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PAHO PROGRAM ADVANCES AND STRATEGIES FOR INCORPORATING THE GENDER PERSPECTIVE

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The methodological instruments for the monitoring and evaluation of sectoral reforms also serve to measure the processes and outcomes of changes in the health systems and to guide the identification and selection of priority interventions, both for policy-making by the Member States and for the technical cooperation of the Pan American Health Organization (PAHO). This document presents a summary of the principal methodological instruments for the monitoring and evaluation of health system reforms—System Profiles, Sectoral Analysis, Monitoring of Equitable Access, and Measurement of Exclusion in Health —, identifying the gender-related indicators and variables utilized by each of them, as well as their limitations and potential.

The document proposes a proactive role for PAHO in defining and proposing adjustments to the level of disaggregation of information appropriate to the nature of each instrument through specific considerations related to each methodology, using a threefold strategy: for universal, general instruments; for instruments aimed at ensuring in-depth analysis; and for the planning/evaluation of sweeping changes or reforms in the health sector of a country.

The Subcommittee is requested to make recommendations for strengthening the effort to incorporate gender indicators and analysis into the instruments and processes for the monitoring and evaluation of sectoral reforms, while ensuring the viability and feasibility of those methodologies. The Subcommittee is furthermore requested to urge the Member States to comply with Resolution CSP26.R21 of the 26th Pan American Sanitary Conference, on the production and utilization of information disaggregated by gender, and to support the dissemination by PAHO of the methodological instruments described in this document, especially health sector analysis, and its utilization by the countries of the Region.

CONTENTS

Page

Introduction....................3

Methodological Guidelines for the Preparation of Health System Profiles and Health Sector Analysis....................4

"Guidelines for Monitoring Equitable Access to Basic Health Services"....................7

"Methodology for the Measurement and Characterization of Social Exclusion in Health in Selected Countries of Latin America and the Caribbean"....................9

Lessons Learned and Cooperation Strategies for Intensifying and Consolidating the Incorporation of Gender Indicators and Analysis into the Monitoring and Evaluation of Sectoral Reform Processes....................13

Action by the Subcommittee on Women, Health, and Development....................15

Gender Indicators in the Methodologies and Instruments for the Monitoring and Evaluation of Sectoral Reform Process

Introduction

1. Health Sector Reform (HSR) has been defined as 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** in satisfying the health needs of the population. It is an intense transformation of the health systems that takes place within a given time frame and is generally guided by a legal and regulatory framework, as stated during the Special Meeting on Health Sector Reform, held during the 38th Directing Council of the Pan American Health Organization (PAHO).

2. The regional reality in this area is highly diverse, since significant variations occur in both the dynamics and the contents of the changes being introduced by the majority of the countries. In some cases, these changes are substantive, broad, and planned, while in others they have gradually been introduced into specific areas.

3. At its September 1996 meeting, the Directing Council of PAHO analyzed the progress made in the Region's HSR activities, taking into account the Plan of Action approved by the Summit of the Americas, held in Miami in 1994, stating in Resolution CD39.R7 that the countries should reaffirm their political commitment to health sector reform. Furthermore, it requested that PAHO emphasize the continuous monitoring and periodic evaluation of the progress made and problems encountered by national HSR processes in the Region.

4. In this context, the Latin America and Caribbean Regional Health Sector Reform Initiative was launched in 1997, supported by both PAHO and the U.S. Agency for International Development (USAID). The Initiative has made significant progress toward the objective of supporting the national HSR processes during its first stage (1997/2002), through activities centered on the development of instruments, the dissemination of information, the monitoring of reform processes, and the creation of networks of relevant actors in the countries.

5. The specific purpose of monitoring and evaluating the HSR processes is to analyze the extent to which the changes may be helping to improve the levels of equity, effectiveness and quality, efficiency, sustainability, and participation and social control of health systems and services. All these elements will make it possible to judge the direction of the current or programmed HSR from the standpoint of the final objectives

that have been established. These, in turn, constitute the frame of conceptual reference for a series of variables and indicators to try to measure the impact of the reforms.

6. The major technical cooperation activities of PAHO include: strengthening national capacity for the design, implementation, and effective use of methodologies and instruments to detect and evaluate changes in the living conditions and health of populations; capacity building for policy analysis, planning, and formulation; and strengthening the leadership and administrative capacity of the ministries of health and other sector institutions in both the regular operational areas and the HSR processes. The methodological instruments for monitoring and evaluation of HSR also serve to measure the processes and outcomes of the reforms and to guide the identification and selection of priority interventions, both for the country and for PAHO technical cooperation.

Methodological Guidelines for the Preparation of Health System Profiles and Health Sector Analysis

7. Until 1998, PAHO did not have reports on the health services system of each country that could systematically describe the context in which these services operate, the organization, operation, and resources of the respective health services systems, and the impact of the HSR initiatives on them. The methodology for preparing health system profiles and monitoring sectoral reforms emerged in response to this need.

8. The monitoring and evaluation of HSR, based on the framework originally developed by PAHO in 1998/1999 through the Latin America and Caribbean Regional Health Sector Reform Initiative, was conducted by the countries of the Region and presented at the 41st Directing Council, held in San Juan, Puerto Rico in 1999. Resolution CD41.R12 was adopted by the Member States and briefly stated, proposes the following:

- To recognize the efforts of the Member States and PAHO to design and implement the “Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean”;

- To urge the Member States to institutionalize the monitoring and evaluation of their HSR processes; and

- The request that PAHO continue the process for improving and adapting the “Methodology” with the active participation of the ministries of health of the Region.

9. The purpose of the Methodological Guidelines for the Preparation of Health System Profiles, the methodological instrument for monitoring and evaluation of HSR, is

to guide the production of a **document summarizing the structure and dynamic of the health services system of each country**. Thirty-three countries in the Americas have institutionalized the monitoring and evaluation of their HSR processes through the application of the instrument. Twenty-three of those countries have prepared two versions of the profiles, and all 33 profiles have been updated or reviewed during the last two years. The regional analyses are continually updated, and subregional analyses for Central America, the English-speaking Caribbean, and the Andean countries were conducted in 2001/2002. These products are readily accessible through the website of the Latin American and Caribbean Regional Health Sector Reform Initiative (www.americas.health-sector-reform.org).

10. The national authorities can take the results of these processes into account in policy design and implementation and use them to make informed decisions on the development of their health systems.

11. The principal **gender**-related variables/indicators utilized in the profiles are:

- On the demographic and epidemiological context: the time series for the total fertility and maternal mortality rates;

- On service coverage: prenatal check-ups performed by trained personnel and the percentage of women who use contraceptives;

- On the right to health care and health insurance, asking: Have specific programs been introduced or are they being designed to increase coverage? If so, by whom? For what groups (for example, based on age, sex, ethnicity, social or economic status, or specific pathologies)?;

- On service supply and models of care, asking: Are programs and activities in place for the identification and/or care of vulnerable groups, as defined by income, specific risk, age, sex, ethnicity, or marginalization criteria?;

- In the performance audit of HSR, regarding equity, asking: Is there any evidence that HSR has led to a reduction in gaps in all or some of the following indicators for each territorial unit: sex, age, race, socioeconomic status, and coverage system; and

- In the performance audit of HSR, regarding effectiveness and quality, asking: Is there any evidence that HSR has led to a reduction in gaps in all or some of the following indicators for each territorial unit: maternal mortality; mortality from cervical cancer (among several others).

12. An initiative such as the preparation of health system profiles for **all the countries** of the Region faces a number of methodological problems and certain limitations. In some countries, the available information is insufficient, or unreliable, or is not sufficiently disaggregated, and in others, even if the information exists, it is not compiled and disseminated systematically. Selecting the most appropriate indicators to measure the changes in each variable is not simple nor is it free from controversy. The diversity of cultural factors and organizational models in the health systems produces significant variations in the definition of concepts and/or the terminology utilized. Finally, the health services systems are complex and dynamic realities, in which the separation between periods of continuity and periods of rapid and deliberate change can not always be clearly established. For these reasons, **each profile should be as objective as possible**, based on the available data in the country, manageable in scope, easily updated, and widely accessible. The selection of categories and analytical variables should conform to the principles of **simplicity and generality**.

13. The profiles are tools that can be complemented by the use of other methodologies and/or specific studies that measure exclusion or monitor equitable access, according to the needs and potential of each country, provided that the analytical strategy emphasizes a detailed knowledge of **socioeconomic, ethnic, gender or other pertinent** characteristics. Examples of such studies are detailed below.

14. In cases where the objective is to plan an intense phase of major reforms or to evaluate the impact of prior changes of great importance, experience suggests that PAHO undertake an intensive technical cooperation effort, organized within the context of an exercise of **health sector analysis**, where the **gender perspective** tends to be sufficiently disaggregated in the indicators and in-depth analysis.

15. The **analysis of a country's health sector** is an **in-depth study** of the **situation in the sector**, the production or distribution of goods or services, the elements that comprise it, and the relationships among them, taking into account the historical, cultural, political, economic, social, demographic, and epidemiological context. The general objectives of sectoral analyses are: to describe situations and evaluate policies; to identify problems and diagnose their causes; to describe future scenarios; to contribute to policy-making; to propose strategies for solutions; and to suggest implementation modalities.

16. In the framework of the new generation of reforms taking shape in recent years, health sector analysis plays a key role as a basic tool for the analytical sectoral planning and decision-making process in the countries of the Region. That instrument constitutes the **central element in guiding strategy- and policy-making and promoting the development of specific programs and projects**. The Governing Bodies of PAHO/WHO have underscored the need to strengthen the capacity of the Member States to analyze the health sector, its resources, and its operations in terms of the need for

sectoral change. The methodology for health sector analysis, designed and implemented by PAHO in its strategy for cooperation with the countries, is continuously reviewed and improved, and a revised version of the methodological guidelines will be available at the end of this semester. Health sector analysis can influence the formulation of national health plans, master plans of investment, sectoral reform projects, strategies for the organization of health service networks, and programs to expand coverage or guarantee health insurance, etc., where the gender-related priorities defined in each country can be fully realized.

"Guidelines for Monitoring Equitable Access to Basic Health Services"

17. The "Guidelines" have been conceived as a complement to the methodology for monitoring and evaluation of reform processes, to facilitate the most in-depth analysis of equity aspects not covered by the general instrument. That instrument is an operational reference that traces the path of three principal areas: the level of access, its degree of equity, and the policies, strategies, and mechanisms developed to facilitate this access. The "Methodology" was reviewed and tested in pilot studies over the past three years. It was discussed at two consultative meetings with international experts (1999 and 2002) and tested in Brazil, Paraguay, and Guatemala. A new version of the "Guidelines" is now available for use by the countries of the Region.

18. This type of monitoring is an informational and analytical process to support action, serving as an early warning system to assist in the decision-making process as variations are detected through historical monitoring. It becomes necessary, given the critical limitations in access found in the majority of Latin American and Caribbean countries, especially among certain sectors of the population, and the diverse efforts put forth by the authorities in many of the countries to overcome them gradually. It places special emphasis on disparities or gaps in access among the different socioeconomic groups, where the action to overcome them occurs mainly at two levels: achieving the maximum expansion of health services coverage, and giving priority to groups and population areas whose lower socioeconomic status makes them those most vulnerable and in need of health care.

19. The "Guidelines" contain conceptual, methodological, and empirical elements. Its definitions are operational. The conceptual reference describes the relevant concepts and principles of access, equity, and basic health services; the factors responsible for variations in access to and use of services, whether related to demand or social factors (including socioeconomic, cultural, gender, and income factors, and financial and geographical barriers), or to supply or institutional factors. A central premise is the assumption that equity in access to and the use of health care exists when the use occurs to meet the different health care needs of the various groups in a population.

20. In its basic and expanded modules, the "Guidelines" utilize **few summary indicators** and consider, among other factors, those related to health service needs and socioeconomic health determinants. For each selected indicator, the "Guidelines" state that the degree of vulnerability, poverty, social exclusion, or need can lead to the possibility of and interest in evaluating different population groups, for example based on the gender perspective.

21. The basic indicators in which the population can be grouped, including the gender variable, are as follows:

- Life expectancy at birth,
- Infant mortality rate,
- Mortality of children under 5,
- Mortality in the population aged 15 to 64,
- Maternal mortality rate,
- Child malnutrition,
- Incidence of communicable disease (at the local level),
- Adult literacy rate,
- Average years of schooling, and
- Per capita income.

22. With regard to the **use of services**, the proposed indicators are:

- Annual outpatient consultations per inhabitant (any type);
- Annual hospitalizations per 100 population;
- Percentage of pregnant women attended during pregnancy by trained staff;
- Percentage of deliveries attended by trained staff; and
- Vaccination coverage for children under 1 against diphtheria, whooping cough, and tetanus.

23. The pilot studies already done using the instrument did not provide sufficient evidence either for outpatient consultations or for annual hospitalizations to infer the relevance of monitoring these indicators by gender. Furthermore, with regard to the percentage of pregnant women attended during pregnancy by trained staff and the percentage of childbirths attended by trained staff, these indicators *per se* employ a gender approach.

24. With respect to the indicator of vaccination coverage of children under 1 against diphtheria, whooping cough, and tetanus, recent data collected from demographic and health surveys in 42 countries worldwide show gaps and differences in total immunization coverage based on income level and gender. This analysis in terms of income level verified that gaps exist between the rich and the poor in all regions, without exception. This same analysis in terms of gender supports the observation that virtually no gender-based gaps exist in any region; in the particular case of Latin America, a gap in favor of women exists, with coverage of 50.2% for women and 48.7% for men.

25. The "Guidelines" suggest the use of two different information sources: the administrative system (in which the countries generally produce and utilize consolidated information that is not disaggregated by gender) and household surveys (which generally contain individual data to facilitate consideration of the variables related to gender, ethnicity, and socioeconomic status). The information from the administrative system that can be disaggregated by gender is that which contains individual data, such as deaths, hospitalizations, and record of communicable diseases requiring notification.

"Methodology for the Measurement and Characterization of Social Exclusion in Health in Selected Countries of Latin America and the Caribbean"

26. Social exclusion in health is a matter of growing importance in public policy, not only as a issue that must be addressed and resolved but also as an analytical tool to evaluate interventions designed to improve the health situation of the people. Despite the importance of social exclusion as a social phenomenon and public policy issue, sectoral reforms have only touched on it indirectly and in a piecemeal fashion.

27. One factor that interferes with an adequate approach to exclusion in health in the countries of the Region is there is no precise information on its magnitude and causal factors, nor is it clear which interventions are the most effective in combating it, due to its multidimensional nature and the scarcity of methodological tools to characterize and measure the problem. Knowledge of those factors will make it possible to identify the most appropriate ways of expanding social protection in health in different situations and contribute to better decision-making in this area.

28. PAHO has taken up the challenge of deepening the understanding of this phenomenon, recognizing its complexity and multidimensional nature. The development of a specific protocol for measuring and characterizing social exclusion in health and implementing it in selected countries, with SIDA support, is the first in a series of research and methodological development efforts proposed for the coming years to obtain an overview of exclusion in health in the Region, identify its determinants, and move ahead in proposing the most appropriate strategies to combat it.

29. The protocol utilizes the following **gender**-related indicators:

- Mortality by five principal age groups and by sex;
- Percentage of institutional births or those not attended by trained staff;
- Percentage of pregnant women who do not receive prenatal care;
- Maternal mortality by income quintile;
- Years of life lost due to disability, by sex and income quintile;
- Poverty level by sex and age;
- Poverty level by sex of the head of household;
- Percentage of the employed population by sex and occupational sector;
- Composition of the population of workers in the informal sector by labor category, sex, and income level;
- Differentiation by sex in affiliation with existing health protection systems (public or private); and
- Differentiation by sex in coverage, cost, and copayments of available health plans.

30. The results of the pilot studies on the application of the instrument in four countries have yielded diverse responses with respect to **gender**:

- The response to the question, “Who is excluded from health services?” systematically involves women, as can be observed in the following table:

Table 1-- Who is excluded from health services?

Country	Excluded
Ecuador	- The poor - Indigenous people - Inhabitants of rural areas
Guatemala	- The poor - Indigenous people - Women, especially if they are heads of household - Inhabitants of rural areas - The unemployed, underemployed, and workers in the informal sector
Paraguay	- Those in the lowest income quintile - Those who speak only Guaraní - People aged 6 to 29 and those over 50 - Those who lack health insurance - People with no formal education or with formal education only at the primary level - The unemployed - Workers in the private sector - Domestic workers - Workers in the agricultural sector and construction workers
Dominican Republic	- The poor - Haitian immigrants - Children under 5, female adolescents, and people over 65 years of age - Women, especially the poor, heads of household, and pregnant women - Workers in the agricultural and informal sectors

- The reasons for women’s exclusion in health are related mainly to barriers created by their employment status, with unemployment, underemployment, and informal employment being the most important exclusion variables. In all those variables, the figures are systematically higher for women (tables 2 and 3).

Table 2. Informal employment

Country	Percentage of the economically active population that works in the informal sector (%)		Year
	Men	Women	
Ecuador	nd	nd	-
Guatemala	61.5	66.8	1998
Paraguay	29.8	42.1	1999
Dominican Rep.	nd	nd	-

Table 3. Unemployment

Country	Total unemployment rate (%)		Year
	Men	Women	
Ecuador	10.8	19.6	1999
Guatemala	nd	nd	-
Paraguay	11.7	22.3	2000
Dominican Rep.	9.2	23.9	1999

- These variables are strongly associated with lower income and poverty, very important determinants of exclusion in health. Women suffer greater exclusion in health when they live in a rural environment and are of indigenous origin.

- The indicators of mortality, noninstitutional births, and pregnant women without prenatal care clearly reveal a situation of greater exclusion in health for poor/rural/indigenous women when compared with their non-poor/urban/non-indigenous peers.

- Insurance enrollment percentages and questions referring to differentiation by sex in plan enrollment, cost, and coverage do not show significant differences between men and women, perhaps because in the countries studied, insurance enrollment is generally very low and the most marked difference occurs between the poor and the non-poor, regardless of gender.

31. The conclusions of the four pilot studies point to other gender indicators that could be added to the protocol and other variables to consider, depending on the availability of information from the countries:

- Waiting time for health care. The study in Ecuador shows differences in the waiting time for men and women and also for the inhabitants of rural and urban environments, with longer waiting times in the rural environment and for women, as can be observed in table 4.

Table 4: Average waiting time (minutes)—Ecuador

	Average waiting time			
	Men		Women	
Region	Rural	Urban	Rural	Urban
Coast	31	33	35	44
Mountains	32	39	40	38
Average	32	36	37	41

- Health expenditure per inhabitant, by sex of the principal breadwinner in the household. The health expenditure per inhabitant directly affects the health care received, particularly in the absence of effective insurance systems. The results of the study in Ecuador reveal that the health expenditure per inhabitant varies with the sex of the principal breadwinner in the household, with higher expenditure when this is a woman. In this context, the fact that the woman is the principal breadwinner in the household would act as a protective factor for the family in terms of meeting the health demands of its members.

- Rate of health coverage consistent with the demand for care by sex, age group, and income quintile.

- Rate of health coverage of chronic noncommunicable diseases consistent with the demand for care by sex, age group, and income quintile.

- Unmet demand by gender and age group.

Lessons Learned and Cooperation Strategies for Intensifying and Consolidating the Incorporation of Gender Indicators and Analysis into the Monitoring and Evaluation of Sectoral Reform Processes

32. The lessons learned, experience gained, and evidence generated by the countries' specific application of the various methodologies mentioned above show that the gender variable plays an important role in the development of phenomena linked to exclusion in health and inequity in access to health care. This role is complex and can not be reduced to discrimination against women as seen in demographic, labor, and use of service variables, but rather relates to the importance assigned to men and women in societies in the different stages of life. Thus, while in most countries of the Region, a health system structure based on the mother-child binomial clearly persists, whereby women of childbearing age--and especially pregnant women--receive far more care than their male peers in the same age stratum, occupational medicine is also heavily based on a model of care geared to male workers that does not take the specific health needs of working women into account.

33. Recognizing this situation, PAHO proposes to make additional efforts to incorporate gender issues, as well as others designated priorities by the Member States, in the various methodologies used to evaluate HSR processes and outcomes, particularly in characterizing exclusion in health and analyzing equitable access. This strategy should be strengthened gradually, as the countries also increase the production and utilization of information disaggregated by sex, pursuant to the commitment contained in Resolution CSP26.R21.

34. In order to support this effort and ensure the viability and feasibility of the various instruments for the monitoring and evaluation of major changes and/or reforms in the health systems, PAHO should play a proactive role in defining and proposing adjustments to the level of disaggregation of information appropriate to the nature of each instrument.

35. In addition to the specific considerations with regard to each instrument mentioned in the respective sections, a threefold strategy is recommended:

- For instruments of universal general use, such as health system profiles, which are based on widely available secondary data in each country and require objectivity, synthesis, and frequent updating, the level of disaggregation of gender-related variables should be the minimum considered essential.

- When the purpose of each instrument is to ensure the depth of the analysis, gender variables tend to be detailed according to the priorities of each country, as in the case of the "Guidelines for Monitoring Equitable Access to Basic Health Services" and the "Methodology for the Measurement and Characterization of Social Exclusion in Health in Selected Countries of Latin America and the Caribbean."

- In the planning/evaluation of sweeping changes or reforms in the health sector of a country, the information and analyses generated by the application of the aforementioned instruments can be aligned and integrated with other specific studies in a health sector analysis, in which the gender perspective, as well as other relevant categories, tends to be fully expressed. Health sector analysis distinguishes itself in adding prospective and analytical components to the primarily retrospective and descriptive approach of situational diagnosis that characterizes the methodologies previously described, since it includes the construction of hypotheses and the formulation of policy guidelines for plans, strategies, and programs, while ensuring the full and complete possibility of incorporating the gender perspective into the monitoring of health system performance and the results of changes or reforms.

Action by the Subcommittee on Women, Health, and Development

36. The Subcommittee is requested to make recommendations for strengthening incorporation of gender analysis into the instruments and processes for monitoring and evaluating sectoral reforms and to urge the Member States to comply with Resolution CSP26.R21 of the 26th Pan American Sanitary Conference on the production and utilization of information disaggregated by gender.

37. The Subcommittee is furthermore requested to support the dissemination by PAHO of the methodological instruments described in this document, especially health sector analysis, and their utilization by the countries of the Region.

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