



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



**19th SESSION OF THE SUBCOMMITTEE OF THE
EXECUTIVE COMMITTEE ON WOMEN, HEALTH,
AND DEVELOPMENT**

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FINAL REPORT

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FINAL REPORT

The 19th 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 12-14 March 2001.

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: Belize, Canada, Chile, Cuba, Nicaragua, and United States of America. Venezuela was not represented. Present also were observers for Brazil, France, Mexico, Peru, and the United Kingdom. Representatives of the World Health Organization (WHO) and other intergovernmental and nongovernmental organizations also participated.

Election of Officers

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

<i>President:</i>	Nicaragua	(Ms. Mariángeles Argüello)
<i>Vice President:</i>	Canada	(Ms. Lynne Dee Sproule)
<i>Rapporteur:</i>	Cuba	(Ms. Arelys Santana Bello)

Sir George Alleyne (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Marijke Velzeboer-Salcedo (Coordinator, Program on Women, Health, and Development) served as Technical Secretary.

Opening of the Session

The Director opened the session and welcomed the participants. He was pleased to see so many Member States represented. Their presence was an indication of the interest that the countries of the Americas had in issues relating to women, health, and development. For the benefit of newcomers, he reviewed the history of the Subcommittee and the PAHO Program on Women, Health, and Development, noting that initially their focus had been on the status of women within the Organization. Gradually, the Program had evolved into a full-fledged program of technical cooperation within PAHO and the Subcommittee had become more of a technical advisory committee on matters relating to gender equity and health. Although it had been proposed that "women" should be changed to "gender" in the names of the Subcommittee and the Program to reflect that new focus, both bodies continued to be concerned mainly with women's health issues

because the Organization maintained that women were still far more affected than men by gender discrimination, which was an egregious manifestation of the inequity that led to unequal health status.

One of the Program's main priorities in recent years had been increasing the availability of gender-disaggregated data, since such data were essential to identify inequalities that would indicate where gender inequities existed and take action to eliminate them. Violence against women—another serious manifestation of gender inequity—was also a major concern. The Subcommittee would be examining both issues.

Dr. Alleyne concluded his opening remarks by pointing out that it had been several years since the Executive Committee and the Directing Council had had the opportunity to debate issues of gender discrimination and gender equity as they related to health. He suggested that the Subcommittee might therefore wish to propose, in its recommendations to the Member States, that those topics be included as an item on the agendas of the Governing Bodies in 2002.

Adoption of the Agenda and Program of Meetings (Documents MSD19/1 and MSD19/WP/1)

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

Report on the Activities of PAHO's Program on Women, Health, and Development, 1999-2000 (Document MSD19/3)

Dr. Marijke Velzeboer-Salcedo (Coordinator, Program on Women, Health, and Development, PAHO) presented an overview of the situation of women and gender equity issues in the Region and then reviewed the achievements of the Program on Women, Health, and Development (HDW) during the period 1999-2000 in the following areas:

Integrated Model for Addressing Intrafamily Violence

The model, developed by HDW in collaboration with national counterparts and the Governments of Sweden, Norway, and the Netherlands, had been implemented in ten countries, and the Inter-American Development Bank (IDB) had replicated it in six other countries. The aim of the model was to identify the actions, or "critical path," that women took to escape violent situations in order to then establish an intersectoral community network to support and assist victims of intrafamily violence and carry out educational

and preventive activities. A total of 100 community networks were now functioning. In addition, the Program had published *Domestic Violence: Women's Way Out*, the English translation of the research protocol used in the critical path studies, and had played a leading role in organizing Symposium 2001: Gender Violence, Health, and Rights, tentatively scheduled to be held on 4–7 June 2001, in Cancún, Mexico.

Gender Equity in Health Sector Reform

The Program was coordinating six studies on gender inequities in access to health services and health care financing, the results of which were expected by the end of March 2001. In addition, HDW was developing several instruments to enable the countries to conduct gender analysis, advocacy, and monitoring of health status and access of men and women to health services. With support from the Ford Foundation, those instruments were being applied in two countries.

Gender Equity in Quality of Care

The Program had conducted research in six countries that looked at how gender differences influenced perceptions of health status and illness among health service users and health care providers. The results were being incorporated into training for health personnel in the areas studied.

Involvement of Indigenous Women in Health Promotion, Care, and Training

The Program was planning a four-year project to promote intercultural and gender equity in health sector reform in the Central American countries using a model developed in nine Guatemalan communities. HDW had worked with the Ministry of Health and councils of indigenous women in Guatemala to provide training to the women and to health personnel in the use of both modern and traditional indigenous health care practices and traditional medicines and remedies. The project would be launched during 2001.

Involvement of Men in Reproductive Health Programs

HDW had received support from the Government of Germany to carry out operations research in seven Central American countries. First, in four countries, the study would look at men's knowledge, attitudes, and practices (KAP) toward their reproductive health and that of their families. Then, based on that information, models would be created with a view to better addressing the reproductive health needs of men.

Incorporation of Gender Equity in PAHO's Work

The Program's primary mandate was to mainstream gender in all of PAHO's policies and technical cooperation activities. The Subcommittee provided guidance on how to fulfill that mandate within PAHO and also in the technical cooperation that the

Program provided to the Member States. Among other activities, HDW was collaborating with the various divisions to include gender indicators in health sector reform instruments, incorporate a gender perspective in a project on pesticide use in Central America, develop gender-sensitive occupational health standards, and devise community-based and gender-sensitive approaches to mental health problems, especially depression.

Providing Information on Gender Equity

One of HDW's key functions was provision of information to its focal points in the countries, counterparts in ministries of health and national women's offices, and other stakeholders and groups concerned with gender equity issues in the Region. The Program had produced a number of publications, copies of which were made available to the Subcommittee. It also maintained a Website and a listserv (gensalud@paho.org) that provided information on conferences, studies, legislation, and advocacy on gender equity in the countries. In addition, the Program was working on establishing links to other information systems, including PAHO's Virtual Health Library.

Additional information about the Program's activities in the above areas was included in Document MSD19/3, which also suggested ways in which the Members of the Subcommittee could assist the Program in strengthening gender equity in health and development.

The Subcommittee applauded the Program's ambitious agenda for action. In particular, its activities and involvement with women's groups at the local level, notably indigenous groups, were praised. The differing impact of violence on men and women was highlighted. It was pointed out that, in addition to the other problems mentioned in the document's introduction, in countries where violence and other external causes were major causes of death, the discrepancy in life expectancy between men and women was increasing and more women were ending up widowed, poorer, and with an increased burden to bear. Moreover, the "feminization of HIV" was a growing phenomenon in various countries, as infection rates were rising at a faster rate among women than men.

More specific information was requested on the integrated model for addressing intrafamily violence, in particular its replicability, its impact in terms of reducing gender violence in the countries, and PAHO's strategy for sustaining the community-based support groups mentioned in the document. Questions were also asked about the success of the initiative for including gender equity criteria in national health situation analysis and policy-making and the incorporation of a policy component into the studies on gender inequities in access to health services and health care financing.

Dr. Velzeboer-Salcedo noted that the document presented only a brief summary of the Program's activities. HDW would be pleased to make available more in-depth information to any Member State that desired it. With respect to the impact of the

integrated model, the Program did not have hard data to show whether there had been a decline in violence as a result of the model's application. An evaluation, or "best practices review," scheduled for June 2001, was expected to yield some information in that regard, although it would produce mainly qualitative information, not quantitative data, in keeping with the main objective of the model, which was to improve the care and services being provided to victims of intrafamily violence. The Program was optimistic that the intrafamily violence surveillance systems now operating in some countries would provide information on the extent of the problem that would be useful for the design of policies and programs. The WHO multicountry study on women's health and domestic violence, although it would include only two countries from the Americas, would also generate data on prevalence, and the protocols from that study might be adapted and applied in other countries.

As for the replicability of the model, many components could indeed be replicated or adapted for use in different countries. Based on the best practices study, the Program was planning a publication that would present the model in such a way that countries could adapt and expand it to suit their specific needs. HDW would also make available prototypes of the norms and protocols developed in conjunction with the model. With regard to the community support groups, while the Program had provided some technical support for their formation, they were mainly an outgrowth of the community networks and were not supported with PAHO funding. Their degree of sustainability therefore varied from community to community.

Concerning the incorporation of gender equity criteria in country analysis and policies, Dr. Velzeboer-Salcedo explained that the analysis, advocacy, and planning instruments developed by the Program would be tested in Chile and Peru. HDW was working closely with the ministries of health, health sector reform commissions, and other stakeholders in those countries to determine how to go about obtaining good information and disseminating and utilizing it. As for the research on gender inequities in access to and financing of health services, one of the chief objectives of those studies was to produce information that would be useful for policy-making, and training had been conducted prior to the start of the research to ensure that the results would translate into policy.

HDW was aware that the feminization of HIV was a growing problem. However, the Program had not made HIV/AIDS one of its priority areas of action because PAHO had a program devoted specifically to the issue and that program was applying a gender perspective in its work. HDW did collaborate with the HIV/AIDS program where appropriate. Similarly, the Program was very conscious of the differing impact of violence on men and women and the fact that women were mainly affected by domestic violence, whereas men were more often victims of social violence. HDW worked closely with PAHO's program on violence prevention and was indirectly involved in the

Inter-American Coalition for the Prevention of Violence, formed by PAHO, the Organization of American States, the Inter-American Development Bank, the World Bank, the United States Centers for Disease Control and Prevention, and the United Nations Educational, Scientific, and Cultural Organization. However, HDW's main focus was women and the impact that intrafamily violence had on them.

Echoing Dr. Velzeboer-Salcedo's comments, the Director said that the Coalition was looking at the issue of violence as a whole. HDW was not concerned with all aspects of violence, but only with those that were gender-related.

Analysis and Monitoring of Gender Equity in Health and Development: Why and How? (Document MSD19/4)

Dr. Elsa Gómez Gómez (Program on Women, Health, and Development, PAHO) presented the document on this item, which summarized the steps taken by HDW in response to recommendations from the 13th and 14th Sessions of the Subcommittee, which had called for the development of a regional system for monitoring and evaluating gender equity in health. The term "gender equity in health" referred to the elimination of avoidable, unnecessary, and unfair differences between women and men in terms of health status and its determinants, allocation of resources and availability of services based on their specific needs, use and payment for appropriate care, and participation in work and decision-making relating to health.

In fulfillment of the Subcommittee's recommendations, the following actions had been taken: (1) identification of priority problems and development of indicators; (2) formation of an interprogrammatic advisory group to HDW that had guided the development of a regional profile of women's health and the formulation of a proposal for the development of gender equity monitoring and information mechanisms to be instituted in the countries; (3) procurement of partial financing to bolster national capacity for situation analysis and monitoring of health reform policies; and (4) inclusion of a basic set of gender indicators in the instruments used by PAHO's Special Program on Health Situation Analysis and by the Division of Health Systems and Services Development for health situation analysis and monitoring of reform processes.

The first step in formulating the proposal for the information and monitoring system (known by its Spanish acronym: SIMEGS) had been to identify the nature of the information needed to show the disparities in health due to gender inequities. The document listed the kinds of information to be collected. The plan of action for implementing the proposal sought primarily to build capacity for the production of gender statistics at the national level, since the Organization did not generate its own data but rather relied on information collected by Member States. The plan had three main objectives: production of policy-oriented information, simple and effective communication of the information to key audiences in government and civil society, and

institutionalization of the production, dissemination, and monitoring of gender statistics. The pending activities and the strategies to be employed in carrying out the plan of action and mobilizing resources to implement the proposal were outlined in the document.

The Subcommittee voiced strong support for the proposal and plan of action and affirmed the importance of producing gender statistics in order to address gender inequities in health. It was felt that the proposal would afford the possibility to make significant headway with regard to gender equity at both the international and national levels. The Subcommittee therefore urged PAHO and Member States to make the issue of gender equity a top priority. It was pointed out that gender equity was not only a matter of social justice; it was an essential condition if countries were to develop to their fullest potential. To achieve that, political commitment and financial support at the national level were critical. Several delegates also noted that, while production of accurate disaggregated data was essential, it was equally important to have a framework for analyzing them that would reveal gender inequities and then to design interventions to eliminate the inequities detected.

Various Members described efforts under way in their countries to identify gender inequities in health and offered to share information and experiences from their countries. The importance of exchanges and collaboration between countries was underscored.

Dr. Gómez was pleased that the Subcommittee considered monitoring of gender inequities a priority for the Organization. It had been a priority for the Secretariat for a number of years but had received less attention in the Member States. The fact that many countries were taking steps to collect and analyze gender statistics was an encouraging sign.

The Director was also gratified by the Subcommittee's enthusiasm for the initiative and for sharing experiences in monitoring of gender inequities. Analysis of the inequalities in health due to gender inequities was intrinsically difficult. It was hard to get good data on differences in health between men and women and on the determinants of those differences. Even when disaggregated data were available, it was difficult to ascertain whether health outcomes were related to socially determined gender factors or to biological differences between the sexes. Moreover, differences in social constructs in the countries meant that there would be differences in the extent to which health determinants could be attributed to gender. Nevertheless, those difficulties would not weaken the Organization's resolve to move forward with the development of indicators to show which differences in health were due to gender. Without such indicators, it would be impossible to design interventions to modify the gender determinants that led to inequalities in health, which was the ultimate objective.

Experiences with Including Gender Violence Indicators in Health Information and Monitoring Systems (Documents MSD19/7 and MSD19/8)

Two presentations were made on this item. First, Ms. Cathy Alma Cuéllar (Subregional Coordinator for Central America, Program on Women, Health, and Development, PAHO) described the development of intrafamily violence surveillance systems in the Central American countries in the framework of the integrated model for addressing intrafamily violence (IFV). The increased attention to intrafamily violence resulting from the application of the model had pointed up the need for better information and surveillance systems to document the magnitude of the problem. Although much remained to be done, great strides had been made since the mid-1990s, when the issue of intrafamily violence had still been largely invisible in Central America and most cases of physical abuse were being classified and reported in health information systems under the broad category of “injury.”

All seven Central American countries were now collecting IFV data. Indicators to monitor fulfillment of international commitments, such as the Belem do Pará Convention, were also being developed. Document MSD19/8 contained information for each of the countries on the levels of surveillance, the data collection instruments used, the sectors involved in the collection and production of information, the variables and indicators monitored, the users of the information, and the sector with primary responsibility for intrafamily violence surveillance. It also included sample reports on intrafamily violence produced from the data collected.

The Central American experience had suggested several characteristics of effective IFV surveillance systems, namely: surveillance systems should be consolidated with health surveillance and information systems, emphasize timely production of reports, and make information widely available; be linked to surveillance systems of different sectors to facilitate referrals, follow-up, and sharing of results; analyze surveillance data to formulate and monitor policies aimed at reducing inequities in public health; close the gap between researchers, policymakers, providers, and users of intrafamily violence interventions; and be tested and continually evaluated, with broad participation by stakeholders. Above all, surveillance systems should produce information that could be translated into policies and interventions that would protect victims of intrafamily violence and enhance their health and human development.

The second presentation was given by Dr. Dora Caballero (Focal Point for Bolivia, Program on Women, Health, and Development, PAHO), who reported on the inclusion of intrafamily violence indicators in the health information and surveillance systems of Bolivia, Ecuador, and Peru. As in Central America, the development of IFV information and surveillance subsystems had taken place in the framework of the integrated model of the project entitled “Violence against Women and Girls: A Proposal to Establish Coordinated Interventions,” launched in all three countries in 1995. That project had sought to increase public awareness of intrafamily violence as a public health problem. In the three countries, IFV variables had been incorporated into existing

epidemiological surveillance systems of the ministries of health. Document MSD19/7 provided details on the types of information produced, the reporting and data collection instruments used, the scope and users of the system, the entity responsible, and some of the results derived from application of the information on IFV in each country.

Among the difficulties that had needed to be overcome in order to include IFV data in existing information and surveillance systems and raise awareness of intrafamily violence as a public health problem were the belief that IFV was a private matter, resistance by institutional human resources to take on new tasks, fear among health workers of getting involved in judicial and police matters, and lack of understanding on the part of decision-makers regarding the magnitude of the problem or its implications for health and socioeconomic well-being. Although it was now possible in all three countries to obtain information on IFV, its characteristics, and the contexts in which it occurred, various problems remained, notably, problems in collecting information owing to lack of training for operational and statistical personnel; deficient quality control of the information; lack of appropriate methodologies for analyzing the data collected; and limited use and dissemination of the information.

Challenges for the future included ongoing monitoring and evaluation of current systems and the variables and indicators being used with a view to making any necessary adjustments; tailoring of variables to meet service delivery needs; strengthening multisectoral action and involvement of multiple actors; systematic training of operational personnel in order to improve the quality of the information obtained; development of mechanisms for intrainstitutional, interinstitutional, and mass dissemination of IFV information; and utilization of the information for policy- and decision-making.

The Subcommittee agreed on the need to monitor and characterize intrafamily violence in order to raise awareness of the problem as a public health concern and design effective policies and interventions for addressing and preventing it. It was pointed out that, without the necessary evidence base, IFV would continue to be dealt with through crisis intervention measures rather than prevention strategies. One delegate noted that better data about the nature and magnitude of IFV would show that it not only affected individuals and their families, but had a direct impact on health and economic development of countries. Another delegate underscored the need for qualitative as well as quantitative information in order to gain a better understanding of the phenomenon of intrafamily violence and the risk factors and consequences associated with it.

The Subcommittee also stressed the importance of linking information to action, since the ultimate aim of gathering information was to stop the violence. Data collection should not be an end in itself but should be geared toward the needs of policymakers, intervention planners, and service providers. The necessity of protecting victims was also emphasized. It was recommended that reliable ethical and safety guidelines, such as those developed for the WHO multicountry study, should be followed in conducting research on intrafamily violence. Several delegates brought up the need for appropriate training for the health personnel involved in collecting and analyzing IFV data.

PAHO was encouraged to continue supporting the countries in developing IFV information and surveillance systems and promoting a public health approach to the problem. The need to take advantage of existing information resources and data collection instruments was underscored, as was the need for common definitions and uniform instruments in order to ensure validity and comparability of the data collected. It was suggested that questions on intrafamily violence might be added to demographic and health surveys or to smaller surveys associated with them. The WHO multicountry study was also cited as a resource on which PAHO and the countries might draw.

Several questions were raised about specific aspects of the experiences described by the two presenters. One question concerned changes in patterns of intrafamily violence in disaster situations. Ms. Cuéllar was asked to elaborate on the results of screening for partner violence following Hurricane Mitch, which was mentioned in Document MSD19/8. One delegate said that efforts to implement IFV surveillance in her country had been unsuccessful largely because health personnel were reluctant to get involved in the legal proceedings associated with reporting cases of intrafamily violence. Dr. Caballero was asked to comment further on how that obstacle might be overcome.

Dr. Caballero agreed that laws that required health care providers to report cases of suspected physical abuse to judicial or law enforcement authorities could be a disincentive to reporting and a hindrance to surveillance of IFV. In Bolivia, for example, health personnel who did not report abuse cases were subject to sanctions. At the same time, however, physicians in Bolivia and other countries enjoyed professional protection and were not required to disclose confidential patient information. It would be necessary to reexamine the legal provisions relating to reporting of abuse with an eye to encouraging health care providers to register information on IFV and facilitating a public health approach to the problem. In relation to the addition of questions on violence to demographic and health surveys, she noted that in Bolivia and Peru IFV variables were being added to those surveys.

Responding to the question concerning post-disaster surveillance of domestic violence, Ms. Cuéllar explained that, following Hurricane Mitch, screening for partner violence had been conducted in specific health care facilities to determine whether IFV increased in the wake of a disaster and study the factors that might contribute to such an increase. The results of that exercise were being prepared for public dissemination, but preliminary data confirmed that active surveillance of intrafamily violence should be stepped up in disaster situations. In reply to another question regarding the data collection instruments used in Central America, she said that all the instruments were compatible with the International Classification of Diseases, Tenth Revision (ICD-10), although the actual reporting forms used varied from country to country.

The Director pointed out that only in the previous 15-20 years had violence begun to be viewed as a public health problem, and the idea that domestic violence was a public health issue was more recent still. That being the case, he felt that a great deal of progress had been made in a short time. Violence against women took various forms. Some violence was gender-based, while other kinds of violence were related to women's biology—for example, some reproductive health practices. The latter kind was a separate issue which the Organization would be looking at in the future. With respect to intrafamily violence, the aim was to identify those aspects of the problem that could be addressed through interventions. It would be much easier, for instance, to design an intervention to address factors in the geographic/spatial context that might be conducive to IFV than to attempt to modify power relationships between men and women, which were deeply entrenched and difficult to change.

Nevertheless, before the public health sector could begin to be prescriptive about what could be done to reduce intrafamily violence, it was necessary to determine the full extent of the problem and understand its causes. Much remained to be done in that regard. One of the primary obstacles to surveillance efforts was their reliance on victim reporting, since acts of domestic violence were rarely reported by third parties. The information gathered to date was minimal. For every case reported, undoubtedly many more were going unreported. Still, he reiterated, the headway that had been made in the two experiences reported to the Subcommittee was cause for hope.

PAHO's Production, Analysis, and Dissemination of Health Information Disaggregated by Sex

Dr. Cristina Schneider (Special Program for Health Analysis, PAHO) described the sex-disaggregated information produced as part of PAHO's core health data initiative. The initiative, launched in 1995, was aimed at enhancing the capacity of the Secretariat and the Member States to systematically compile and analyze health information for use in decision-making. It was also a vehicle for technical cooperation to stimulate the

development of health information systems in the countries and encourage analysis of inequalities in health. The core health database included 124 indicators in five categories: demographic; socioeconomic; mortality; morbidity; and access, resources, and coverage of health services. Fifty-three of those indicators were disaggregated to some degree. For example, the demographic data on life expectancy at birth were disaggregated by sex, as were the socioeconomic data on literacy and the mortality data for 17 causes of death in 24 countries.

Dr. Schneider demonstrated how to access the core data system through the PAHO Website (www.paho.org), noting that the system was being restructured to make it more user-friendly. She also distributed a pamphlet on the core data. Additional information could be requested from the Special Program on Health Analysis.

The Subcommittee acknowledged PAHO's leading role in making core health information available to facilitate decision- and policy-making in the Region and encouraged the Organization to continue seeking to produce disaggregated data. Dr. Schneider was asked to comment on how the Special Program on Health Analysis was dealing with the difficulties, noted repeatedly by the Subcommittee during the session, of producing statistics that would permit analysis of gender inequities in health.

Dr. Schneider explained that the indicators selected for the inclusion in the core data initiative were proposed by the Organization's various programs and then carefully scrutinized by an advisory committee, which assessed the importance of the indicator and the feasibility of collecting the necessary data. In some cases, though the importance of the indicator was recognized, it was not selected because there were problems with availability or comparability of data. The Subcommittee was welcome to propose possible indicators to the Program on Women, Health, and Development, which would submit them for consideration by the advisory committee. Dr. Elsa Gómez, of HDW, participates in the committee's deliberations.

The Director pointed out that the core data were intended to be a set of minimum data that presented an overview of the health situation in the Region. Accordingly, PAHO was concerned with keeping the number of basic indicators to a manageable number. That did not mean, however, that other data were not being produced. Information on health inequalities related to gender, geographic location, and other determinants was indeed being generated and could be accessed through the Organization's Website and publications.

Experiences with Analysis and Monitoring of Gender Equity in Health and Development (Documents MSD19/5 and MSD19/6)

Six presentations were given on this item, two by representatives of Member States, three by representatives of organizations in the United Nations system, and one by a representative of a civil society organization.

Ecuador

Dr. Lily Jara (National Council of Women (CONAMU, Ecuador) outlined the efforts of CONAMU, a government agency under the Office of the President of Ecuador, to develop an information system with gender indicators that would facilitate the detection of gender inequalities. With technical assistance from the Economic Commission for Latin America and the Caribbean (ECLAC), CONAMU had identified a series of indicators based on the different roles that women played in the private sphere, the public sphere, and in relation to social and economic well-being. Document MSD19/5 listed the principal indicators in the areas of health, education, political participation, intrafamily violence, and employment and access to resources.

CONAMU was also working with other institutions at the national level to incorporate a gender perspective into the collection of data and the analysis of information. CONAMU had collaborated with the National Statistics and Census Bureau in providing training in the use of gender statistics with a view to introducing a gender perspective in all official statistics. With the Integrated System for Social Indicators of Ecuador (SIISE), it had developed the *SÍMUJERES* database, which included gender indicators for monitoring and evaluating fulfillment of the Platform for Action of the Fourth World Conference on Women (Beijing, 1995) and other international mandates. CONAMU had also worked with other institutions in the areas of planning and urban development, and it had signed agreements with various ministries, including the ministries of education, health, and urban development and housing, to provide technical assistance for the incorporation of a gender perspective in their plans and programs. CONAMU sought to ensure the use of gender indicators in all public policy-making. The Council's future plans included research aimed at developing indicators in areas not yet studied in Ecuador, such as women's use of time, and a project to build a system of gender indicators for monitoring, analysis, and impact analysis.

Dr. Jara concluded her remarks by emphasizing that institutionalizing a complete information system that incorporated the gender perspective would require international cooperation, as well as interinstitutional collaboration at the national level to avoid duplication of efforts and optimize the use of resources. She then demonstrated how to access the *SÍMUJERES* database at www.siise.gov.ec.

Mexico

Ms. Marcela Eternod Arámburu (National Institute of Statistics, Geography, and Informatics, Mexico) provided a brief account of the activities carried out by the National

Institute of Statistics, Geography, and Informatics (INEGI) to adapt the Mexico' national information system to the need for information with a gender perspective. The adaptation process had originated in 1993, when the Mexican Office on Women, which was responsible for preparing information in preparation for the Fourth World Conference on Women in Beijing, had requested INEGI's assistance in producing sex-disaggregated statistics. The process had encompassed not only the statistics produced by INEGI, but also those generated by the health, education, labor, and other sectors. The Institute had focused on two main areas: analysis of existing data from various sources and development of indicators disaggregated by sex.

In collaboration with the Regional Office of the United Nations Development Fund for Women (UNIFEM), INEGI had analyzed how best to take advantage of existing information. Numerous workshops, involving both producers and users of gender statistics, had been held to discern the kinds of information needed to design public policies aimed at achieving gender equity. The Institute had also worked with the National Commission on Women to design indicators to monitor and evaluate the activities of the National Program on Women (PRONAM) and meet emerging needs in areas in which information gaps had been identified, including exercise of power, participation in decision-making, violence, and use of time.

The end result had been the creation of the System of Indicators for Monitoring of the Situation of Women in Mexico (SISESIM), which reflected the demographic, economic, social, and political situation of Mexican women with respect to that of Mexican men. SISESIM could be accessed on the Internet at <http://dgcnesyp.inegi.gob.mx/sisesim/sisesim.html>. In addition, the gender perspective had been incorporated into many of the reports and publications produced by INEGI, including the 2000 population and housing census and other national surveys. Document MSD19/6 provided additional information on a number of INEGI publications designed to provide evidence of the existence of gender differences in the situation and participation of Mexican women and men in various spheres and highlight the generally disadvantageous conditions for women.

Ms. Eternod emphasized that INEGI was convinced of the importance of incorporating the gender perspective in the national statistical information system and providing information to reveal inequalities related to social class, age, and gender. In order to continue advancing toward that objective, it would be necessary to provide ongoing training to those involved in the production of statistics.

United Nations Development Fund for Women (UNIFEM)

Dr. Guadalupe Espinosa-González (Regional Director, United Nations Development Fund for Women) described the strategy utilized by UNIFEM to promote

and support the production and use of gender statistics in the countries of the region served by her office: Cuba, Dominican Republic, Mexico, and the countries of Central America. She began by emphasizing that the institutionalization of gender statistics was a lengthy process that required political will. The first step in the process was to sensitize producers and users of statistics to the need to generate indicators that would reveal the inequities between men and women. The next step was the construction of databases and information systems with a gender perspective. Once gender statistics were being produced, the final—and most important—step was to utilize them to design and evaluate policies.

The key participants in the process were the institutions that produced statistics in the countries and the national offices responsible for designing policies to improve the situation of women. Without their cooperation, it would be impossible to make any headway in the production and use of gender statistics, but it was not always easy to persuade them to work together. It was crucial that they speak a common “language” and understand each other’s needs and constraints. To that end, UNIFEM had organized a series of meetings and seminars in the countries to bring together producers and users to identify needs and establish priorities. In the process, a number of gaps and biases had been detected in the way information was being collected and analyzed. For example, the language in many of the training manuals for personnel who collected data in the field was gender-biased, referring only to males or using masculine nouns and pronouns. Gaps in information sources had also been identified, notably with regard to intrafamily violence.

The countries served by her office were at different stages in the process of institutionalizing the production and use of gender statistics, but they were now all generating and publishing information disaggregated by sex, which was a major step forward. With good data that reflected the reality in which women lived, it would be possible to identify inequities and design effective macromeasures and policies to address them. In several countries, for example, time use studies were yielding valuable information about women’s unpaid contribution to the national economy. In some cases, satellite accounts had been created within national accounts to estimate the economic worth of the work done by women in the home. One country had created such a satellite account for the health sector.

UNIFEM’s work with producers and users of gender statistics in the health sector had clearly shown that the health of men and women was influenced by more than their biological makeup. Differences in their roles and responsibilities, occupations, lifestyles, exposure to risks, and care-seeking behaviors led to differences in health. To design effective programs and policies to address the health needs of men and women, it was essential to produce health information disaggregated by sex and analyze that information from a gender perspective.

United Nations Statistics Division (UNSD)

Dr. Joann Vanek (United Nations Statistics Division) outlined the work of UNSD in relation to the analysis and monitoring of gender equity. The information base for the Division was the data collected by national statistics offices, which had been compiled in an international database, the Women's Statistics and Indicators Database (WISTAT). Several basic considerations had shaped the development of WISTAT. One was the location of the data on gender issues, which covered a broad range of fields and areas. The data were therefore often located in different national institutions, which sometimes made it difficult to access them. The framework for the database was another consideration. Once the data were available, they had to be organized so as to obtain a clear picture of the situation of men and women in a country. The framework used for Wistat was the basic framework of social indicators adopted by UNSD in the 1970s, which had been adapted to reflect gender concerns. The topics of concerns and specific indicators were selected through intense collaboration with users. Dr. Vanek distributed a handout showing all the indicators in WISTAT relating to health and health services, reproductive health and reproductive rights, and violence against women.

For many years, the scope of the Division's work had been limited to collection and compilation of data; analysis of the information produced had been left to others. However, in the late 1980s UNSD had been asked by several key United Nations agencies to prepare a report on gender issues and trends. The result was the publication *The World's Women*, three issues of which had been published to date. The success of that publication had prompted several agencies to ask the Division to go one step farther and provide guidelines to assist the countries in preparing similar reports at the national level. Accordingly, UNSD had developed the *Handbook on Preparation of National Statistical Reports on the World's Women*, which showed how to take basic statistics and create an indicator which could be analyzed for its policy relevance. Mexico had applied some of those guidelines in preparing one of the publications mentioned by Ms. Eternod in her presentation.

The Division also worked with the countries in providing training to enhance capacity for the production, analysis, and dissemination of gender statistics at the national level. In August 2000, it had collaborated with the Secretariat of the Caribbean Community (CARICOM) to organize a workshop in the Caribbean region, in which PAHO had also participated. The topics covered in the training workshops included identification of key gender issues and concerns; definition of statistics and indicators for the issues identified; assessment of the availability of data; compilation, analysis, and presentation of data; and identification of data gaps and improvement of gender statistics. The workshops had been quite successful in sensitizing participants to the need for gender statistics and for close cooperation between producers and users. They had also

generated interest in and knowledge for working toward the improvement of gender statistics.

Dr. Vanek concluded her presentation by noting that there was increasing interest in social statistics within UNSD. The Division was grappling with how to approach the very ephemeral area of social indicators and identify the key indicators needed to measure the social well-being of a country. Judging by the quality of the papers presented to the Subcommittee, PAHO was in the forefront of the field of social statistics.

Economic Commission for Latin America and the Caribbean (ECLAC)

Ms. Diane Alméras (Economic Commission for Latin America and the Caribbean) outlined ECLAC's efforts to develop gender indicators in the framework of the project "Use of Gender Indicators in the Development of Public Policies." The project utilized the set of gender indicators developed by ECLAC in May 1999 for follow-up and evaluation of the Regional Program of Action for the Women of Latin America and the Caribbean, 1995-2001, and the Beijing Platform for Action. The recommendations of the Meeting of Experts on Gender Indicators and Public Policy in Latin America, held in October 1999, had formed the basis for the formulation of the initial version of the project, which had been under way for about one year and was a joint initiative involving a number of United Nations agencies and the governments of the countries of the Region.

The project was aimed at constructing an integrated system of gender indicators, utilizing existing social and economic indicators in combination with other indicators of participation, empowerment, citizenship, and violence. It sought to answer four key questions: (1) What information will make visible not only the different reality in which men and women live, but also elucidate the relationship between them and the new areas in which inequities are occurring as a result of women's advancement? (2) What are the issues for which indicators are needed to design public policies? (3) How can the necessary links be established between indicator design and methodological development, on the one hand, and policy formulation, on the other? (4) How can relationships between producers and users of gender statistics be fostered and strengthened? The project was not designed to improve gender statistics but rather to improve their use for the formulation of public policies.

As expected outcomes, the project was expected to yield a system of gender indicators that would make it possible to monitor changes in the situation of women in comparison to that of men, which could be utilized by governments, the international community, and civil society; increased demand for and use of gender indicators by governments and civil society to formulate and monitor public policies; and availability of information on gender indicators on a Website could be used on a network and would

be interactive and user-friendly. The Website had been launched in March 2001 and could be accessed at www.eclac.org/mujer.

Latin American and Caribbean Women's Health Network (LACWHN)

Dr. María Isabel Matamala Vivaldi (Associate Coordinator, Latin American and Caribbean Women's Health Network) described the indicators being developed by the Network, as a civil society organization, to monitor the extent to which governments were fulfilling the international commitments emanating from the United Nations International Conference on Population and Development (Cairo, 1994). To that end, LACWHN had developed a matrix of indicators with a gender perspective that revealed the inequalities between men and women but also showed efforts to reduce those inequalities by deconstructing stereotyped gender roles or, conversely, showed a lack of political will to promote change and the persistence of policies that served to reinforce existing gender roles. The baseline for the monitoring was 1994—the year of the Cairo conference—and monitoring exercises were carried out every three years. Women's groups and networks in the following seven countries were currently participating: Brazil, Chile, Colombia, Mexico, Nicaragua, Peru, and Suriname.

Initially six priority women's health issues had been identified for monitoring: (1) girls' living conditions and sexual violence against girls; (2) male responsibility in sexual and reproductive health; (3) participation by civil society, especially women's organizations, in decision-making; (4) access of adolescents of both sexes to services and information on sexual and reproductive health; (5) quality of sexual and reproductive health services; and (6) humanized care for abortions. Subsequently, a seventh issue—HIV/AIDS prevention and comprehensive care for women living with the virus—had been added. The matrix of indicators included both quantitative and qualitative indicators. The results of the first stage of monitoring had been published in 1998 and had been presented at the Cairo+5 conference in 1999.

The first stage had suggested several areas in which indicators should be added or prioritized in future monitoring. For example, it had revealed difficulties on the part of governmental institutions in operationalizing the gender perspective, equity, and sexual and reproductive rights, which might be attributed to an insufficient understanding of the conceptual frameworks or to resistance to cultural changes that would modify power relationships. In addition, there was often a disjunction between stated policy and program objectives and the allocation of resources to achieve them, which pointed up the need for civil society to extend its advocacy beyond the social sectors to the finance sector. As a result of that finding, the second stage of monitoring would include more indicators relating to allocation of resources to achieve gender objectives and ensure sustainability of policies and programs. The second stage would also include transparency indicators, since the first stage had found a lack of transparency among public institutions

vis-à-vis civil society, which was expressed in barriers that prevented access to information systems, lack of disaggregated data, and sometimes great inconsistency in the data.

An evaluation of the first stage had shown that, although the matrix contained more than 80 indicators, some of the information generated that was too general and needed to be more specific in order to be useful for policy-making. The Network had therefore adjusted the matrix, adding a number of new indicators. The expanded matrix would be used in the second stage of monitoring during 2001. The results of the second stage of monitoring were expected to be available on the Internet by the end of the year.

Much of the Subcommittee's discussion of the experiences presented revolved around the question of what constitutes a gender indicator. The Director pointed out that the fact that a phenomenon occurred in women alone was not enough to say that it was an indicator of gender inequity. In the case of excess maternal mortality, for example, what criteria could be adduced to define it as a gender indicator? Similarly, if differences were found between rural and urban women in terms of some health outcomes, how could it be shown that they were gender-related and not simply a reflection of geographic distribution of services that had nothing to do with the inequality that was one of the manifestations of the inequity between males and females? Based on the way PAHO had defined gender equity, there were three basic criteria for determining whether inequities existed: the differences were avoidable, they were beyond the volition of the person affected, and there was some agent responsible for the differences.

Dr. Jara emphasized that application of a gender perspective in the use of statistical data was essential. Disaggregating data by sex was not enough because, though the numbers often revealed differences, they did not reveal the underlying reasons for those differences. A gender perspective must be applied in their analysis in order to identify how the differences were related to the functions and roles socially assigned to men and women. For that to occur, personnel must be trained in the use of gender indicators and the application of a gender perspective. Ms. Eternod added that such training was important not just for public officials but for the population in general. Mexico was promoting a "culture of statistics." Starting in primary school, children were being taught to interpret census and survey data so that they could better understand the reality in their communities. Only through such an understanding could any meaningful change occur.

As for what constituted a gender indicator, Ms. Eternod noted that, in the case of maternal mortality, studies in Mexico had provided ample evidence that maternal deaths were linked to the treatment that women received from health care providers during pregnancy and childbirth. The quality of that care was sometimes truly abusive. Dr. Espinosa-Gonzalez remarked that one of the findings that had emerged from

UNIFEM's work with producers and users of gender statistics was that there were definitely gender-related factors that influenced rates of HIV/AIDS in women. In addition to the biological differences that made women more susceptible to HIV infection, social factors came into play, notably women's lack of power to negotiate safe sexual relations.

Ms. Eternod pointed out that sometimes the data in themselves did clearly reveal discrimination—for example, when it was found that women who had the same or better job qualifications than men were earning 35% less than their male counterparts for performing the same work. At the same time, data that might seem to show no difference between men and women might be concealing the true situation, as in the case of data on women's economic participation. In order to get good data that could be analyzed for inequities, it was necessary to ask the right questions, which called for application of the gender perspective in data collection. In relation to women's participation, Dr. Espinosa-Gonzalez pointed out that data on the unpaid labor done by women was essential to provide evidence of the existence of gender inequities and advocate for budgets that that would better address those inequities.

Other Matters

The Subcommittee endorsed the idea of satellite accounts within national accounts that would show women's unpaid contribution to the production of health, and felt that countries should be encouraged to create such accounts. The Subcommittee also emphasized the need to involve both producers and users in the identification of information needs and the definition of indicators. Several participants stressed the need for political will and action, including the allocation of resources, to eliminate the inequities identified through analysis of gender indicators, although the Director cautioned that sometimes what appeared to be a lack of political will was simply the result of a failure to present clear data and proposals. For example, when data showed that health services were not friendly to women, it must be demonstrated to policymakers that society was not well served when services were not friendly to women, and a proposal showing the benefits of rectifying the inequities must be formulated.

Finally, the concept of health as a human right was emphasized. The Subcommittee underscored the importance of producing information that would show the extent to which international commitments relating to gender equity in health were being fulfilled.

Presentation of Recommendations to the Director of the Pan American Sanitary Bureau

The Subcommittee presented the following recommendations to the Director for submission to the Executive Committee.

Recommendations

1. *Recommendations to the Executive Committee of the Directing Council*

The Subcommittee recommends that the Executive Committee urge the Member States to:

- (a) work towards a new vision for the health of women that adopts a holistic approach within the framework of human rights;
- (b) ensure that the health framework adopted includes mental health as an explicit integral health component;
- (c) ensure that statistics on individuals are compiled, processed, analyzed, and presented with a breakdown by sex and age, at the same time reflecting matters and areas related to gender inequities;
- (d) include and utilize statistics that will make it possible to monitor the differential impact by sex of the health sector reform processes;
- (e) give high priority to and allocate resources for the establishment of quantitative and qualitative information systems that will guide health policies and indicate the degree of fulfillment of national and international commitments assumed on gender equity in health;
- (f) establish for this purpose mechanisms for sustained consultation and collaboration between the Ministries of Health and the Bureaus or Ministries devoted to women's issues;
- (g) ensure that users and producers of statistics in government and civil society participate in the definition of contents and processes for the production, dissemination, analysis, and monitoring of information on gender and health;
- (h) give priority to training their personnel to conduct quantitative and qualitative analyses and interventions with a gender perspective;
- (i) work to develop satellite accounts in the health sector with a view to recognizing and measuring the economic contribution to health of the unremunerated work of women;
- (j) encourage and support intersectoral research initiatives on the use of time that will help to measure the contribution to health of the unremunerated work of women;

- (k) facilitate, for research and monitoring purposes, the use of health information by other government agencies, academia, and civil society;
- (l) include "gender, women, health, and development" as an item on the agendas of the Governing Body sessions in 2002.

2. *Recommendations to the Director*

The Subcommittee recommends that as financial resources permit, the Director:

- (a) ensure that quantitative and qualitative information on individuals produced by the technical units of the Secretariat are collected, processed, analyzed, and presented with a breakdown by sex and age, at the same time reflecting matters and areas related to the issue of gender;
- (b) conduct a program of activities that will enhance gender analysis capacity among data producers, within the Secretariat and in Member States;
- (c) produce and present a progress report on this program for the 20th Session of the Subcommittee of the Executive Committee on Women, Health, and Development;
- (d) give high priority to interprogrammatic collaboration within the Secretariat to establish an electronic regional information platform that articulates information disaggregated by sex in the area of health and development;
- (e) support the production by the Secretariat of periodic publications on gender, health, and development, specifically a biannual statistical bulletin and a regional profile to be updated every four years;
- (f) support technical cooperation among countries in the production, systematization, analysis, and utilization of quantitative and qualitative information on gender, women, health, and development;
- (g) encourage and promote collaborative efforts with other international agencies that share similar objectives.

The Director thanked the Subcommittee for a solid and constructive set of recommendations. He would do his best to see that, as resources permitted, the Secretariat carried out the "recommendations to the Director." In that regard, he thanked the Subcommittee for recognizing that the Secretariat faced certain financial constraints.

He was pleased that information occupied such a prominent place in the recommendations, since the production, analysis, and dissemination of information constituted one of PAHO's primary mandates. Certainly, information in the area of gender and development was of critical importance to the Secretariat and the countries.

Closing of the Session

The Director thanked all the presenters and participants for their valuable contributions to the Organization's work in the area of women, health, and development. Ms. Sproule (Canada, Vice President) expressed the Subcommittee's appreciation to the staff of PAHO for their support prior to and during the session. She thanked the delegates for their active and insightful participation in the Subcommittee's deliberations and then declared the 19th 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. Report on the Achievements of PAHO's Women, Health, and Development Program, 1999-2000
5. Analysis and Monitoring of Gender Equity In Health and Development: Why and How
6. Experiences with Analysis and Monitoring of Gender Equity in Health and Development
 - Ecuador
 - Mexico
 - United Nations Agencies
7. Experiences with Including Gender Violence Indicators in Health Information and Monitoring Systems
8. PAHO's Production, Analysis, and Dissemination of Health Information Disaggregated by Sex
9. Other Matters

LIST OF DOCUMENTS

Working Documents

MSD19/1	Agenda
MSD19/2	List of Participants
MSD19/3	Report on the Achievements of PAHO's Women, Health, and Development Program, 1999-2000
MSD19/4	Analysis and Monitoring of Gender Equity In Health and Development: Why and How
MSD19/5	Experiences with Analysis and Monitoring of Gender Equity in Health and Development – Ecuador
MSD19/6	Analysis and Monitoring of Gender Equity in Health and Development – Mexico
MSD19/7	Experiences with the Inclusion of Sexual Violence Indicators in the Health Information and Surveillance Systems of Bolivia, Ecuador, and Peru
MSD19/8	Domestic Violence Surveillance Systems in Central America

INFORMATION DOCUMENTS

MSD/RP	Rules of Procedure for Meetings
MSD/TR	Terms of Reference

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