care or health policies. While women should certainly be encouraged to study medicine, from a gender equity standpoint it was more important to work to change the rather authoritarian health care model of the past to a model that involved patients more actively in their own care and encouraged a more equal relationship between patient and provider, regardless of the sex of either.

79. Dr. Rico agreed that having more female providers would not necessarily guarantee more gender-sensitive care. Certainly, there were many men in the health sector who were extremely gender-sensitive—more so even than some of their female counterparts—and who were working to achieve more equitable gender relations. Nevertheless, the Women and Health Program did feel that some sort of affirmative action was necessary to correct the gender inequities that currently existed in the health workforce in Mexico and to ensure greater access for women to positions of authority. In that regard, she pointed out that incorporating a gender perspective in reproductive health programs—one of the points raised by the Subcommittee—might be easier precisely because a woman had recently been named to head the Directorate of Reproductive Health. Nevertheless, reproductive health was an area that was still very much equated with women in their traditional role as mothers, and it was difficult to persuade people to look at issues relating to sexual and reproductive health from a gender perspective and understand the need for gender-sensitive policies and programs that addressed the different needs of men and women.

80. Returning to the issue of gender-based violence, she suggested that, while it was true that the factors that prompted violence against women—such as women’s increased participation in the labor market—might have changed, in fact there might not have been any real increase in its frequency. Instead, the perceived rise in the prevalence of the problem might be due to better surveillance and reporting and to increased public awareness of its existence. In any case, the Subcommittee’s discussion had unquestionably illustrated the complexity of the problem and the need to take into account a wide array of factors in designing solutions. Among those factors were cultural differences. As had been pointed out, Mexico had a large indigenous population, and within that population there was great diversity. Specific culturally appropriate approaches were therefore needed to address the problem of gender-based violence in indigenous communities. One such approach was to utilize the knowledge and experience of practitioners of traditional medicine. Another was to involve organized groups of indigenous women. In that way, indigenous communities would feel that they were the originators of solutions to their own problems, not passive recipients of solutions imposed on them without regard for their cultural traditions.

81. Ms. Kammermayer, replying to a comment regarding Canada’s Centers of Excellence for Women’s Health, said that a very strong feature of the research conducted by those centers is its multidisciplinary and intersectorial approach. It takes into consideration not just biological/medical aspects of women’s health, but the whole social context in which women lived. It is also collaborative research, that actively involves women’s groups in identifying the issues of particular concern to women and posing the research questions. That research is yielding some very interesting findings, which could be accessed on the website of the Canadian Women’s Health Network (www.cwhn.ca).

82. Ms. Jodi Lynn Brown, a member of the delegation from Status of Women Canada, part of the delegation from the Women’s Health Bureau, Canada, responded to the questions concerning the impact of Canada’s Family Violence Initiative. Surveys conducted in 1993 and 1999 had indicated that there had been growth in the number of shelters and services for women and children who were fleeing situations of abuse. Social support services in the community had also increased. In addition, 5-year prevalence rates of spousal assault had decreased between 1993 and 1999, and there had been a general decline in the number of women who were victims of spousal homicide. Surveys of public perceptions of violence against women showed an increase in public awareness of the issue and greater recognition of the need to provide services for victims at the community level. Other changes included amendments to the Canadian Criminal Code relating to prosecution of perpetrators of violence. Much of this information is documented in the recently published, *Assessing Violence Against Women: A Statistical Profile*—a collaborative project of Federal, Provincial and Territorial Ministers Responsible for the Status of Women. Canada also noted the significant lessons learned

from this report, including the fact that more information and data needs to be tracked relating to violence among Aboriginal women and refugee and immigrant women.

83. Dr. Sáenz reported that an effort was under way within the Costa Rican Parliament to develop a national system for surveillance of domestic violence, for which input had been sought from various sectors, including justice and law enforcement, as well as the health sector. While it had been recognized that the health sector had the most well-developed capacity for surveillance, it had been pointed out that surveillance in the health sector began with the violent act itself, since the health sector dealt with the consequences of the act for the victim. What was needed was a preventive approach that identified the presence of risk factors that might lead to violence against women, such as a history of violent behavior or growing up in a situation of domestic violence. However, as that type of surveillance was clearly outside the purview of the health sector, intersectoral collaboration was essential. The domestic violence surveillance project had originated largely at the initiative of the former Minister of Women's Affairs, who was now a member of Parliament, which exemplified what the Subcommittee had said earlier about the difference that women could make when they gained access to influential positions in the political sphere.

84. Another phenomenon which she had not mentioned in her presentation but which was interesting from the viewpoint of monitoring public policies with a gender perspective was the unprecedented reduction in Costa Rica's birth rate during the previous year. That rate had dropped by almost 8%, which signified some 5,000 fewer births. Never before had the country experienced a decline of that magnitude, and the only factor that seemed to account for it was the enactment in 2001 of the Paternity Law, which had obliged men to accept responsibility for the children they fathered or submit to a DNA test to prove that they were not the fathers of those children. That situation was an eloquent demonstration of the impact that public policies could have on gender-related issues; however, much more analysis was needed to understand exactly how a law mandating responsible behavior could bring about such a dramatic change.

85. Dr. David Brandling-Bennett (Deputy Director, Assistant Direct, a.i., PAHO) said that he would not presume to speak for the Director, who, unfortunately, had been called away prior to the conclusion of the Subcommittee's discussion. However, he did wish to share some reflections on the functions of the Subcommittee, whose meetings he had had the opportunity to observe for some 12 years. In that time, he had seen a definite shift in the Subcommittee's orientation, and that change had been particularly evident at the 20th Session. In its early years, the Subcommittee had tended to serve more as an advisory committee to the Program on Women, Health, and Development. While that had been a valuable contribution, it was not the function of the Subcommittee to advise a single program out of the Organization's 20 or 30 programs.

86. The Subcommittee was a subsidiary body of the Executive Committee, one of the Governing Bodies of the Organization, whose function was to prepare for meetings of the Directing Council or, once every five years, the Pan American Sanitary Conference. Hence, the Subcommittee's role was to advise the Executive Committee and, through the Committee, the Council or the Conference on what the Organization—including both the Secretariat and the Member States—should do to better address issues of gender and health. The work that the Subcommittee had done during the 20th Session would do just that because the discussions had related far less to the activities of the Program and much more to issues that needed to be dealt with in Member States.

87. Why was that? A major reason was that the countries were making real progress in the area of gender and health. Delegates could therefore come to the meetings and share experiences, discuss what had worked and what had not worked in their countries, and learn from one another. In that respect, the way in which the Subcommittee had approached its deliberations might well serve as an example for the meetings of the other Governing Bodies. Often, in those meetings most of the interaction took place between Member States and the Secretariat; there was little discussion between delegates. The Subcommittee's discussion, in contrast, had been characterized by an extraordinarily rich exchange of views, in which much of the dialogue had taken place between Members States.

88. The Subcommittee's ideas would be reflected in the final report of the 20th Session, which would be submitted to the Executive Committee in June, along with its recommendations to the Secretariat and to Member States. He urged delegates to share the report widely with others in their countries, as it would be a source of much valuable and intelligent information on the challenges that needed to be addressed in gender and health. He also encouraged the Subcommittee to make its recommendations as practical as possible in order to provide sound guidance to Member States on how to meet those challenges and to enable the Secretariat to know how it could best assist the countries in their efforts.

PAHO Program Advances and Strategies for Incorporating Gender (Documents MSD20/7, Rev.1, MSD20/8, MSD20/9)

89. Presentations were made under this item on the incorporation of the gender perspective into three PAHO initiatives: the Core Health Data Initiative, the Latin America and Caribbean Regional Health Sector Reform Initiative, and the Regional Initiative for the Reduction of Maternal Mortality.

Core Health Data Initiative

90. Dr. Carlos Castillo Salgado (Area Manager, Health Analysis and Information Systems, PAHO) summarized the content of Document MSD20/7, Rev. 1, which described the progress in incorporating the gender perspective into the Organization's Core Health Data Initiative. The objective of the area of Health Analysis and Information Systems (AIS) was to strengthen the capacity of Member States and the Secretariat of PAHO to generate, analyze, disseminate, and utilize strategic information to assess health situations and trends and to measure the impact of health interventions. In recent years, in keeping with various resolutions of the Governing Bodies and mindful of the monitoring requirements associated with the Millennium Development Goals, AIS had worked very hard to ensure that the indicators included in the core data were disaggregated by sex, which had made it possible to appreciate the significant differences that existed in health indicators from a gender perspective. AIS was also working to help countries include sex-disaggregated data in their information systems.

91. The sex-disaggregated indicators that had already been incorporated into the Core Data Initiative included demographic data, socioeconomic data, mortality data, morbidity data, and data on health care access, resources and coverage. In addition, specific gender equity indicators had been included, such as the gender empowerment measure of the United Nations Development Program. The document summarized the most important male-female differences revealed by monitoring of those indicators. Information on gender and health had been disseminated through various publications, including *Health in the Americas, 2002*, the core data pamphlet, the Annual Report of the Director, the *PAHO Epidemiological Bulletin*, and several specific documents and publications relating specifically to gender and the core data.

92. To continue mainstreaming gender into the Organization's data collection and analysis activities, AIS recommended the following actions: maintain and update PAHO's regional system of core health data and promote the preparation of a pamphlet on women's health indicators for regional distribution; support the periodic development of country health profiles with core data that incorporated the gender perspective; collaborate with other PAHO programs in the monitoring of events, factors, strategies, and mandates in health in the countries of the Region from a gender perspective; and, in collaboration with the Gender and Health Unit, support the strengthening of national capacity to develop health information and surveillance systems with indicators disaggregated by age, sex, and other gender-sensitive variables. Dr. Castillo concluded by underscoring the crucial importance of the last recommendation, since PAHO's ability to produce gender-sensitive statistics depended on the countries' ability to generate reliable sex-disaggregated data.

93. The next presentation was given by Dr. Eduardo Levcovitz (Regional Advisor, Health Policies and Systems, PAHO), who described the principal methodological instruments for monitoring and evaluating health system reforms. Health sector reform, as defined by the Directing Council in 1995, was a process for introducing substantive changes into the different agencies and functions of the health sector with a view to increasing equity in benefits, efficiency in management, and effectiveness and quality in health activities, thereby satisfying the health needs of the population. As such, it was an intense transformation of the health systems that took place within a given time frame and was generally guided by a legal and regulatory framework. In the Region of the Americas, that legal and regulatory framework had been provided by the First Summit of the Americas (1994), which had reached a general agreement on some of the goals that health reform processes should seek to achieve in the Region. One of the most important of those goals was to ensure equitable access to basic health services for the entire population.

94. That agreement had led to the Latin America and Caribbean Regional Health Sector Reform Initiative, launched by PAHO in collaboration with the United States Agency for International Development, in 1997. The Initiative had three major objectives: monitoring, evaluation, and regional support for reform processes in the countries; development of methodological tools; and organization and dissemination of information. Subsequently, the 41st Directing Council (1999) had established that five guiding principles should be applied in monitoring and evaluating reform processes: equity, efficiency, effectiveness and quality, sustainability, and social participation. Those principles had been applied not only in developing instruments for monitoring health sector reform but in the design of all the methodological instruments used to measure changes in health systems and provide orientation for the identification and selection of priority interventions for policy-making by Member States and for PAHO technical cooperation.

95. With specific reference to variables associated with gender, methodologies had been designed in four major areas: health system profiles, monitoring of equitable access to basic health services, measurement and characterization of exclusion, and health sector analysis. The document contained details of the gender variables and indicators employed in those instruments. Additional information could be found on the website of the Health Sector Reform Initiative (www.americas.health-sector-reform.org). Some of the most interesting findings had been yielded by the methodology for measuring social exclusion in health, which had shown a clear association between gender and exclusion. Also revealing were the cross associations between gender variables and race/ethnicity, culture, and social class variables. Indeed, the application of the gender perspective in monitoring and evaluation of health sector reform was directly related to the idea of extending social protection in health, since it was obvious that gender-related factors were closely linked to inequalities and inequities in access to health services, and

identifying and addressing those factors would strengthen the overall effort to extend social protection in health.

Regional Initiative for the Reduction of Maternal Mortality

96. Two presentations were made on this topic. First, Dr. Virginia Camacho (Regional Advisor, Maternal Mortality Reduction Initiative, PAHO) summarized the content of Document MSD20/9 and then Dr. Luis Guillermo Seoane (Interinstitutional Council for Safe Motherhood, Bolivia) described a monitoring initiative under way in Bolivia.

97. Dr. Camacho began by pointing out that maternal mortality was not only a grave public health problem, it was also a serious ethical and gender equity issue. Indeed, it was one of the most egregious and unjust manifestations of the gender inequity that persisted in many countries. In the Americas, 23,000–25,000 women continued to die each year from largely preventable causes and, relatively little progress had been made in reducing the problem, as evidenced by the fact that in the previous 15 years, of 35 countries in the Region, only 5 had succeeded in bringing down their maternal mortality rates by 15%.

98. In 2002, the 26th Pan American Sanitary Conference had approved the Regional Strategy for Maternal Mortality and Morbidity Reduction and had requested the Director to strengthen information and surveillance systems for monitoring progress in the reduction of maternal mortality and morbidity. Document MSD20/9, which would also be presented to the 37th Session of the Subcommittee on Planning and Programming, outlined the steps that had been taken to comply with that request. The document presented a proposal designed to assist the Secretariat and the countries, at both the national and local level, in monitoring progress towards the Millennium Summit goal of reducing maternal mortality by 75% between 1999 and 2015. Two indicators had been established for that goal: maternal mortality rate and proportion of births attended by qualified personnel. In addition, the proposal set out in the document aimed to help the Member States meet the commitment they had made in Resolution CSP.R13 of reducing the gaps in maternal mortality that existed both between and within countries in the Region.

99. Maternal mortality was tremendously difficult to monitor, owing to insufficient and deficient information, underreporting and incorrect classification of maternal deaths, lack of uniformity in gathering and recording data, and the existence of multiple information sources with little or no linkage between them. In addition, some countries did not have functioning maternal mortality audit committees, which were a key instrument for analyzing the causes and determinants of maternal deaths. Another major monitoring challenge was measuring the impact of indirect causes of maternal mortality, notably AIDS and gender-based violence.

100. The proposal presented in the document approached the question of monitoring from three perspectives: how to measure progress in terms of impact indicators (e.g., maternal mortality rates), how to measure the efforts that were being made across the Region to address the problem of maternal mortality (e.g., formulation of policies, plans, and programs), and how the Organization could best support the countries' efforts. In implementing monitoring systems at the regional, national, and local levels, PAHO proposed to build on existing systems and make optimum use of good practices and lessons learned in the countries of the Region. Improving capacity for monitoring at the local level was considered crucial, as it was that level that generated the information that went into monitoring systems and it was at that level that the affected population lived.

101. Based on the Regional Strategy, the proposal identified key components of a maternal mortality and morbidity monitoring system, together with related indicators and questions to be answered under each one. Those components were: creation and implementation of policies, plans, and programs for the reduction of maternal mortality and morbidity; allocation of public investment resources for that purpose; availability and use of essential obstetric care (basic and comprehensive) and skilled attendance at birth; strategies to empower women, families, and communities, which research had shown could have a great impact in reducing maternal mortality and improving maternal health; vital statistics, surveillance systems, and use of information for action; and forging partnerships, another crucial element that had a great impact, not only on the development of public policies, but in ongoing review of the implementation of plans and programs and of the participation of civil society in the process.

102. Dr. Seoane then described the experience of Bolivia's Interinstitutional Council for Safe Motherhood, which was working to address the problem of maternal mortality in that country. In 1996 a safe motherhood committee had been formed with the aim of rapidly reducing maternal mortality in Bolivia, which had the second highest maternal death rate in the Region. The Interinstitutional Council for Safe Motherhood, established in 2002, was a reflection of the ongoing political will to make motherhood safe for all Bolivian women. It had been created at the initiative of the President of Bolivia, who had named the First Lady as the Council's president. Its members included representatives of various sectors of government, as well as multilateral and bilateral cooperation agencies, nongovernmental organizations, women's groups, universities, labor unions, and indigenous communities.

103. The Council's efforts were concentrated in three fundamental areas: advocacy and awareness-raising, community mobilization, and institutional strengthening. In the area of advocacy, activities carried out to date had included the development of communication strategies to raise awareness of the rights of Bolivian women with respect to safe motherhood, support for the formulation and monitoring of policies and programs

with community participation, sharing of successful experiences in the areas of maternal and child health and sexual and reproductive health, and promotion of an intercultural approach and improvements in the quality of health services. With regard to community mobilization, the aim was to involve the community in order to foster a sense of community ownership of safe motherhood initiatives. Activities had included promotion of community participation in the identification of needs and creation of strategies to reduce maternal and perinatal mortality and support for community epidemiological surveillance, educational communication, social monitoring, and participatory planning in maternal and perinatal health. As for institutional strengthening, partnerships had been created with departmental and municipal committees, working groups on specific issues had been organized, and the indicators for monitoring progress towards safe motherhood had been adapted and harmonized.

104. The activities planned for the future included consolidation of the Council and of departmental and municipal committees on safe motherhood, monitoring of post-census studies which had yielded considerable valuable information on the problem of maternal mortality, a campaign to promote the rights of pregnant women through various communication strategies, promotion of evidence-based best practices in maternal and neonatal health, and support for plans and programs in maternal and perinatal health, especially through universal maternal and child insurance system.

105. Among the challenges that remained to be addressed were the demand for more humane and culturally sensitive care for mothers and the need to assure greater access to health services from both the geographic and economic standpoints. In addition, a better institutional environment was needed for mothers and children, including better infrastructure, adequate supplies, more efficient referral and counter-referral systems, and improved training for health care providers.

106. The Subcommittee welcomed the information on PAHO's efforts to improve data collection and analysis with a gender perspective. Several delegates noted, however, that while the documents reflected considerable progress in that regard, they did not contain much information on how the information being compiled had been translated into concrete policies and programs, which was one of the primary purposes of collecting data. It was also pointed out that collecting sex-disaggregated data did not necessarily mean that a gender perspective was being employed. Gender-based analysis was needed to identify and understand the gender differences underlying the figures and utilize that information to improve policies and programs. Training of national personnel was critical to build national capacity to carry out gender analysis. It was suggested that PAHO might consider sponsoring a series of workshops for national epidemiologists and statisticians that would sensitize them to gender issues and teach methodologies for incorporating gender indicators in their systems and performing gender analysis of the data collected.

107. In relation to the Core Data Initiative, the Subcommittee underscored the importance of examining gender differences not only in the three conditions mentioned by Dr. Castillo (diabetes, AIDS, and lung cancer, which were among the most significant contributors to the burden of disease among women in 2000), but in emerging diseases such as dengue. In Central America, at least, the number of new cases of dengue seemed to be higher among women, and it was important to determine whether that difference was gender-related. Monitoring of gender differences in noncommunicable diseases, particularly cardiovascular diseases, was also crucial. In addition, it was felt that the core data should include specific indicators relating to women's mental health, an area in which tremendous gender inequities existed.

108. The Delegate of Dominica called attention to the need for a different approach to the collection and analysis of data in the case of small countries. She pointed out that many statistics were calculated on the basis of 100,000 population; however, in the Caribbean, a number of countries had populations smaller than that. She also stressed the need not to overlook gender inequities in men's health. Specific indicators were needed to understand why, for example, men often postponed seeking care for their health problems. Such information might help to explain men's shorter life expectancy and other gender-related differences in health status.

109. With respect to monitoring of health sector reform, the need to analyze reforms from a budget standpoint was underscored. It was pointed out that, on paper, some reforms might appear to represent an improvement from a gender perspective; however, when they were looked at in terms of budgetary allocations and the extent to which they would benefit men and women, respectively, it became evident that they were not really equitable. Gathering data on the shift towards community-based care and the impact of that change on women was also seen as a critical need. Delegates applauded the document's acknowledgement of the link between women's health and their economic status and its examination of health systems and coverage in the informal sector, a sector in which women were overrepresented. The country profiles were also praised as a rich source of information; however, it was suggested that the variables and indicators used in their development could be refined to offer a more complete picture of the gender equity situation in countries. In relation to monitoring of access to health services, the need to examine all the various dimensions of access—including such aspects as affordability, accessibility, and acceptability of services—was emphasized.

110. Concerning maternal mortality, it was pointed out that while the title of the document referred to monitoring of both maternal mortality and maternal morbidity, neither the document nor the presentation had contained much information on the latter. Attention to maternal morbidity was considered essential for all countries, but especially for those that had relatively low maternal death rates in order to ensure that mortality remained low and, if possible, reduce it even further.

111. The Subcommittee recommended that the Units of Health Analysis and Information Systems, Health Policies and Systems, and Women and Maternal Health be asked to report during the 21st Session on the progress achieved under the initiatives presented during the 20th Session, in particular progress in utilizing the data collected to design policies and programs to rectify the gender inequities identified.

112. Responding to the Subcommittee's comments on maternal morbidity, Dr. Camacho said that while the document might have placed more emphasis on maternal mortality, PAHO was also monitoring maternal morbidity through its perinatal information system. She pointed out that it was important to bear in mind that maternal morbidity was a very complex issue and that not all maternal illness resulted in death. The focus of the document, however, was on monitoring the Regional Strategy for the Reduction of Maternal Mortality. Accordingly, it was concerned mainly with very serious morbidities that were likely to lead to mortality.

113. Dr. Seoane, replying to a question concerning community participation in the safe motherhood initiative in Bolivia, explained that roles and responsibilities were defined at the local level. One community action initiative carried out in 134 communities had demonstrated how extremely effective community interventions could be in reducing maternal and perinatal mortality at the local level. However, in order to achieve real impact in reducing the problem, it was necessary to link those efforts with national efforts.

114. Dr. Levcovitz remarked that the fact that the delegates had spoken of health sector reforms and not health sector reform was evidence of the conceptual progress that had been made with regard to health sector reform in recent years. It was now accepted that there could not be a universal recipe for reform nor a single basic package of services that would meet the needs of all countries. Rather, each country had to, through a collective participatory process, establish its own priorities and, based on those national priorities, seek to provide the most comprehensive health protection possible for its population. It was also now recognized that cost-effectiveness should not be the sole criterion for setting priorities. Those were definitely signs of progress. With respect specifically to monitoring of health sector reform from a gender perspective, he agreed on the need to look at the interaction of gender with other variables, such as ethnicity and socioeconomic status. In that connection, he reported that a group consisting of representatives of several countries in the Region was working to develop an approach known as the "dashboard approach" to health system analysis. That approach did not look at variables in isolation but rather took account of the whole complex set of factors that influenced health system performance.

115. Dr. Castillo, alluding to the comments regarding the linkage between women's health and their economic status, noted that an analysis of life expectancy in countries of

the Region had shown clearly that women who lived in countries in which there was a large gap between the highest and lowest income quintiles had a lower life expectancy, regardless of whether the country was rich or poor. That finding had enormous implications from a gender standpoint because it provided evidence of the impact that inequality could have on health. Regarding the comments of the Delegate of Dominica, he said that in the case of countries with fewer than 100,000 inhabitants, PAHO recommended reporting of actual numbers of deaths, not rates, and that was how data for those countries were recorded in the core data. As for the suggestion concerning the possibility of holding training workshops for national personnel, PAHO would be very receptive to the idea.

Globalization and Health (Document SPP37/5)

116. This item was considered in a joint meeting with the Subcommittee on Planning and Programming, which held its 37th Session on 26 and 27 March 2003. Presentations were given by Dr. César Vieira (Area Manager, a.i., Governance and Policy, PAHO), Dr. Ilona Kickbusch (Division of Global Health, Yale University), Prof. David Warner (Lyndon B. Johnson School of Public Affairs, University of Texas), Dr. Nick Drager (Strategy Unit, Director-General's Office, WHO), and Dr. Maitreyi Das (Human Development Network, World Bank).

117. Dr. Vieira outlined the main points of Document SPP37/5, which examined some of the repercussions of globalization, with particular attention to its impacts on population health. He also described the proposed areas for PAHO/WHO technical cooperation in this area, which was aimed at ensuring that health concerns were taken into account in international trade negotiations. Dr. Kickbusch spoke on some of the ways in which globalization was affecting governance and vice versa, and then examined some of the challenges of global governance in health and the role of international health organizations in the new globalized context. Dr. Warner focused his remarks on the four modes of trade in health services—cross-border delivery, movement of patients, commercial presence of foreign health service providers, and migration of health professionals—and the major issues surrounding each one, identifying possible roles for PAHO in the area of health services trade. Dr. Drager outlined the work being undertaken by WHO, much of it in partnership with PAHO, to try to inform trade negotiation processes in order to place public health interests higher on the trade agenda.

118. Dr. Das described some of the potential linkages between globalization and women's health, explained some of the problems inherent in identifying and studying those linkages, and suggested some ways in which ministries of health could help ensure that globalization did not impact negatively on women's health. She pointed out that globalization could have an impact on women's health through three main mechanisms: women's employment, trade agreements, and health sector reform. In all three areas, the effects might be positive or negative. For example, female employment had grown

massively in the years since globalization had begun. On the positive side, that had led to increased income, self-esteem, and mobility for women, which had increased their access to health and support structures. However, the rise in women's employment had also had negative consequences, such as heavier workloads, loss of leisure time, increased stress, and exposure to occupational risks. With respect to trade agreements, positive impacts included greater potential access to drugs, technologies, information, and services. But the cost of those drugs and services might be prohibitive. Another negative consequence might be out-migration of skilled personnel. As for health sector reforms, the principal issue was whether they were creating an equity-efficiency trade-off. While trends such as increased competition and involvement of the private sector could improve efficiency and quality of services, they might also compromise access for the most vulnerable women. Similarly, cost recovery schemes might improve financial sustainability, but they could also deny services to those who needed them most.

119. She suggested that ministries of health could help minimize the potentially negative effects of globalization on women's health by sensitizing ministries of finance and trade and building alliances with ministries of labor, drawing attention to women's health priorities in the framework of international trade negotiations and ensuring that analysis of the possible health effects of trade liberalization was done *ex ante* rather than *ex post*, promoting women's needs and issues of equity and access in the debate on health care financing, involving women's health activists and community-based organizations in monitoring and evaluation of health sector reform and macroeconomic policies, and making health sector reform work for women's health and for the most vulnerable women.

120. The delegates welcomed PAHO's efforts to call attention to the effects that globalization could have on health and to minimize its negative impacts. The Organization was encouraged to continue seeking ways to help Member States deal successfully with the health implications of globalization and, in so doing, to view the issues through a gender lens. Nevertheless, it was emphasized that PAHO should take care not to become involved in trade issues that fell outside its mandate and competence. Rather, the Organization should maintain a focus on the public health aspects of globalization, seeking to help countries take advantage of the health benefits that it could offer and mitigate its undesirable effects on health.

121. The President of the Subcommittee on Women Health and Development pointed out that the document and the presentations did not seem to contain much discussion of the specific needs of vulnerable groups, notably women. The role of PAHO and WHO should be to identify the positive and negative health effects of trade agreements under discussion in the global and regional arenas, with particular attention to their potential impact on the most vulnerable populations. The Subcommittee on Women, Health, and Development, during its 20th Session, had underscored the need to apply a gender

perspective in all health planning, policy-making, and monitoring activities. That perspective should also be applied in negotiating and monitoring the impact of trade agreements on health. The Subcommittee was preparing a set of recommendations aimed at mainstreaming gender in the planning, implementation, and monitoring of the policies and programs of PAHO and its Member States. Those recommendations would be submitted for consideration by the Executive Committee in June.

122. The Director emphasized that the Organization was working to maximize the positive effects and reduce the negative impacts of certain aspects of globalization. Its technical cooperation was directed towards encouraging dialogue among different sectors at the national level and ensuring that the health sector had a voice in trade negotiations so that, as Dr. Das had recommended, the potentially adverse effects of trade decisions would be analyzed and addressed before they occurred.

123. A fuller account of the presentations and discussion on this item appears in the Final Report of the 37th Session of the Subcommittee on Planning and Programming (Document SPP37/FR).

Recommendations of the 20th Session of the Subcommittee on Women, Health, and Development to the Executive Committee

124. The Subcommittee prepared the following recommendations for submission to the Executive Committee:

125. Recognizing the importance of incorporating gender in the mechanisms for monitoring ongoing globalization and health sector reform processes;

126. Having considered the strategies and lines of action contained in the reports presented to the Secretariat and Member States (MSD20/3, MSD20/4, MSD20/5, MSD20/6, MSD20/7, MSD20/8, MSD20/9), and Resolution CSP26.R21 of the Pan American Sanitary Conference, particularly Article 2a on incorporating data on gender, social class, ethnicity, and social territories;

127. Acknowledging that the gender perspective must address the different realities and needs of both women and men and involve them in addressing these issues.

128. Considering that the task of incorporating a gender perspective is a comprehensive commitment that includes monitoring effectiveness and outcomes, and involving the Secretariat, Member States, and civil society stakeholders;

129. Keeping in mind the commitments made by Members States (in Cairo, Beijing, and at the Millennium Summit) to mainstream gender equity in the formulation and monitoring of policies, while involving stakeholders;

Recommendations for Member States

130. The Subcommittee on Women, Health, and Development recommends that the Executive Committee urge the Member States to:

- (a) Develop goals, qualitative and quantitative indicators, and time-frames for incorporating a gender perspective in planning, allocating and utilizing resources, implementing, and monitoring programs and policies at the national and local levels;
- (b) Set up formal structures that work across sectors at all stages in identifying priority gender and health issues and developing, implementing and monitoring programs and policies at the national and local levels;
- (c) Formalize the participation of civil society at all stages of programming and policy formulation;
- (d) Promote the establishment, within the ministries of health of Member States, of a high level representation and mechanism that will be responsible for the aforementioned actions;

Recommendations to the Director

131. The Subcommittee on Women, Health, and Development recommends that the Executive Committee urge the Director to:

- (a) Strengthen the capacity of the Gender and Health Unit to coordinate the implementation of the Gender Policy within the Secretariat, and to continue to provide technical cooperation to Member States to incorporate a gender perspective in policies, programs, projects, and information including both physical and mental health;
- (b) Support participation across PAHO for formulating and implementing the PAHO Gender Policy, and assess the human and financial needs to assure its sustained implementation;
- (c) Encourage all PAHO units and country offices to incorporate a gender perspective in their monitoring activities including: increased recognition of diversity in data gathering and reporting; increased analysis of data with the goal of capturing inequalities in health and changes resulting from planned interventions and health reform strategies; and monitoring the differential impact of changes over time;
- (d) Support the establishment of reporting mechanisms within the meetings of Governing Bodies to monitor the progress of PAHO units and country offices on the development and application of the gender perspective;
- (e) Charge the Units of Health Analysis and Information Systems, Health Policies and Systems, and Women and Maternal Health with preparing, in collaboration with the Gender and Health Unit, progress reports on the initiatives presented during the 20th Session of the Subcommittee to be presented during the 21st Session.

132. Dr. Brandling-Bennett accepted the recommendations on behalf of the Director, who regretted that she was unable to be present owing to the concurrent meeting of the Subcommittee on Planning and Programming. He thanked the Subcommittee for a sound set of recommendations that would be very useful to both the Secretariat and the Member States as they endeavored to apply a gender perspective in all health activities.

Closing of the Session

133. Dr. Brandling-Bennett said that both he and the Director felt that the session had been extraordinarily productive. He extended heartfelt thanks to the Subcommittee for its

valuable insights into the issues that needed to be addressed in the area of gender and health. He also thanked the President for her skill and efficiency in conducting the meetings.

134. The President thanked the delegates for their participation and declared the 20th Session closed.

Annexes

AGENDA

1. Opening of the Session
2. Election of the President, Vice President, and Rapporteur
3. Adoption of the Agenda and Program of Meetings
4. Advances of the Women, Health, and Development Program
5. Country Experiences with Monitoring Health Policies with a Gender Perspective
6. PAHO Program Advances and Strategies for Incorporating Gender
7. Other Matters
8. Closure of the Session

LIST OF DOCUMENTS

MSD20/1, Rev. 1 and MSD20/WP/1	Agenda and Program of Meetings
MSD20/3	Advances of the Women, Health, and Development Program
MSD20/4	Country Experiences with Monitoring Health Policies with a Gender Perspective: Experience in Canada
MSD20/5	Country Experiences with Monitoring Health Policies with a Gender Perspective: Experience in Mexico
MSD20/6	Country Experiences with Monitoring Health Policies with a Gender Perspective: Experience in Costa Rica
MSD20/7, Rev. 1	PAHO Program Advances and Strategies for Incorporating Gender: Presented by the Special Program for Health Analysis (SHA)
MSD20/8	PAHO Program Advances and Strategies for Incorporating Gender: Presented by the Program on Organization and Management of Health Systems and Services (HSO)
MSD20/9	PAHO Program Advances and Strategies for Incorporating Gender: Presented by the Regional Initiative for the Reduction of Maternal Mortality

**LIST OF PARTICIPANTS
LISTA DE PARTICIPANTES**

MEMBERS OF THE SUBCOMMITTEE/MIEMBROS DEL SUBCOMITÉ

CANADA/CANADÁ*

Ms. Jean Kammermayer
Senior Policy Analyst
Women's Health Bureau
Health Canada
Ottawa

Ms. Jodi Lynn Brown
International Policy Analyst
Policy and External Relations Directorate
Status of Women Canada
Ottawa

Mr. Martin Méthot
Director, International Health Division
International Affairs Directorate
Health Canada
Ottawa

Mr. David Strawczynski
Program Officer
International Affairs Directorate
Health Canada
Ottawa

Ms. Patricia Hoes
Senior Advisor
International Affairs Directorate
Health Canada
Ottawa

* Designated by the Director
Designado por la Directora

MEMBERS OF THE SUBCOMMITTEE/MIEMBROS DEL SUBCOMITÉ (cont.)

CHILE*

Dra. Carmen López Stewart
Asesora Equidad de Género
Oficina de Cooperación y Asuntos Internacionales
Ministerio de Salud
Santiago

COSTA RICA*

Dra. María del Rocío Sáenz Madrigal
Ministra de Salud
Ministerio de Salud
San José

DOMINICA

Mrs. Shirley Augustine
Coordinator Special Projects
Ministry of Health and Social Security
Roseau

MEXICO/MÉXICO*

Dra. Blanca Rico Galindo
Coordinadora del Programa Mujer y Salud
Secretaría de Salud
México, D.F.

Dr. Víctor Arriaga
Director General
Dirección General de Relaciones Internacionales
Secretaría de Salud
México, D.F.

Lic. Manuel Herrera-Rábago
Representante Alterno de México
ante la Organización de Estados Americanos
Washington, D.C.

* Designated by the Director
Designado por la Directora

MEMBERS OF THE SUBCOMMITTEE/MIEMBROS DEL SUBCOMITÉ (*cont.*)

MEXICO/MÉXICO * (*cont.*)

Aurora Del Rio Zolezzi
Directora de Institucionalización
Secretaría de Salud México, D.F.

PARAGUAY

Dr. Roberto E. Dullak Peña
Director General de Planificación y Evaluación
Ministerio de Salud Pública y Bienestar Social
Asunción

UNITED STATES OF AMERICA/ESTADOS UNIDOS DE AMÉRICA

Dr. Cristina Beato
Principal Deputy Assistant Secretary for Health
Department of Health and Human Services
Washington, D.C.

Ms. Debbie Maiese
Director, Office of Women's Health
Health Resources and Services Administration
Department of Health and Human Services
Rockville, Maryland

Ms. Ginny Gidi
International Health Officer for the Americas
Office of Global Health Affairs
Department of Health and Human Services
Rockville, Maryland

Ms. Lindsay Stewart
Advisor, LAC/RSD's Population, Health and Nutrition Team
U.S. Agency for International Development
Washington, D.C.

* Designated by the Director
Designado por la Directora

OBSERVER MEMBER STATES/ESTADOS MIEMBROS OBSERVADORES

ARGENTINA

Sra. Silvia Merega
Ministro
Representante Permanente Alterno de la República Argentina
ante la Organización de Estados Americanos
Washington, D.C.

BOLIVIA

Dr. Víctor J. A. Calderón C.
Director de Cooperación Externa
y Relaciones Internacionales
Ministerio de Salud y Previsión Social
La Paz

CUBA

Sra. Marisabel de Miguel Fernández
Segunda Secretaria
Sección de Intereses de Cuba
Washington, D.C.

PRESENTERS/PONENTES

Ms. Jean Kammermayer
Senior Policy Analyst
Women's Health Bureau
Health Canada
Ottawa, Canada

Dra. Blanca Rico Galindo
Coordinadora del Programa Mujer y Salud
Secretaría de Salud
México, D. F., México

PRESENTERS/PONENTES (*cont.*)

Dra. María del Rocío Sáenz Madrigal
Ministra de Salud
Ministerio de Salud
San José, Costa Rica

Dr. Luis Guillermo Seoane
Jefe de Gabinete
Despacho de la Primera Dama
La Paz, Bolivia

Dr. Virginia Camacho
Maternal Mortality Reduction Initiative
Pan American Health Organization
Washington, D.C.

Dr. Carlos Castillo-Salgado
Area Manager, Health Analysis and Information Systems
Pan American Health Organization
Washington, D.C.

Dra. Alma Catharina Cuellar
Asesora Subregional de la Unidad de Género y Salud
Organización Panamericana de la Salud
San José, Costa Rica

Dr. Eduardo Levcovitz
Regional Advisor
Health Policies and Systems
Pan American Health Organization
Washington, D.C.

Dra. Maria Isabel Matamala Vivaldi
Consultora Proyecto Equidad, Género y
Reforma de Salud
Organización Panamericana de la Salud
Santiago, Chile

Dr. Marijke Velzeboer-Salcedo
Chief, Gender and Health Unit
Pan American Health Organization
Washington, D.C.

**REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS
REPRESENTANTES DE ORGANIZACIONES INTERGUBERNAMENTALES**

**Inter-American Commission of Women
Comisión Interamericana de Mujeres**

Ms. Carmen Lomellin
Executive Secretary

**REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS
REPRESENTANTES DE ORGANIZACIONES NO GUBERNAMENTALES**

**Latin American and Caribbean Women's Health Network
Red de Salud de las Mujeres Latinoamericanas y Caribe**

Dr. Esperanza Cerón Villaquirán
Coordinadora General

**PAN AMERICAN HEALTH ORGANIZATION
ORGANIZACIÓN PANAMERICANA DE LA SALUD**

**Director and Secretary ex officio of the Subcommittee
Directora y Secretaria ex officio del Subcomité**

Dr. Mirta Roses Periago
Director
Directora

**Advisers to the Director
Asesores del Director**

Dr. David Brandling-Bennett
Deputy Director/ Director Adjunto
Assistant Director a.i./Subdirector a.i.

Mr. Eric J. Boswell
Director of Administration
Director de Administración

Dr. Daniel López Acuña
Director of Program Management
Director de Gestión de Programas

**Technical Secretary
Secretaria Técnica**

Dr. Marijke Velzeboer-Salcedo
Chief, Gender and Health Unit
Jefa, Unidad de Género y Salud