



Guide for analysis and monitoring of gender equity in health policies



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*

GUIDE FOR ANALYSIS AND MONITORING OF GENDER EQUITY IN HEALTH POLICIES



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Organization**

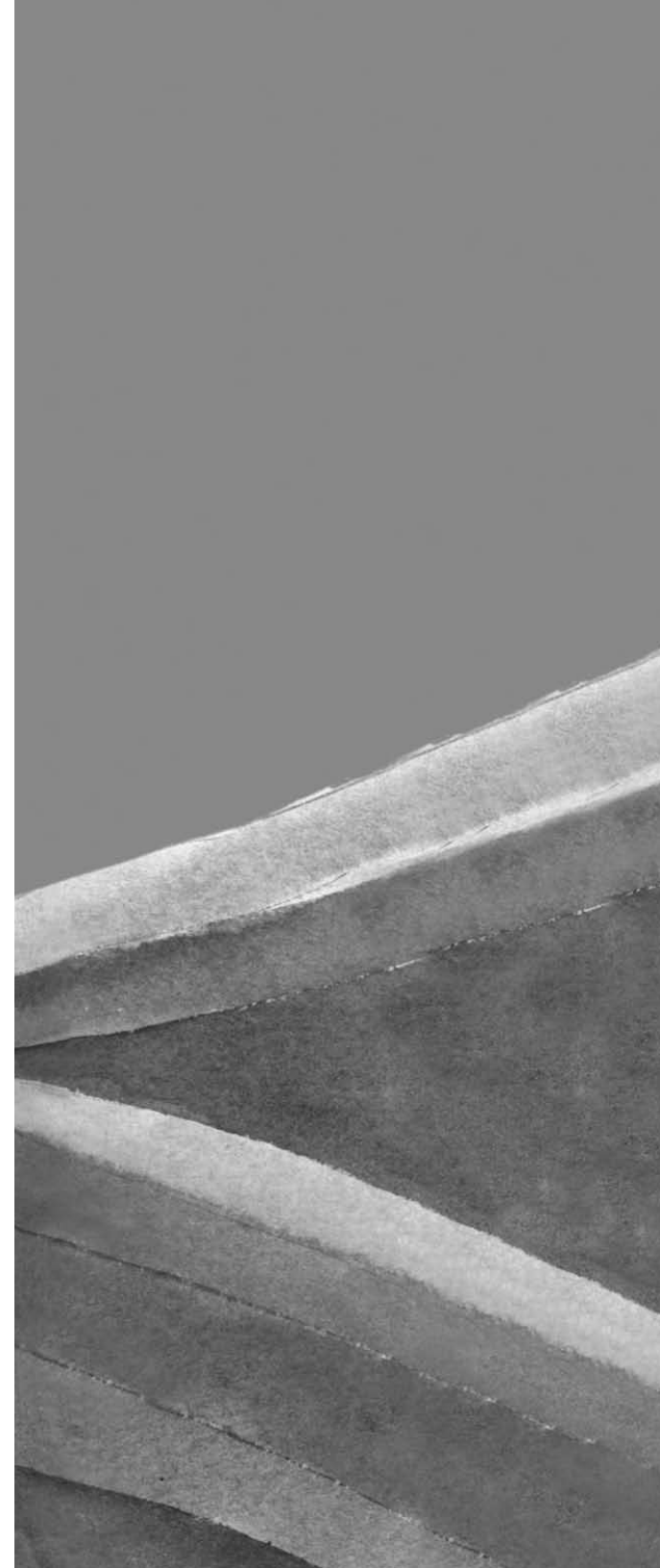
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Ana Isabel Arenas, Alma Catharina Cuéllar, Mónica Gogna, Ana Cristina González, Elsa Victoria Henao, Amparo Hernández, Dinys Luciano, Magda Palacio, María Rosa Renzi, José Ruales, and Inés Reca each reviewed the original version and then discussed it as a group.

Dinys Luciano prepared the revised version that was submitted for validation and also coordinated the validation exercise in four countries. Mónica Gogna and Ana Rita Díaz oversaw validation in Argentina, Dora Caballero did so in Bolivia, Amparo Hernández in Colombia, and Silvia Narváez in Nicaragua.

Ana Cristina González contributed her valuable experience as former Public Health Director in the Colombian Ministry of Health and Social Protection for the preparation of a third version, which incorporated the results of the validation exercise in the countries and formed the basis for the present document. Pat Armstrong, of the University of York in Ontario, Canada, and Cecilia Acuña, of HP/PAHO, also offered detailed suggestions for the third version.

Elsa Gómez Gómez prepared the present version, which encompasses the contributions received throughout the process. She assumes ultimate responsibility for its content as well as for any omissions or redundancies.

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FOREWORD

Health policies are not gender-neutral. Research throughout the world has demonstrated that they do not affect women and men in the same way. As a result, gender equality has become a major subject of concern and commitment at international summits.

All too often, the formulation and monitoring of health policies fail to include the dimension of gender. Even when sex differences are considered, they are cast in terms of “women” rather than “gender relations” – i.e., the socially unequal relationships between women and men that affect the health and well-being of society as a whole. The gender perspective is rarely applied, despite the commitments States have made to achieve gender equality objectives.

Failure to consider gender in the analysis and implementation of policies can limit not only the advancement of policies consistent with the principles of ethics and human rights, but also the development of best practices in public health. This is true for several reasons. First, when the gender perspective is absent, the situation analysis, the objectives established, and the weighting of external factors will not reflect or respond to the differential needs of women and men. Second, lack of a baseline makes it impossible to monitor gender inequalities. And third, the gaps in the analysis caused by failure to include some stakeholders will hinder the effective development and monitoring of organizational changes in this area. In other words, the absence of gender considerations in policy development has adverse repercussions not only on the effectiveness of

policies for achieving equity and equality, but also on the effectiveness, efficiency, and sustainability of interventions.

Progress toward gender equality requires an intersectoral political commitment to bring about change, the technical capacity to implement it, the institutional infrastructure to support it, the financial resources to pay for it, and mechanisms of accountability and monitoring to ensure that it becomes a reality. Civil society plays a central role in this process because it provides the driving force to place the issue on the political agenda, demand that principles of gender equality be respected, and see that rights are upheld.

This instrument, prepared under the coordination of the Gender, Ethnicity, and Health Unit of the Pan American Health Organization, is intended to contribute to progress toward the goals of gender equality in health. It offers health planners, advocacy groups, and researchers an analytical framework for the evaluation and monitoring of evidence-based policies that are guided by the principles of social justice, human rights, and citizen empowerment.



I. . NATURE, OBJECTIVES, AND USES OF THE GUIDE

This guide was prepared by the Gender, Ethnicity, and Health Unit of the Pan American Health Organization (PAHO/WHO) to support initiatives for incorporating the analysis and monitoring of gender equity into health policies in the Region. The process of designing and validating the guide has been part of an overall initiative to mainstream a gender equity perspective in health policies, in keeping with the Gender Equality Policy of the Pan American Health Organization (2005a). The guide provides a conceptual and methodological framework for evaluating the degree to which health policies—in particular, those associated with health sector reform (HSR)—are consistent with the commitments assumed by Member States at the national and international level to work towards achieving the objectives of gender equality in health and health management.

This instrument seeks to broaden the definition of equity that has guided the evaluation of health system reform policies introduced in the Region since the 1990s, which has tended to focus on economic criteria and overlook other major dimensions of inequality such as gender. It is intended to help elucidate the implications of such policies for gender equity, recognizing, of course, that they will vary depending on a country's specific circumstances. The guide provides a basis for discussion and advocacy in a process aimed at building consensus around the identification of problems, the establishment of priorities for action, the formulation or reformulation of policy objectives, and the definition of indicators and strategies for monitoring application of the resulting policies.

Background

The preparation of this guide involved a diverse group of individuals with recognized expertise in various theoretical and practical aspects of the subject. The basic elements were drawn from the pioneering works of Standing (1997, 1999, 2000, 2002), Daniels et al. (1996, 2000, 2005), Luciano (1998), and Gómez (2002). The last-mentioned author, a member of the PAHO Gender, Ethnicity, and Health Unit, also coordinated the overall process.

Preparation of the initial version of this instrument was overseen by Hilary Standing, professor and researcher at the Institute of Development Studies of the University of Sussex and the Health Sector Reform

Program of the Liverpool School of Tropical Medicine. The first draft also benefited from the work of Norman Daniels, professor in the Department of Philosophy at Tufts University, as well as suggestions by Gustavo Nigenda, researcher at the Mexican Foundation for Health. This preliminary version was then reviewed by a group of experts from governmental and nongovernmental organizations, technical cooperation agencies, research centers, and universities in Argentina, Chile, Colombia, Costa Rica, and Nicaragua, who met in Bogotá, Colombia in 2004. This consultation process yielded valuable recommendations with regard to the content and structure of the guide and the methodology for validating it. The following individuals participated in this phase of the process: Ana Isabel Arenas, Catharina Cuéllar, Mónica Gogna, Elsa Victoria Henao, Ana Cristina González, Magda Palacio, María Rosa Renzi, José Ruales, Amparo Hernández, Inés Reca, Dinys Luciano, and Elsa Gómez Gómez. Dinys Luciano prepared a second version of the guide based on the group's suggestions and coordinated validation of the instrument in four countries. In addition, Mónica Gogna and Ana Rita Díaz led the validation in Argentina, Dora Caballero did so in Bolivia, Amparo Hernández in Colombia, and Silvia Narváez in Nicaragua.

Ana Cristina González then prepared a third version incorporating the suggestions and observations generated throughout the process. This version also benefited from a detailed review by Pat Armstrong, professor at York University in Ontario, Canada, as well as suggestions by Cecilia Acuña of the PAHO Health Policies and Systems Unit. The present version, which synthesizes the contributions of those who nourished and stimulated the process over a period of three years, was prepared by Elsa Gómez Gómez.

Target audiences

This guide is intended for two main audiences:

- ✱ Decision-makers, planners, and officials responsible for the development of systems for monitoring the impact of policies on specific population groups.
- ✱ Advocacy groups, universities, and research centers, especially those concerned with women's health and the impact of health policies on equity.

Objectives

The guide is designed to be used for evaluation and also for advocacy and policy impact, depending on the group that uses it. Its objectives are to:

- ✱ Provide a conceptual framework for the evaluation of gender equity in health policies that will be applicable to different political, socio-economic, and health sector reform contexts
- ✱ Support decision-making with regard to basic criteria and indicators for the formulation and monitoring of policies from a gender-equity perspective
- ✱ Facilitate intersectoral policy dialogue on gender equity in the content, processes, and impact of policies
- ✱ Assist in defining objectives for advocacy and for policy impact vis-à-vis decision-makers and key stakeholders, especially, but not exclusively, in the health sector.

Organization

The guide has been divided into four sections. The first section outlines its background, objectives, scope, and possible uses. The second reviews the conceptual and ethical framework for the proposed methodology. The third identifies the specific elements which, from a gender perspec-

tive, should be included in the analysis of a situation being addressed by policies. And finally, the fourth section provides detailed descriptions of the eight observation fields around which the analytical exercise is structured.

The eight observation fields in the fourth section are presented in separate chapters, as follows:

- 1) Intersectoral action
- 2) Access to the health system
- 3) Comprehensiveness of benefits
- 4) Quality of care
- 5) Health system financing
- 6) Management of human resources
- 7) Participation, accountability, and empowerment
- 8) Fulfillment of international commitments

Although, for purposes of analysis, each of these observation fields is considered separately, in practice, of course, they overlap. This means that some of the same issues are considered more than once. This repetition is difficult to avoid if each of the components is treated separately. A clear example of overlap is the issue of unremunerated health care provided in the home, mainly by women, which comes up in the analysis of all the components, but is addressed most explicitly in the chapters on access, financing, and human resources.

Each of the chapters in the fourth section begins with a description of the scope of the corresponding observation field and the aspects and issues that are of particular importance for the attainment of gender equity. Supporting this description is a table that outlines (a) the issues that are frequently associated with gender inequities; (b) the gender equity benchmarks or strategic objectives—which are based on principles of social justice and human rights—towards which policies and interventions

should ideally be aimed; and (c) some questions that should be raised regarding gender equity in existing and proposed policies and practices in light of the issues indicated—questions which, depending on the information available, could be reformulated as indicators. These elements will facilitate the identification of problem areas, the establishment of baselines, and the definition of indicators and strategies for monitoring progress toward the goals of gender equity.

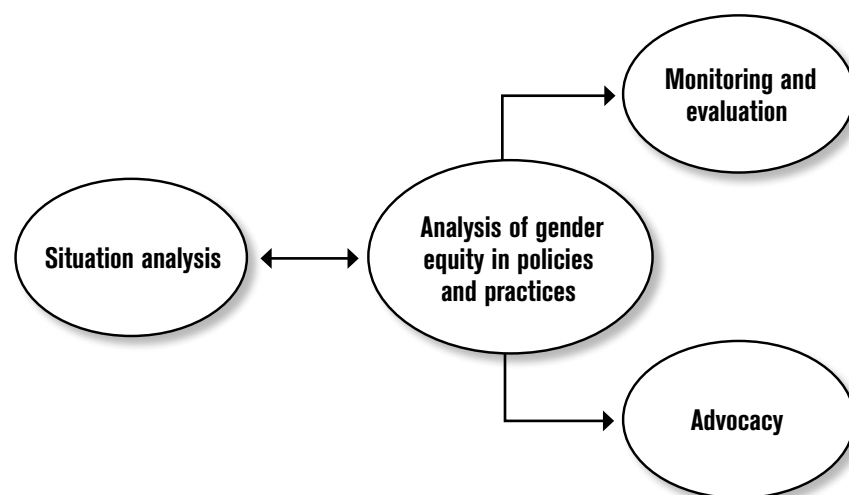
The benchmarks or objectives for gender equity in these fields are especially important because the achievement of equity has been declared a central objective in the various reforms undertaken in the Latin American and Caribbean region, which is recognized as the most inequitable region in the world. The explicit inclusion of gender in the overall objectives for equity in proposed reforms responds to the need to address the effects of an axis of inequality which, despite its ubiquity, has not been included in these objectives—namely, unequal access by men and women to resources and power. Focusing the debate on the economic dimension has made it possible to avoid considering other inequalities such as ethnicity and gender and the articulation between these realities and the economy.

Uses

The countries of the Region differ considerably in terms of their level of economic development and the type and coverage of their health systems, and therefore not all the observation fields proposed in the guide will be equally applicable to all countries or localities. Similarly, not all the issues suggested as priorities in the various observation fields will be the most appropriate ones for each audience or context. This instrument is not intended to be a recipe or prescription. The groups that use it will need to decide whether its various components are relevant and applicable for their purposes and whether others need to be added. They

will also need to determine the best way to proceed operationally. For example, decisions will have to be made about whether to consider the observation fields as a whole or whether to use only the fields that are deemed to be pertinent or are considered priorities in a particular case. It will also need to be decided how to measure changes over time. The proposed *questions* within each field and subtopic can easily be turned into indicators, and these can be weighted in terms of the gender equity *benchmarks* suggested in each case.

The guide underscores the importance of starting the analysis of each of these dimensions from the premise that gender determinants lead to differences throughout the health system. It is therefore suggested that users first read the conceptual framework that ties the analysis together (Section II) and then undertake a gender-sensitive situation analysis (Section III). In some countries, such an analysis may already be available, at least in part. In others, it will be necessary to carry it out as an essential aspect of monitoring and evaluating the possible gender impact of reforms.



The following steps might be followed in applying the guide:

- a. The group leading the analysis reviews the content and makes any changes or additions that it considers necessary.
- b. Discussions and/or meetings are set up with other interested stakeholders to refine the content so that it reflects local realities.
- c. An executive team is formed, operational procedures are decided on, and work on the situation analysis begins.
- d. Based on the results of the situation analysis, the team evaluates the chosen policy dimensions and discusses them with the interested stakeholders.
- e. Conditions for carrying out a political advocacy process are agreed upon.
- f. The analysis is refined and the results are passed on to decision-makers, politicians, the media, women's organizations, and other groups engaged in advocacy for equity and human rights.

Information sources

The situation analysis and the characterization of each analytical dimension should be supported by quantitative and qualitative information available in the country from:

- * Official national sources: vital statistics, censuses; surveys, on health, fertility, nutrition, employment, and time use; and budgetary allocations
- * Routine records from health centers, hospitals, social security, mandatory disease reporting systems, surveillance systems, local budgets
- * Quantitative and qualitative studies conducted by research centers, NGOs, universities, and international cooperation agencies.

In addition to health information, contextual information should be included on the cultural, social and economic factors that increase vulnerability to certain health problems and the response to them. It will also be important to identify, and determine the political and practical implications of, gaps and biases in the information on certain issues.



II. FRAME OF REFERENCE

Gender equality as an international commitment

Health policies are not gender-neutral: they do not affect women and men in the same way. In recent years, research conducted in various parts of the world has revealed significant inequalities between women and men in terms of access to services, quality of care, share of health expenditure, balance between contributions to and compensation for health care, and participation and representation in decision-making. As a result of these findings, gender equity is becoming a key area of concern, as evidenced by three important international summits.

The first of these events, the International Conference on Population and Development (ICPD), held in Cairo in 1994, generated a fundamental change in the thinking about family planning and maternal and child health programs. Interest shifted from programs aimed at achieving demographic goals to comprehensive health programs that were sensitive to the particular needs of women and men. The ICPD spurred a movement away from vertical programs that took a fragmented approach to health needs and towards integrated reproductive health programs that addressed the needs of women and men throughout the life cycle and that went beyond a purely biological perspective. This emphasis was supported by solid evidence of existing inequalities.

This change was accompanied by strong emphasis on the rights and empowerment of women and by affirmation of the need for the health sector to play an active role in achieving gender equity goals. This chal-

lenge was reinforced in the Platform for Action adopted at the Fourth World Conference on Women, held in Beijing in 1995, which linked the health of women with the broad human rights agenda. Subsequently, during the Millennium Summit in 2001, States explicitly identified the achievement of gender equality and the empowerment of women as one of eight development goals (2001).

Equity in health and health as a human right are guiding principles for PAHO's technical cooperation. In this context, the quest for gender equity is regarded as an essential component of the Organization's mandate. Evidence of this are the WHO Gender Policy adopted by the World Health Organization (WHO) in 2002, the PAHO Gender Equality Policy approved in 2005, and the gender strategy put forward by WHO in 2006.

The concepts of equality, equity, and empowerment that inform the PAHO Gender Equality Policy are explicitly linked to the view of health as a human right. *Gender equality* in health means that women and men enjoy similar conditions and opportunities for exercising fully their right and their potential to be healthy, contribute to health development, and benefit from the results of this development. *Gender equity* means fairness in the distribution of responsibilities, resources, and power between women and men. The concept of fairness recognizes that differences exist between the sexes in these areas, and hence that resources must be allocated differentially to rectify unfair disparities. In other words, equity is the means and equality is the end. The policy also emphasizes that equitable interventions are not sufficient to attain equality. Empowerment, in particular the empowerment of women, is seen as a sine qua non for achieving gender equality.

Beyond the recognition given to the ethical imperatives of fairness that underpin the search for gender equality in health, it is important to point out that international cooperation agencies are increasingly emphasiz-

ing the importance of gender equality and the empowerment of women for the effective achievement of development objectives. Consequently, these agencies are also stressing the need to incorporate a gender perspective in all government sectors and programs as a critical component in the design of policies and practices. The United Nations Millennium Project has emphasized that achievement of the goal of gender equality and empowerment of women will require a strong political commitment at the highest levels, both nationally and internationally, which will translate into public policies and allocation of resources that will contribute effectively to that end. In the health sphere, it is essential that such policies and allocations should be aimed at ensuring equity not only in access but also in diagnosis, treatment, outcomes, health work, and participation in decision-making.

The foregoing commitments are a response to the situation, which has been documented throughout the world, of the differential relationship that women and men experience with the health system in terms of both utilization and production of health services and their benefits.

Why the emphasis on women in efforts to rectify gender inequalities in health?

It is often asked why women are emphasized in discussions of equity, since women live longer than men and use health services more often. But while it is true that women tend to live longer and use more health services, these facts are not necessarily indicative of better health or greater access to resources because the biological differences between the sexes make it impossible to set a common standard for longevity and health care needs.

The analysis of equity in health emphasizes the preventable nature of the conditions and problems that affect health and, at the same time, the extent to which people have the capability and opportunity to access the resources needed to ensure their health. Equity in access to services is measured not in terms of parity between the sexes, but rather in terms of differential needs. Thus, ensuring equity in interventions and in the allocation of resources means giving priority to disadvantaged groups in order to respond to unmet needs and level the field of opportunity. This reasoning has been the basis for targeting populations that live in poverty, excluded ethnic groups, and, in this case, women, especially those who experience multiple forms of exclusion, whether for economic reasons or because of their ethnic origin.

The main reasons for this emphasis, based on the available evidence, are:

- (1) Women's health care needs are not only different from those of men, they are also greater.
 - ❖ Women and men differ in terms of the type of work they do, where they work, the resources to which they have access, and the compensation they receive. These factors make for differences in the health status of women and men, with variations in health conditions and consequences depending on the socioeconomic context. These differences reflect inequalities that place women in an economically disadvantaged and subordinate position with respect to men, which affects their chances for achieving, recovering, and maintaining an optimal level of health.
 - ❖ Some health care needs are unique to women, in particular those related to reproduction.
 - ❖ Disabilities, especially those related to aging, are more prevalent among women.
 - ❖ There are health conditions which, although they are called by the same name, affect women differently from men and may require different treatment depending on the patient's sex.
 - ❖ Women and men experience different types of violence. Domestic violence is the most common type of violence, and it affects mainly women.
 - ❖ Women's responsibility for their children affects the nature of their health service needs.
- (2) Women's lower rate of participation in paid employment limits their access to health services, insurance plans, and social protection in the long term.
- (3) Women frequently receive a lower quality of care for reasons that have to do with cultural stereotypes and with the fact that clinical research has focused mainly on men.
- (4) Because of women's greater need for health services, in most countries women spend more on health, in both absolute and relative terms, than men do.
- (5) Women, or some subgroups of women, generally have less decision-making power than men over the factors that affect their health, including sexuality, reproduction, service utilization, and contraceptive methods.
- (6) From the standpoint of health production, women represent the majority of both paid and unpaid health workers, yet they are in the minority at decision-making levels in health systems. Women are concentrated in the jobs with the lowest pay and the least prestige and power in the formal health care sector; they perform without pay the informal work of health promotion and health care in families and communities; and they remain underrepresented in the community power structures that set priorities and allocate resources for health.
- (7) Women are the primary providers of health care in the family: they bear the largest burden in providing such care and are therefore most affected by any increase or reduction in public health services.

Why the emphasis on women in discussions of effectiveness and efficiency of interventions?

- (1) Women are the principal managers of family health—especially the health of children. Women's health and the control that they have over resources are therefore key factors in ensuring the effectiveness, efficiency, and sustainability of health interventions.

(2) Millennium Development Goal 3, “Promote gender equality and empower women,” in addition to being an end in itself, has been recognized as essential to achieving the other seven development goals.

Thus, recognition of gender differences and inequalities is essential to a full understanding of the current reality and to the achievement of interventions that are not only more equitable but also more effective and efficient.

Conceptual pillars of the gender equality approach

The following basic concepts underlie the mandate to mainstream the gender perspective in PAHO technical cooperation programs: health, gender equality and equity, and citizen participation.

a. Health

According to the definition adopted by WHO/PAHO, health is “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Health is thus a positive concept that emphasizes both physical capacities and personal and social resources, and therefore it is not just the responsibility of the health sector, nor is it limited to healthy lifestyles (Ottawa Charter for Health Promotion, 1986). Achievement of the highest attainable level of health is a fundamental human right, enshrined since 1946 in the Constitution of the World Health Organization. Health care is only one aspect, albeit an important one, of the achievement of health.

b. Gender

The term *gender* refers to the ways in which relations between the sexes are organized in a society and to the division of roles and power associated with that organization. It is different from the concept of sex, which refers simply to the biological differences between women and men.

Hence, the focus of interest in the gender approach is not women—or men—per se, but rather the relationships of social inequality between the sexes.

A gender approach to health goes begins with an examination of the effects of social relationships between the sexes on citizens’ ability to exercise the right to health and on fairness in the allocation of resources and power in the management of health. Such an approach takes account of the broader context of power relationships within society and of the way in which gender inequalities, in combination with other power imbalances, affect epidemiological profiles and the characteristics of access to and management of health systems.

c. Equality and equity

As noted above, the concepts of equality and equity that guide the PAHO Gender Equality Policy are linked to the view of health as a human right in which *equity* is the means and *equality* is the end. Equality refers to the principle of nondiscrimination in the exercise of rights, in this case the right to health and its determinants, and to participation in health development. Equity, on the other hand, is based on principles of social justice and refers to interventions aimed at eliminating systematic, unfair, and avoidable disparities between social groups—women and men—with regard to level of health; access to necessary resources for the promotion, recovery and maintenance of health, including but not limi-

ted to health care; and participation in health development processes.

The idea of need that underlies the concept of equity in the allocation of resources implies that resources are allocated not on the basis of criteria of equality/parity but of differentiation, based on need. Accordingly, to rectify inequity, resource allocation and interventions must target the groups with the greatest need. Women—particularly those who are poor and those who belong to populations that are excluded for reasons of ethnicity, civil conflict or forced displacement—are one such group.

The understanding of gender equality from a human rights perspective originated with the United Nations Charter in 1945, which affirms the equality of the sexes. In accordance with the Charter of the United Nations, several agreements adopted subsequently impose obligations on signatory governments to promote gender equality through the promotion of women's health and the elimination of barriers hindering its achievement. For example, 130 States signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979. This Convention explicitly recognizes the right to health care and family planning services.

CEDAW went beyond the initial principle of nondiscrimination between the sexes, calling for a special effort to address discrimination *against* woman in specific areas. It focuses on the so-called “second generation” of rights: economic, social, and cultural. It is within this second generation that health care is understood to be a human right. For example, the principle of the “right to life” includes the right not to die during childbirth due to avoidable causes. This rights-based approach was to become an integral part of the resolutions on health adopted at the Fourth World Conference on Women, held in Beijing in 1995.

Some of the key characteristics of the rights-based approach to gender equality in health are:

- * The health-related disadvantages that women experience are injustices that infringe their rights both as individuals and as a group.
- * The concept of the right to health goes beyond the delivery of health services, encompassing a view of health that includes *empowerment and social participation*.
- * Although signing the various international agreements is voluntary, the States that do sign have the obligation to undertake positive actions to address the problems that are deemed to be most pressing.

d. Citizen participation and empowerment

Although participation by women in the production of health has been—and has been recognized to be—essential to improving the collective health, historically this participation been limited to the fulfillment of responsibilities that do not entail the exercise of power.

Participation in health, which is crucial to the achievement of equity and equality, means the right of citizens to exercise a degree of control over the factors and processes that bear on health, both their own health and that of the collective. It is not limited to carrying out tasks prescribed by others, nor is it intended to serve as a means of cutting costs in the delivery of services. The emphasis placed on women, especially poor women, comes in response to the urgent need to eliminate this instrumentalist approach to women's participation that has thoroughly permeated the family and community health care system. It seeks to promote, instead, a fairer distribution of labor, compensation, and decision-making regarding the production of health, as well as assumption of the responsibilities of citizen control and demand for accountability for policy implementation.

The empowerment of women alluded to in Millennium Development Goal 3 refers to women taking control of their lives. Empowering women is essential if gender equality is to be achieved in areas that are crucial to health. Empowerment means being able to choose from among

several options, make decisions, and put them into practice in contexts where this ability had previously been denied. It is a process, but it is also a result; it is collective and at the same time individual. Others cannot empower women; only women can empower themselves. However, institutions can facilitate empowering processes at both the individual and the collective levels (PAHO, 2005a).

Dimensions for the analysis of gender equality in health

For purposes of analysis, the following dimensions of gender equality in health are considered: health status and its socioeconomic determinants; health care, not only as one of the determinants of health but also as the basis for sectoral policies; and formal and informal processes of health management.

- * With regard to **health status**, gender equality does not translate into equal mortality or morbidity rates, but rather into comparable levels of health and well-being for women and men. Because the health needs of women and men are measured differently, it is not always feasible to draw comparisons between the sexes with regard to particular conditions. Hence, the comparison parameter for assessing equality and equity would include not only the health status of the opposite sex, but also the levels of health attainable by persons of the same sex among the most socially privileged groups in specific contexts.
- * With regard to the **socioeconomic determinants** of health, gender equality means equal opportunity to have access and control over the resources that make it possible to exercise the right to health (food, housing, healthy environment, education, information, work, remuneration, technologies, services, etc.).
- * In the area of **health care**, gender equity means that:

- ◆ Resources are allocated according to the particular needs of women and men, bearing in mind that women have reproductive health needs associated with pregnancy and childbirth that demand additional resources.
 - ◆ Services are received according to the particular needs of each sex regardless of ability to pay.
 - ◆ The financial burden of health care is distributed in society on the basis of citizens' economic capacity and the risks associated with sex, age, socioeconomic status, or "preexisting" health conditions.
- * In the area of **participation in health management**, gender equity demands a fair balance between the sexes in the distribution of work (paid and unpaid), compensation associated with that work, and decision-making power.

Strategy for mainstreaming gender equality in health

A gender approach in health analysis and planning means recognizing and taking into account the biological and social differences between women and men. However, consideration of these differences can serve different purposes. One such purpose might be to exploit gender differences for "efficiency" reasons—for example, in order to reduce public health services and shift the burden to households on the assumption that women will take over providing these services. Another purpose of accommodating gender differences might be to facilitate the performance of gender roles—for example, providing child care in maternal health centers or training mothers to provide child health care. A third purpose, which is the one envisioned in the strategy proposed here, would be to transform gender relations with a view to promoting equality, while at the same time ensuring health care to meet immediate needs stemming from biological differences or a sex-based division of labor.

The strategy for mainstreaming gender equality in health includes the following components:

- * Producing evidence of inequalities between women and men of different socioeconomic groups in terms of:
 - ◆ Division of labor and consequent limited access and control over the resources necessary for promoting, recovering, and maintaining health (including material resources, information, political support, services, and time)
 - ◆ Differential exposure to risks associated with the division of labor
 - ◆ Health needs associated with biological differences, a sex-based division of labor, and power relationships between the sexes
 - ◆ Distribution of responsibilities and compensation in the production of health at the level of the family, community, and formal health system
 - ◆ Representation in the decision-making processes whereby priorities are established and the public and private resources needed to ensure health are allocated
 - ◆ Differences in social and political responses to needs common to both sexes and needs that are exclusive to each sex.
- * Recognizing the interdependence between the formal and informal spheres of health care, which means that policies that affect the delivery of public services also affect the burden of informal care, which falls primarily on women.
- * Promoting the active participation of women—and of the most disadvantaged groups—in strengthening partnerships and the empowerment of women to achieve a fairer redistribution of the responsibilities, the benefits, and the power to influence health development.
- * Developing intersectoral coordination mechanisms for formulating and monitoring pro-equity policies that address the social determi-

nants of health and incorporate representatives of civil society organizations working to promote gender equity.

- * Developing mechanisms to monitor policies and accountability, with the active participation of gender equality advocacy groups.

The interface between gender equality objectives and health sector reform policies

Since the 1980s, health sector reforms have been being implemented throughout Latin America and the Caribbean. Although they have taken different forms, depending on the national context, they share common denominators having to do with macro processes of globalization and State reform and with an international reform agenda promoted and supported by multilateral agencies. Generally speaking, it can be said that the paradigm of health care as a public good, rooted in recognition of “shared risks” and “social solidarity,” has given way to a paradigm in which the market ensures the economic efficiency, quality, and effectiveness of care, and guarantees individual freedoms and responsibilities.

Health sector reforms have targeted, among other areas, health care financing systems, mechanisms for setting priorities, and aspects of service organization such as decentralization and integration of services. A central feature of these reforms has been change in the State’s role—and greater involvement of the private sector—in the regulation, delivery, and financing of services. These reforms, depending on their nature and scope, may affect all facets of the health system, including financing, human resources, management, planning, access to services, and quality of care.

In general, health sector reforms have tended to:

- * Promote less reliance on public financing and greater emphasis on mixed public/private funding mechanisms aimed at enhancing cost

containment and recovery (through prepaid medicine, user fees, insurance) and, theoretically, improving the quality of care

- * Separate service regulation, delivery, and financing functions and reduce the State's role in the provision and financing of services
- * Develop selective approaches to primary health care, identifying a guaranteed minimum set of low-cost high-yield services, usually referred to as a "basic package," as well as insurance systems to provide access to these services
- * Strengthen curative services at the expense of health promotion and disease prevention
- * Decentralize the health sector to local levels or to other agencies, on the assumption that decentralized structures will be more responsive to local needs, more effective in the delivery of care, and more accountable to the population
- * Link, in the name of efficiency, human resources management to civil service reforms, including staff cutbacks, flexible labor practices, and new methods of performance evaluation
- * Reduce institutional services, transferring certain care and treatment functions to the home on the assumption that this approach is more economically efficient and that patients receive more humane care
- * Involve the for-profit private sector in policy-making.

The language of health sector reform has evolved since its beginnings in the early 1990s. The "first generation" of reforms was strongly driven by the supply side and focused on internal reorganization of the sector. With the "second generation," the central elements of economic adjustment and liberalization remain firmly in place, but the emphasis has shifted towards the demand side, and the language has broadened to include issues relating to poverty and intersectoral approaches to health. In the first generation, the focus was on effecting internal changes in the system, with no associated monitoring of the impact that these changes were having on health outcomes and the delivery of care. Changing the system was seen as a set of technical and managerial activities, rather

than as a political process to be negotiated with stakeholders. There was no consideration of indicators of social disadvantage, such as gender, in the planning, implementation, and monitoring of reforms. Indeed, the shift in language to the demand side reflected in part an acknowledgment of the failure of the earlier reforms to produce any improvement in health indicators (Standing, 2000b).

The implications of health sector reforms for gender equity vary depending on the context in which they occur and the nature of the changes undertaken. However, although the evidence is still fragmentary, it is sufficiently solid in some areas to point up the adverse impact that certain modalities of health sector reform have had on gender equity in health, especially for the poor (Standing, 1997; Gómez, 2002a, 2002b; Vega et al., 2001; OPS, 2002).

The evidence suggests, for example, that:

- * Measures aimed at cost recovery and privatization of services disproportionately affect health services use by women: the proportion of unmet need for services is greater for women, especially poor women, because they have a greater need for services, particularly those related to reproductive health, and yet they have the least capacity to pay for them.
- * Cutbacks in health promotion and disease prevention services have a disproportionately adverse effect on women, since these services represent the major portion of care sought by women.
- * Risk-based payment systems have a more negative effect on women: because women use services more frequently, especially reproductive health services, they have greater out-of-pocket expenditure and pay higher private insurance premiums. As noted above, this disparity in the payment burden is exacerbated by women's lower earning capacity.
- * Health insurance and social protection systems tied to employment in the formal sector of the economy exclude a larger proportion of

women than men from direct access to benefits because the proportion of women in the paid labor market is smaller and more women work in informal and part-time jobs, and are therefore not covered by social security.

- * The underrepresentation of women in national, local, and sectoral power structures puts them at a disadvantage in the setting of priorities and the allocation of resources for reproductive health. Moreover, collective gains in the assertion of sexual and reproductive rights at the national level may not necessarily find an echo at local levels, where attitudes are often more conservative.
- * Women are not only the major users of health services, but also the main health care providers. Service cutbacks and staff reductions in the formal sector affect women more than men, often leading to loss of employment, excessive workloads, and lower wages for women and resulting in an increase in the burden of informal care being provided in the home and the community.

In response to each of these situations it must be asked: To what extent does the policy help to reduce unfair health disparities and actively promote gender equity and equality? In what socioeconomic and geographic contexts? Or, on the contrary: To what extent does the policy disregard, create, or exacerbate gender inequalities in health? Which socioeconomic or geographical groups are most affected? Thinking about the circumstances associated with the results in either direction will contribute to the development of proposals aimed at strengthening, reorienting, complementing, or replacing existing policies.

The Challenges

It is important to emphasize that health systems, beyond improving the health of the population in general, have the potential to promote equality and social justice when their design and management specifically consider the circumstances and needs of socially disadvantaged and marginalized populations (WHO, 2007).

Health systems must address the following critical challenges if they are to improve the level and distribution of health with particular emphasis on gender equality (WHO, 2007):

- a. Exercise of leadership for the development of processes and mechanisms for **intersectoral action** by the various sectors of the State that work with the determinants of health and inequality
- b. Development and maintenance of an **information system** that will enable identification and measurement of health care inequalities, **evidence-based** planning, monitoring of progress in the fulfillment of policies, and **accountability** for their implementation
- c. Promotion of organizational mechanisms and practices that **involve affected population groups**, especially women, and civil society organizations that are working for gender equity in decisions and actions aimed at identifying needs and allocating resources to meet them
- d. Development of health care financing and delivery mechanisms that aim at **universal coverage** and offer special benefits for marginalized and socially disadvantaged groups
- e. Revitalization of the integrated **primary health care** approach as a strategy that reinforces and integrates the other equity-promoting measures identified above.

An additional challenge is **strengthening the governance role of the State** in establishing regulatory frameworks and in monitoring and oversight of resources, stakeholders, and health management, with the goal of eliminating all forms of discrimination and enforcing rights.



III. GUIDELINES FOR CONTEXT ANALYSIS

The purpose of this section is to provide guidance for examining the legal, political, economic, and health context of the society in which health sector reforms are being analyzed. An examination of this kind helps to identify existing needs and resources, understand the differential implications of reforms for women and men, and pinpoint factors that cause these reforms to evolve in different directions depending on the specific context in which they occur.

Analyzing gender inequalities in health means examining the differential positions that women and men occupy as beneficiaries and as agents of health system development, which is understood to mean the total of all “actions primarily intended to promote, restore, or maintain health.” Accordingly, the analysis should include a macro level that refers to the society as a whole, an intermediate level that focuses on the health sector in particular, and a micro level that looks at individuals and households. All these facets need to be examined, because gender inequality has deep roots in people’s attitudes, in social institutions, in market forces, and in political life.

The analysis of the context in which policies have developed serves as a preliminary assessment of the existence, nature, and magnitude of gender inequalities in health. This assessment should include demographic and epidemiological aspects indicative of the nature and extent of the population’s needs, along with key features of the health system that

enable it to respond to those needs. It should also include information on environmental health and access to drinking water and sanitation services. These topics will be addressed in other chapters in this guide.

To delineate the context, the following elements should be taken into account:

- * the demographic profile of the population, including access to basic water and sanitation services
- * gender inequalities in employment, social security, education, political participation, and legislation
- * the epidemiological profile of the population, showing the nature and level of its health needs
- * the sex profile of participation in the work force, remuneration, and health system decisions
- * the health system features that enable a response to the health needs

of the population, including the participation of key stakeholders in formulating and monitoring health policies

- * the content and scope of the health system reforms that have been introduced
- * the geopolitical context

To conduct this type of analysis properly, it is vitally important to have data disaggregated by sex and other key socioeconomic categories that will make it possible to identify and locate inequalities. The sex breakdown should cover situations that involve both women and men and also situations that are exclusive to one or the other sex. Having this information broken down by sex is crucial to gender analysis. It is essential in order to (i) reveal and characterize the *sex differences* in health and its determinants; (ii) estimate the magnitude of the *burden of problems* that limit and prematurely shorten the lives of women and men; (iii) determine, for each sex, the *ratio between contributions and compensation* for their respective health work; and (iv) characterize the level of participation by women and men in health-related decision-making at the family, community, sectoral, and national levels.

Based on this information, the gender analysis then examines the ways in which inequalities in women's and men's roles and access to resources and power have a differential effect on their health status and the nature of their participation in health development. This examination goes beyond the reproduction-based biological dimension and provides an understanding of how a health problem or intervention can affect women and men differently.

Following are some useful criteria and ideas for selecting and utilizing categories of analysis (OPS, Unidad de Género, Etnia y Salud, 2004), together with an array of variables which, depending on the availability of information and its relevance for purposes of the exercise, might be included in a gender analysis of health system reforms. Most of the in-

dicators suggested can be found for each country of the Region at the national level in the biannual statistical pamphlet published by PAHO, *Gender, Health, and Development in the Americas: Basic Indicators*. In addition to the breakdown by sex, depending on the availability of information for each country, disaggregating information by age and other socioeconomic variables, including ethnicity, is strongly encouraged. The specific breakdowns mentioned in the following sections have been chosen bearing in mind the availability of information in most countries.

Demographic Profile

The basic elements for assessing a population's health needs include age structure, mortality and fertility rates, and geographic distribution. From a gender perspective, it is essential to determine fertility patterns among women of childbearing age and to highlight trends and any age-related, socioeconomic, ethnic, or geographical differences that are found. With information on the changing dynamics of age distribution, it is possible to make estimates and projections of the unremunerated care burden that falls mainly on women when there are children and older adults in the home. Knowledge about population aging is especially important in the health context, not only from the perspective of disabilities and chronic diseases but also from that of care requirements. Policies designed to reconcile employment with duties in the home, an important issue for all households, are even more important for single-parent families. Causes of death will be examined below in the section entitled "The health situation," and the subject of work force participation will be dealt with in the section on socioeconomic context.

The following constitute a minimum set of demographic indicators:

- * Total population broken down by sex and age groups
- * Urban and rural population, by sex, age groups, and ethnicity (if known)

- * Population of women aged 15 to 49
- * Dependency ratio, including both the underage population and the older-adult population
- * Percentage of single-parent households and percentage of households headed by women, by rural or urban residence
- * Annual population growth rate
- * Life expectancy at birth, by sex
- * Life expectancy at age 60, by sex
- * Total fertility rate, by level of education, rural or urban residence, and geographic region
- * Percentage of adolescent women who are mothers or expecting a child, by level of education, rural or urban residence, geographic region, and ethnic origin
- * Percentage of displaced persons or migrants, by sex, age group, geographical region, and ethnic origin
- * Percentage of population with access to basic water and sanitation services, by rural or urban residence.

Social, economic, legal, and political context

Access to resources such as education, employment, and income creates opportunities to achieve and maintain health. Inequalities between women and men in these areas tend to be reflected in their health status and in the nature of their engagement with the system.

Education: The educational status of women is the variable associated with the most significant differentials in terms of their own health status and that of their children. Although great strides in education have benefited women in particular, they still face significant disadvantages, especially in rural areas and among indigenous populations. However, gender equity in education is not necessarily reflected in work force participation or remuneration, or in political participation.

Employment: The fact that more women than men live in poverty is closely linked to sex-differentiated work patterns. On the one hand, the social centrality of women's domestic role in the home limits their time and opportunities to participate in the paid job market and results in a lower proportion of women in the paid work force. On the other hand, segmentation of the job market along gender lines means that the predominantly "female" occupations have less prestige and are lower paid. At the same time, more women than men work part-time and have jobs in the informal sector; unemployment rates are higher among women; they are paid less than men, even when they work in jobs for which they are equally qualified; and they are underrepresented in managerial positions and as employers. This gender inequality in the work sphere is reflected in disparities in women's access to their own income and social security benefits, which are usually tied to formal employment. Moreover, women do most of the unremunerated work in the home that is essential for maintaining the current work force, raising the next generation, and caring for the aged. Through this "invisible" work, women make a substantial contribution to domestic economies and to human development, although little has been done to quantify this contribution.

Political participation: In all the countries of the Region women are in a minority in decision-making bodies, within both the executive and legislative branches of government. This situation reduces the likelihood that their interests, views, and needs will be represented in policies.

Legislation and policy-making: It is of interest for the analysis to determine whether pertinent laws and policies include objectives and indicators related to achieving equality between women and men; whether there are plans for achieving equal opportunities for women and men; and whether policies aimed at enhancing women's access to property ownership are being implemented. It is of the utmost importance to ascertain the progress made toward legislation on issues that affect women exclusively or disproportionately, such as maternity rights of female workers, gender violence, divorce, responsible fatherhood, and access to

contraception, including emergency contraception, and to safe abortion.

Governmental institutions that promote women's advancement: The creation of national mechanisms aimed at achieving gender equity has been an ongoing effort in the Region. However, not all countries have assigned the same importance to these mechanisms, and they vary both with regard to their degree of administrative and financial autonomy and in terms of their prestige and the place they occupy within national power structures. Such entities can play an important role in initiating plans for equal opportunity, which are regarded as a strategic means of fostering action from various sectors.

The following indicators and variables may be used to assess the situation in the foregoing areas:

a. Level and distribution of income

- ❖ Gross national income - per capita gross domestic product (GDP) adjusted for purchasing power parity (PPP)
- ❖ Ratio of highest to lowest income quintiles
- ❖ Percentage of population living below the national poverty line
- ❖ Percentage of households headed by women, broken down by poverty level (non-poor, poor, and indigent)

b. Education

- ❖ Illiteracy rate, by sex, age, rural or urban residence, and ethnic origin
- ❖ Average years of schooling of the population aged 15–24, by rural or urban residence and ethnic origin
- ❖ Existence of sex education programs and content thereof

c. Work and remuneration

- ❖ Rate of participation in economic activities, by sex, rural or ur-

ban residence, and years of schooling

- ❖ Open unemployment rate, by sex, rural or urban residence, and ethnic origin
- ❖ Percentage of economically active population (EAP) working in low-productivity sectors, by sex
- ❖ Participation of EAP in the category “employers,” by sex
- ❖ Percentage of EAP working more than 20 hours per week, by sex
- ❖ Male:female ratio of average employment income, by educational level
- ❖ Percentage of population aged 15 – 59 contributing to social security, by sex
- ❖ Percentage of population over 65 years of age receiving a retirement pension, by sex
- ❖ Participation of EAP in managerial positions, by sex
- ❖ Hours per week of unremunerated work, by sex, rural or urban residence, and socioeconomic status (in cases where time use surveys are available)

d. Political participation

- ❖ Percentage of women in the country's senate (upper chamber of the national legislature)
- ❖ Percentage of women in the lower chamber (in countries with a bicameral system)
- ❖ Percentage of women in ministerial positions
- ❖ Percentage of women mayors
- ❖ Presence of NGOs and organized women's groups participating in the political debate and advocating effectively for gender equality.

e. Legal framework

- ❖ Regulatory frameworks for eliminating gender-based discrimination in access to property ownership, housing, and credit
- ❖ Regulatory frameworks for eliminating gender-based discrimi-

nation in current access to education and for promoting gender equality in future employment

- ❖ Provisions to help pregnant adolescents stay in school
- ❖ Recognition of gender inequalities in social protection and measures to close existing gaps
- ❖ Legal status of divorce
- ❖ Length and financing of maternity leave
- ❖ Existence of legislation on responsible fatherhood and paternal leave
- ❖ Regulation of access to and financing for child daycare centers
- ❖ Regulation of access to and financing for care centers for older adults
- ❖ Legal status of abortion, female sterilization, emergency contraception, and access to contraceptives by adolescent women
- ❖ Existence of a quota law applying to legislative elections and proportion of positions allocated to women
- ❖ Agreements regarding the rights of women and girls signed and ratified by the government
- ❖ Knowledge about and fulfillment of such agreements by the appropriate ministries and local government offices
- ❖ Laws or plans to ensure equal opportunities for women and men
- ❖ Laws and programs to prevent, punish, and eradicate violence against women
- ❖ Access to employment-based social security
- ❖ Existence of national institutions (ministries, institutes, advisory bodies) devoted to promoting gender equality and the advancement of women, and level of administrative and financial autonomy, prestige, and influence of such institutions.

The Health Situation

This section should include a description of the health situation from

the perspective of both those who use health services and those who provide them. The health conditions or situations to be included in a gender analysis should be selected on the basis of the following criteria:

- * They are exclusive to one or the other sex (e.g., maternal mortality, breastfeeding, prostate cancer, cervical cancer, abortion, etc.).
- * They are more prevalent in one of the sexes (e.g., osteoporosis, diabetes mellitus, ischemic heart disease, obesity, disability in old age; vaccine-preventable diseases; suicide, homicide, traffic accidents; provision of unremunerated care in the home, representation in power structures, volunteer work; etc.).
- * They have different biological and social consequences in women and men (e.g., access to contraceptives, environmental pollution, smoking, alcoholism, access to public child daycare services, etc.).
- * They involve different risk factors for women and men (e.g., domestic and street violence, occupational health, HIV, etc.).
- * They require specific interventions for each sex and for particular subgroups within each sex (e.g., provision of various methods of contraception; care during childbirth; prevention and treatment of violence, including sexual violence; maternity leave; reproductive health care; mental health care in situations of forced displacement; etc.).
- * They affect the sexes and subgroups within each sex differently in terms of barriers that prevent access to resources and services (e.g., employment-based insurance, requirement of consent from the husband to undergo sterilization, fee for reproductive health services, access to contraceptives during adolescence, etc.).

This type of approach goes beyond the reproductive difference between the sexes and includes the health conditions of men that are affected by the social constructs of masculinity. Of special note are those related to social violence, accidents, dangerous occupations, and risky behaviors involving tobacco, alcohol, and drugs. However, what should be emphasized here for purposes of the analysis is *sexual and reproductive health*, bearing in mind the differentiating effect of reproduction and the fact

that the Member States of the United Nations have recognized that freedom to make decisions about one's own fertility is a basic right which in turn allows women to exercise other rights. Indeed, women bear the greatest burden of biological and social needs associated with contraception, pregnancy, childbirth, abortion, and breastfeeding. In this case, the gender perspective means that needs and interventions are analyzed not only from the biological angle but also in terms of people's capacity and power to make decisions about their own sexuality and their own reproduction. It will also mean that needs and interventions are analyzed for groups that are excluded or in critical situations, such as adolescents, displaced population groups, and men.

For analytical purposes, it is important to reiterate three statements made in the previous chapter. First, gender equality in health **does not mean equal mortality or morbidity rates**, but rather the absence of **avoidable**, and therefore unfair, gaps in health conditions for women and men. Accordingly, the analysis should weigh the extent to which the causes and effects of these gaps could have been modified through policy interventions. Second, gender equity in access to health care **does not mean that men and women receive equal shares of resources and services**, but rather that resources are allocated and used **differentially**, based on the particular needs of each sex and socioeconomic group. And third, gender equality in participation in health work includes both **paid and unremunerated work** and has to do with fairness in the distribution of responsibilities, compensation, and decision-making about the health policy agenda.

- a. In terms of the general population who are health service *beneficiaries or users*, the identification of health conditions and diseases that affect the sexes differentially will vary with the conditions in each country and, in keeping with principles of equity, particular attention should be given to preventable conditions. The following indicators are conditions in which sex has commonly been shown to have a clear differentiating impact:

- ❖ Infant mortality rates, by mother's years of schooling and place of residence
- ❖ Mortality from preventable diseases among children 1 to 4 years of age, by sex
- ❖ Five leading causes of mortality, by sex and age
- ❖ Mortality due to ischemic heart disease, by sex and age
- ❖ Mortality from stroke, by sex and age
- ❖ Prevalence and mortality rates for diabetes mellitus, by sex and age
- ❖ Mortality from lung cancer, by sex and age
- ❖ Mortality from cirrhosis and other chronic diseases of the liver, by sex and age
- ❖ Prevalence of obesity, by sex and age group
- ❖ Prevalence of nutritional deficiencies, by sex, age group, and rural or urban residence
- ❖ Percentage of pregnant women with iron-deficiency anemia
- ❖ Prevalence of hypertension, by sex and age group
- ❖ Prevalence, incidence, and mortality rates for breast cancer, by age group, years of schooling, and place of residence
- ❖ Prevalence, incidence, and mortality rates for prostate cancer, by age group, years of schooling, and place of residence
- ❖ Mortality from accidents, by sex and age group
- ❖ Mortality from homicide, by sex and age group
- ❖ Mortality from suicide, by sex and age group
- ❖ Percentage of women who have experienced intimate partner violence in the home, by age and years of schooling
- ❖ Rates of alcoholism, by sex and age group
- ❖ Rates of tobacco use, by sex and age group
- ❖ Rates of substance abuse, by sex and age group
- ❖ Rates of depression, by sex and age group
- ❖ Rates of poisoning from environmental contamination (pesticides and other chemicals), by sex and age group
- ❖ Rates of other occupational diseases and injuries, by sex and age group, including diseases and injuries associated with perform-

ing domestic activities and providing health care in the home

- ❖ Rates of osteomuscular disease, by sex and age group
- ❖ Percentage of people over 60 years of age who experience disability, by sex, age, and socioeconomic status
- ❖ Existence of medical histories that make it possible to identify sex-differentiated conditions that lead to disease and disability, and then, to health recovery
- ❖ Existence of programs for the prevention and treatment of conditions other than those associated with age or reproductive health, in which the particular situation of women—and men—is taken into account (e.g., occupational health, mental health, intimate partner violence, chronic diseases)

Sexual and reproductive health

- ❖ Trends and differentials in fertility (already indicated in the section on demographic indicators)
 - Total fertility rate, by level of education, rural or urban residence, and geographic region
 - Percentage of adolescent girls who are mothers or are pregnant, by years of schooling, rural or urban residence, geographic region, and ethnic origin
- ❖ Average months of spacing between births, by age group, mother's years of schooling, and place of residence
- ❖ Average number of children per woman at specific ages, by age groups, mother's years of schooling, and place of residence
- ❖ Maternal mortality rate, by age groups, schooling, and mother's place of residence
- ❖ Incidence of and mortality from unsafe abortion, by age group and socioeconomic status
- ❖ Prevalence, incidence, and mortality rates for HIV infection, by sex, age group, years of schooling, and place of residence
- ❖ Percentage of women who have experienced sexual violence, within or outside the home, by age, woman's years of schooling,

or socioeconomic status of the household

- ❖ Prevalence, incidence, and mortality rates for cervical cancer, by age groups, woman's years of schooling or socioeconomic status of the household, and place of residence
 - ❖ Percentage of deliveries attended by skilled personnel, by age group, mother's years of schooling, and place of residence
 - ❖ Percentage of pregnant women receiving skilled care, by age group, mother's years of schooling, and place of residence
 - ❖ Percentage of cesarean deliveries, by age group, mother's years of schooling, and place of residence
 - ❖ Percentage of women aged 15 to 49 using female and male contraceptive methods, by type of method, age group, years of schooling, place of residence, and ethnic origin
 - ❖ Legal and effective access to emergency contraception, especially for adolescents
 - ❖ Percentage of unmet need for contraception, by age group, years of schooling, woman's rural or urban residence, and ethnic origin, especially among adolescents
 - ❖ Percentage of women over 35 years of age who have had a Pap test in the last three years
 - ❖ Existence of a sex education programs and content thereof
 - ❖ Existence of programs for the prevention of cervical and breast cancer
 - ❖ Existence of programs for the prevention and treatment of sexual and domestic violence against women
- b. From the perspective of ***human resources for health***, the following would be some of the basic indicators for analyzing gender equality:
- ❖ Percentage of men and women in the various health professions and at decision-making levels
 - ❖ Remuneration of health workers in the various professional categories and at decision-making levels, by sex
 - ❖ Illustrative examples of the sex composition (percentages of

- women and men) of local committees that set priorities and allocate resources
- ❖ Illustrative examples of participation by women and men in health promotion work carried out in the communities
- ❖ Male:female ratio of graduates in the health professions
- ❖ Unremunerated health care (for children, ill and disabled persons, and older adults) as a proportion of total health care (figures taken from surveys and time use studies in the specific context of health)
- ❖ Support programs for the provision of health care in the home.

The health system and health policies

The characterization of national health systems is based on two fundamental elements: the economic level of the country, and the degree to which the State assumes responsibility for the provision, financing, organization, and regulation of services. Of central importance in this context are the priority assigned to sexual and reproductive health services, the comprehensiveness of these services, and the modalities for their financing. No less important are the measures that ensure non-employment-based social protection. In this context, the following information should be captured: reforms introduced in the last two decades, degree of influence of the stakeholders who contributed to the design of such reforms, and the type of consultation processes that took place among them. The following indicators are useful for this purpose:

- * National expenditure on health as a percentage of GDP
- * Per capita expenditure on health
- * Sources of financing for the health care system
- * Financing of basic health services and of contraception and maternal care services
- * Degree of State participation in the financing of health services

- * Out-of-pocket expenditure as a percentage of health expenditure
- * Total health services coverage, by type of coverage
- * Degree of State participation in the provision and organization of health services
- * Existence and monitoring of government regulatory frameworks that prohibit gender-based discrimination in access to services, the provision of certain specific services, and the financing of services by the State and the private sector
- * Level of participation by organized civil society groups in the development of national and local agendas
- * Political and financial priority assigned to safe motherhood programs
- * Nature of changes introduced in financing and personnel management mechanisms as a result of health sector reforms, priority-setting with regard to guaranteed services, mechanisms for organizing services, and level of responsibility assumed by the State in the provision, financing, and regulation of services
- * Degree of participation and influence of outside donors, religious institutions, and the women's movement in setting agendas and monitoring their fulfillment
- * Explicit consideration of international agreements related to gender equality and the rights of women in the formulation and implementation of national health plans and health sector reform policies
- * Standards in services that address explicitly mentioned gender specificities
- * Social protection policies aimed at ensuring health for vulnerable and priority groups that specifically include gender considerations

Finally, but no less important, there is the larger geopolitical context in which the country is located. In this area, three dimensions should be distinguished (Ravindran, 2002):

- * The political context, which includes a country's bargaining capacity at the international level

- ✱ The economic context, including level of external debt and financial stability
- ✱ The historical context, notably the State's role in health and social development in the past.



IV. OBSERVATION FIELDS FOR THE ANALYSIS OF GENDER EQUITY IN HEALTH POLICIES

OBSERVATION FIELD 1: INTERSECTORAL ACTION

Health and the way in which it is distributed within the population are a key measure of social justice. This section refers to the ways in which the principal *determinants of health and the health status distribution of the population* are reflected in health sector policies.

Although the determinants of health and their distribution are generally addressed by policies and programs of other sectors, it is an ongoing responsibility of the health sector to raise awareness about the potential health impacts of policies emanating from other sectors and to lead efforts to collaborate with those sectors in advancing health and ensuring that health gains are equitably distributed across the population. Intersectoral action for health therefore means creating relationships between various sectors of society for the purpose of improving health outcomes, and doing so in such a way that these actions have greater potential than if they had been undertaken by the health sector alone.

Two types of determinants are involved in the analysis of health: *structural determinants*, which are those that generate stratification (income, education, gender, ethnic group), and *intermediary determinants*, which flow from stratification and, in turn, determine differences in exposure and vulnerability to health-compromising conditions (living conditions, working conditions, availability of food, barriers to adopting healthy lifestyles, availability and access to health services) (WHO, 2005).

Although an intersectoral approach is usually easier to implement in local contexts, higher levels of government have the obligation to address the structural causes of poor health that have a greater adverse effect on socially disadvantaged groups.

This section focuses on intersectoral collaboration for the improvement of health, and within this context, actions that will contribute to the elimination of gender inequity in health. It looks at measures taken to promote collaboration between different sectors of government and civil society in key areas which determine or influence health and which are especially relevant from the perspective of eliminating gender inequalities. Although it suggests certain spheres of activity to be examined, the final determination of appropriate areas and issues will depend on the conditions in each country and the purpose of the exercise.

Some of the main spheres of intersectoral action for the improvement of health and the advancement of gender equality include education, work, social security, justice, water and sanitation, nutrition, finance, statistics, and equal opportunities for women. In addition to the government agencies involved in these areas, it is necessary to consider the participation of civil society groups that are concerned with ensuring the right to health and gender equality.

※ **Education:** Access to education is closely linked to the empowerment of women. Educated women are better able to improve their own

health and that of their families, break the cycle of intergenerational transmission of poverty, and escape situations of domestic violence. Education increases the potential to generate income, decide on the use of resources within the home, and participate in political decisions that affect health. Sex education is a key component in this area.

- * **Work:** The sex-differentiated pattern of work is reflected in asymmetries between women and men with respect to access to and control over health resources both at the community level and within the family. Women perform most of the unpaid work associated with maintaining households and caring for children, family members who are sick, and older adults residing in the home. These responsibilities limit their opportunity to participate in the paid job market. Women who are employed tend to work in low-paid jobs that offer little security. They represent the majority in seasonal occupations, part-time work, and the informal sector and are therefore not generally covered by **social security**. Women also have higher unemployment rates than men. In addition, women who participate in the paid job market are faced with a double demand on their time and on their health because they perform household duties in addition to their paid job.
- * **Social security:** As long as employment in the formal sector is a condition for enjoying the benefits of social security systems, the labor situation described above will place women at a disadvantage in asserting their right to social protection. Their greater requirement for services often results in reduced benefits, and they are also more vulnerable to loss of coverage as a result of losing their jobs or because of death of or desertion by the spouse. Because their unpaid work in the home is invisible from an economic perspective, this work is not reflected in occupational risk management schemes.
- * **Justice:** Violence against women perpetrated by men is the most blatant expression of the inequality of power between the sexes. It

often becomes a cause of disability and death, unwanted pregnancy, complications of childbirth, and sexually transmitted diseases, including HIV. The manner in which domestic violence is addressed has been identified as a key indicator for analyzing intersectoral action, because it is a problem that demands an intersectoral approach involving all sectors—especially justice, education, and health—and the community. From the standpoint of justice and gender equity, it is essential that the health system, as the most first point of contact for many victims of abuse, address domestic violence through a bio-psycho-social approach.

- * **Environment:** Women and men share the use of natural resources in different ways and contribute to a different degree both to degradation of the environment and to its preservation and conservation. The sex-based division of labor that assigns women day-to-day responsibility for maintaining the home results in a major investment of their time which limits their participation in the public sphere. In the case of poor women, this investment is even more burdensome, since public infrastructure in most poor countries and regions tends to be very weak. The time that women and girls spend on household tasks can be drastically reduced with appropriate infrastructure, thereby also increasing their opportunities for economic autonomy and political participation. Two types of infrastructure are especially critical for women's quality of life: water and transportation.
- ❖ **Water:** Inadequate infrastructure in this area has adverse effects for the health of the entire population, but the consequences are disproportionately negative for women, who are the principal users of water in the home. Women tend to be primarily responsible not only for transporting water (from rivers, fountains or distribution vehicles) when it is not supplied directly to the household, but also for using and treating water to meet the nutritional and hygiene needs of family members. Poor water quality is a frequent cause of illness in the family, and access to safe

drinking water is therefore a key factor in alleviating women's burden of unpaid labor, as well as in preventing afflictions such as low back pain associated with carrying water.

- ❖ **Transportation:** Por su mayor necesidad de servicios, su responsabilidad por el cuidado de los hijos y su menor acceso a ingresos económicos, las mujeres pueden ser afectadas desproporcionadamente por el costo del transporte donde no existen condiciones que faciliten su acceso geográfico a los servicios de salud. Dicho impacto se exagera entre las más pobres, para quienes tales costos pueden resultar en una disminución de la búsqueda de atención en momentos tan críticos como el embarazo.
- * Four other sectors which cannot be left out of any analysis of intersectoral action for the achievement of gender equity objectives are finance, agriculture, statistics, and women's affairs. It is in ministries

of finance and the entities responsible for planning that priorities are set for the **macro allocation of resources**. The problem of malnutrition, especially anemia in pregnant women, points up the need for coordinated action in setting policies on **food security**. Such policies should be aimed at ensuring adequate nutrition at all stages of the life cycle so that malnutrition does not exacerbate vulnerabilities such as anemia in pregnancy and/or low birthweight. **National statistics institutes** play a crucially important role in generating necessary information with the required level of detail through vital statistics, censuses, and surveys so that gender differences can be made visible for purposes of monitoring in various policy contexts. Obviously, ministries, other government offices, and civil society groups concerned with **equal opportunities for women and men** will necessarily be a part of intersectoral actions aimed at eliminating gender discrimination.

□ **TABLE 1. Intersectoral action**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Health plan	The national health plan includes an assessment and objectives and indicators associated with gender equality, and it is developed with the participation of other sectors and civil society, including representatives of the women's movement.	<ul style="list-style-type: none"> • Does the plan specifically recognize the need to identify and address differences between women and men with regard to needs, knowledge, opportunities, and compensation in the area of health? • Does the plan include a situation assessment, objectives, and indicators that make it possible to identify and address gender differences? • Has responsibility been assigned to specific actors in the various sectors? • What sectors of government and civil society were involved in developing the plan? • Are there mechanisms for carrying out intersectoral efforts aimed at improving health? • Has decentralization affected intersectoral cooperation? In what way? • Are women having more or less influence than before on local agendas?
Education	<p>Health policies acknowledge the impact of education on health and include objectives to ensure that a high proportion of young people of both sexes complete primary and secondary education in both rural and urban areas and among indigenous, black, and displaced populations.</p> <p>Educational policies, with support from the health sector, include plans or programs for sexual health education that emphasize respect for sexual and reproductive rights and gender equality. The content of these plans or programs is reflected in the curricula of public and private institutions, and civil society groups working to advance gender equality have been involved in their planning.</p> <p>Measures have been taken to help girls who become pregnant to stay in school.</p>	<ul style="list-style-type: none"> • What actions have been taken and what incentives have been created to reduce the education gap between the sexes in the various population groups? Are there coordination and decision-making entities or mechanisms to facilitate progress towards this objective at the national and local levels and do they involved the health sector? • Are there joint work plans for the health and education sectors to promote health education? • Have plans been developed to promote sex education? • Do sex education plans include goals, identification of actors responsible for their implementation, and budgets? • Have civil society groups and the women's movement participated in developing these plans? • Is expulsion of pregnant girls from school prohibited? • Are effective steps being taken to prevent pregnant students from dropping out or being expelled and pregnant teachers from leaving their jobs? • To what extent does the health sector participate in these initiatives?

Issues	Benchmarks for evaluating gender equity in policies	Questions
Work and social security	Health care and social security coverage are universal and are not dependent on a person's employment status.	<ul style="list-style-type: none"> • What measures are being taken to facilitate access to health care for low-income populations and informal-sector workers? • Have measures been taken to eliminate the employment disadvantages experienced by domestic workers? Is there maternity leave for such workers, and if so, how is it financed? • Do housewives have access to coverage in their own name, or only as dependents of their husbands? • Does the government give priority to especially vulnerable populations (e.g., indigenous, black, displaced, migrant populations)? • Are there government-administered mechanisms that ensure payment of maternity leave for ALL women? Who finances maternity leave? What implications does this financing have for the employment of women? • Are there employment protection mechanisms (maternity rights) for women during pregnancy and the postpartum, or have such mechanisms been proposed? • Has legislation providing for paternity leave been enacted?
	The risks associated with informal or seasonal work and the unremunerated housework and care of ill and disabled persons are regarded as occupational risks.	<ul style="list-style-type: none"> • Are the risks associated with specific jobs in the informal sector—especially paid domestic jobs—regarded as occupational risks? • Are the physical and mental risks associated with unremunerated domestic work performed in the home, especially work related to the care of physical and mental illness and disability, taken into account?

TABLE 1. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Justice and legislation	There are laws and effective mechanisms to ensure coordination among all sectors for the prevention, punishment, and eradication of violence against women and care for victims.	<ul style="list-style-type: none"> • Has there been a thorough discussion of domestic violence with the participation of key sectors, including justice, education, health and forensic medicine, and the media? • Are there standards and protocols in place for the prevention and treatment of domestic violence in the sectors concerned? • Have special measures been taken within police departments and family services? • Are there referral systems between the health, justice, and women's sectors to provide transitory protection for victims of violence? • Does the health sector participate in campaigns aimed at preventing violence and encouraging its recognition as a violation of women's human rights?
	Measures exist and are being applied to ensure responsible fatherhood.	<ul style="list-style-type: none"> • Are there effective measures to ensure and monitor the payment of child support by fathers for children who remain in the custody of the mother?
	There is legislation that protects the exercise of the sexual and reproductive rights; the health sector led the drafting of this legislation, and civil society was also involved, especially the women's movement.	<ul style="list-style-type: none"> • What steps have been taken to ensure access to contraception for all women and men, regardless of age, marital status, or ability to pay? • What steps have been taken to ensure women's access to safe abortion in those countries where it is legal? What mechanisms are in place to ensure access to humane treatment for complications of unsafe abortion?
Environment and basic service infrastructure	There are policies in place to reduce gaps in access to basic services such as water and sanitation and the supply of fuel for domestic use.	<ul style="list-style-type: none"> • What percentage of households have access to drinking water and sanitation services? • How is water supplied in these areas? • In the design of policies for the infrastructure sector, is the need to strengthen preventive education for households without access to drinking water taken into account? • What mechanisms have been created to reduce gaps in the supply of fuel for domestic use? Are the health risks associated with this fuel use being addressed?
Transportation	The Ministry of Transportation has taken measures to eliminate or reduce the cost of public transportation for pregnant women and women with children under 5.	<ul style="list-style-type: none"> • Have special populations been identified who require a government subsidy to enable them to access public transportation? • What measures have been taken to improve roads leading to areas where health facilities are located? • Are there transportation routes that serve health sector institutions specifically as a means of facilitating access?
	There are effective road safety measures and mechanisms to help prevent motor vehicle accidents.	<ul style="list-style-type: none"> • Are seat belt and speed limit laws effectively enforced?

Issues	Benchmarks for evaluating gender equity in policies	Questions
Nutrition	The country is working towards the formulation of food security policies that specifically address the differential needs of women and men.	<ul style="list-style-type: none"> • Does the food security policy take into account the differential nutritional status of women and men, boys and girls? Is it recognized that the nutritional needs of women are greater, and does the policy address those needs? • Have specific measures been taken to address anemia in women, not only when they are pregnant and nursing, but before, when these deficiencies are not so difficult to correct?
Statistical information	<p>The national entities responsible for producing statistics and conducting surveys and censuses regularly collect, analyze, compile, and publish data disaggregated by age, sex, and socioeconomic indicators—including health and health care—for use in the policy and program planning and implementation (Beijing, 1995).</p> <p>The statistics refer not only to households but also to individuals and reflect problems and issues related to women and to men (Beijing, 1995).</p> <p>Research organizations and centers for women's studies are involved in developing and testing appropriate indicators and research methodologies to strengthen gender analysis and monitoring of pro-gender-equality policies, including health-related policies (Beijing, 1995).</p>	<ul style="list-style-type: none"> • Is information collected, analyzed, compiled, and published in all official sources disaggregated by sex? • What agreements exist between statistics institutions and the health sector? • What measures have been taken to solve problems with the quality of information on maternal mortality indicators? • Are issues such as nutrition and violence against women included in demographic and health surveys? • Is household information regarding utilization of health services and spending on health broken down by individual household members? • Have questions been included in household surveys and censuses on women's utilization of time in the home, especially with regard to time spent caring for family members? • Have there been any initiatives to quantify and calculate the economic value of unremunerated domestic work and health care (for sick, elderly, and disabled household members) performed in the home, mainly by women, which contributes to the health care system? • What nongovernmental organizations have been actively involved in the development and testing of indicators and research methods related to health and time use?
Mechanisms for promoting gender equality objectives	The offices responsible for women's affairs and equal opportunities for women and men play an effective role in formulating and monitoring the fulfillment of sectoral policies to ensure that they are contributing to greater equality between men and women.	<ul style="list-style-type: none"> • How much administrative and financial autonomy do these offices have within the government? • What cooperation ties have been established between these offices and the health sector? • How do these offices participate in the processes of situation assessment and policy-making? • What mechanisms exist for monitoring compliance with sectoral policies on equal opportunities for women and men?

OBSERVATION FIELD 2: ACCESS TO THE HEALTH CARE SYSTEM

Achieving equity in access to services entails, on the one hand, ensuring the availability of needed services on a timely basis, and, on the other, identifying and eliminating economic, cultural, legal, and institutional barriers that prevent certain socioeconomic groups from using health services when and as they need them. The concept of social exclusion in health refers to lack of access by certain population groups to goods, services, and opportunities that other groups in society enjoy (PAHO, 2003). This section and the two that follow will examine various aspects of social exclusion in health that involve gender factors. The emphasis in this section is on the various types of barriers that limit access to the health system. The other two will cover inequalities in access to benefits within the system and quality of the care received. The types and degrees of exclusion associated with gender factors will vary, of course, depending on the socioeconomic context in which the system operates.

Economic barriers

Entitlement to insurance coverage

Equity in access to services means that financial barriers are reduced to a minimum through a combination of health services and insurance schemes financed by the public sector. As a starting point, this section will present an analysis of the ways in which gender factors serve as a justification for total exclusion from entitlement to the benefits of certain insurance and social protection programs. This happens because gender is interwoven into the key determinants of access to such programs—employment status, for example. In many countries, a large portion of the population works in the informal sector of the economy and has no access to formal insurance schemes, including coverage for

maternity and other needs related to reproductive health.

Women are especially vulnerable to exclusion from entitlement to the benefits of social protection programs. As mentioned earlier, a high proportion of the Region's women work in the informal sector, especially in domestic service, and are employed in part-time and seasonal jobs. More than 50% of women of economically active age are outside the paid work force and depend on other members of the family for formal health care coverage. This situation is a serious cause for concern, especially in contexts of conjugal instability or where health insurance coverage for dependents is either nonexistent or is less than for the primary beneficiary. In addition, in cases where women who do not have employment-based health care coverage do receive health care coverage in their own right, such care tends to be strictly limited to maternity and aimed at certain socioeconomic sectors (maternal and child health insurance). Thus, the criteria for entitlement to coverage in public and private insurance systems have profound gender implications for access to health care.

Ability to pay

Equitable access to services means that services are available and used when needed regardless of a person's ability to pay. Policies that address the elimination of the barriers imposed by ability to pay will be discussed under Observation Field 4, which deals with equitable financing of health care. In this section it is sufficient to point out that policies need to take the following points into consideration: (1) Women as a group have less economic capacity than men, a situation that is closely linked to sex differences in population work patterns. (2) The costs associated with health care include not only direct (unsubsidized) costs

related to consultations, examinations, drugs, and insurance premiums, but also the indirect costs of time and transportation. Both costs impact women more adversely because of their greater need for services, especially reproductive health services, and their reduced economic capacity. (3) Insurance is a key determinant of service access and utilization and, because women have lower rates of participation in the work force, their proportionate access to their own insurance coverage is lower. (4) The economic barriers are exacerbated for some subgroups of women who are excluded for multiple reasons: poverty, ethnic origin, age, forced displacement, or civil conflict, among others.

Sociocultural barriers

These barriers have to do with the limitations that families and society impose with regard to seeking and utilizing health services. Women's access, more than men's, may be restricted because of limited time and lack of decision-making authority. The time limitation is due to the double shift that many women have to work in order to perform both their job and their role in the household. The unequal balance of power between women and men can be seen in some population groups in women's lack of freedom to decide on the use of household resources, on when to seek medical care or use particular services (such as contraception), and even on the right to leave home without obtaining permission from the husband or an older family member. In some social contexts there are additional cultural and ideological barriers, such as attitudes towards modesty which make women reluctant to be examined by male practitioners, and underestimation of the health needs of women and girls compared with those of men and boys. Figures from Demographic and Health Surveys and several research studies have shown lower rates of health service utilization among females, especially girls from poor families, as a result of unequal distribution of resources within the home. In addition, there is evidence to suggest that social beliefs about masculinity

are a barrier to timely seeking of health services. Health sector reforms can address these issues in various ways—for example, by increasing the system's capacity to offer patients the option of being seen by same-sex providers, abolishing requirements to obtain consent from third parties, and reducing the waiting times in health facilities.

Normative barriers

This type of barrier has to do with legislation, institutional regulatory frameworks, and institutionalized cultural practices that tend to limit the exercise of reproductive rights, especially for women and adolescents. These include limitations on adolescents' access to contraceptive methods; prohibitions against emergency contraception; the requirement to obtain spousal consent for procedures such as tubal ligation or the imposition of requirements, such as age or number of children, for female sterilization; criminalization of abortion; and lack of protocols establishing criteria for the management of complications of unsafe abortion.

Institutional barriers

Policies need to address institutional barriers which impede or limit service utilization and which, depending on the national or subnational context, can have a differential effect on the sexes. Two types of barriers come under this heading: first, those relating to health care facilities themselves, such as geographic location, physical infrastructure, and hours of operation, and, second, those having to do with service providers—for example, attitudes towards male and female patients and the availability of providers of the same sex. These issues apply to services in both the public and the private sectors.

Barriers at the level of health **facilities** have to do with physical infra-

structure problems, such as bathrooms, waiting rooms, and areas that allow privacy; hours of operation suited to the work schedules of users (including both paid and unpaid workers); and arrangements that facilitate transportation to health care centers. It also is important to look at barriers having to do with the configuration of services offered, including the presence or absence of services that meet the needs of specific age groups—for example, an appropriate mix of contraceptive methods based on the ages and particular conditions of the population covered; inclusion of men in sexual and reproductive health programs; detection, prevention, and management of gender violence; mental health; and occupational health services that cover risks associated not only with paid work but also with unpaid care-giving provided in the home. Another

important institutional barrier in terms of the supply and quality of services is the lack of research and education on gender-specific symptoms and disease patterns.

Barriers relating to health **personnel** have to do with attitudes and behaviors on the part of providers who do not show sufficient respect for, or knowledge about, the particular needs of women and men in contexts where there is diversity in age, socioeconomic status, ethnicity, sexual orientation, or disability. Another barrier is the fact that limited information about women's rights is provided during the health care process. Finally, as mentioned earlier, in some contexts the availability of personnel of the same sex as the patient can be important.

□ **TABLE 2. Access to the health care system**

Issues	Benchmarks for evaluating gender equity in policies	Questions
1. Economic barriers a. <i>Entitlement to insurance coverage</i>	Access to insurance is not related to employment or particular types of employment, and therefore does not exclude the majority of working women who work in the informal sector or housewives who work without remuneration in the home.	<ul style="list-style-type: none"> • Is insurance coverage available to people who work, <ul style="list-style-type: none"> – in the informal sector? – in paid domestic service? – in seasonal or part-time work? – in the home without remuneration as housewives? • If so, what type of insurance coverage is available? What is covered? • Are there insurance systems for specific population groups? If so, what are they? • Is there any form of compensation that provides insurance for women who perform unremunerated health services caring for others in their homes and communities? • What percentage of women and men are insured? • What percentage of women and men are primary beneficiaries (i.e., have insurance coverage in their own name)? • What percentage of women and men are secondary beneficiaries? • What percentage of insured women have restrictions on maternity care? • What proportion of women and men over 60 years of age receive a retirement pension?
b. <i>Ability to pay</i> <i>(The policy implications of economic barriers are examined in greater detail in Observation Field 5, which deals with financing)</i>	Policies advocate, implement, and monitor the provision of services based on need, regardless of ability to pay, and services at the primary level are free, in particular sexual and reproductive health (SRH) services.	<ul style="list-style-type: none"> • Are there measures in place to prevent charging of different premiums based on sex or sex-related conditions of eligibility? • Are cost-recovery/copayment fees collected for family planning, pregnancy, contraception, and obstetric care? • Is a minimum battery of diagnostic tests offered free of charge during pregnancy? • Are services for the detection and treatment of HIV, STDs, and cervical cancer offered continuously and at no cost? • Are drugs and contraceptives offered free of charge? If so, what type, and for what population groups? • Has the impact of the fee-for-services system on health and on service use among low-income groups been examined? • Are there subsidies for transportation to and from health services?

Issues	Benchmarks for evaluating gender equity in policies	Questions
2. Sociocultural barriers	<p>Policies recognize and address the barriers to health service access faced by women and girls—or certain socioeconomic or ethnic subgroups of women and girls—for reasons related to sociocultural standards and customs.</p> <p>These barriers mainly take the form of time and mobility constraints imposed by women's domestic responsibilities and lack of autonomy to make decisions regarding the use of family resources and their own health.</p> <p>In some cultural contexts, there are also barriers related to the existence of cultural standards that assign lesser value to the needs of girls than to those of boys.</p>	<ul style="list-style-type: none"> • How have policies addressed the problems faced by certain subgroups of adult women, adolescent women, and girls regarding access to health facilities and/or the use of certain services? Specifically, what measures have been taken to address the following constraints: <ul style="list-style-type: none"> – Scarcity of time because of responsibilities in the home, often compounded by also having to work in a paid job – Difficulty and/or cost of finding child care – Risk of violence associated with seeking health services – Objection to being examined by a man – Limited ability to seek health services, or even to leave the home, without permission from the husband or an older family member – Limited participation in decisions about use of the family budget – Limited ability to use contraception without permission from the husband or an older family member – Requirement to obtain the husband's permission for sterilization – Unequal allocation of resources within the home which gives priority to boys over girls? • Do policies explicitly recognize that women's lack of autonomy is a major barrier to achieving the health-related Millennium Development Goals (MDGs)? What interventions have been proposed to promote the empowerment of women and gender equality in keeping with MDG 3? • To what extent do cultural dictates limit timely access to health services by men, especially preventive services? How do policies address this gap?
3. Normative barriers	<p>Policies affirm that health is a human right and support universal access to health care without any exclusions. Policies on sexual and reproductive health are aimed at achieving gender equality in the exercise of sexual and reproductive rights without regard to age or marital status, in keeping with international commitments signed by the State.</p>	<ul style="list-style-type: none"> • Are there exclusions based on criteria such as employment status, age, sex, marital status, place of habitual residence, or income level that restrict access to certain services and providers? • Has a policy on sexual and reproductive health been formulated and implemented that guarantees the sexual and reproductive rights of women and men? • Are there any restrictions on access to contraceptive methods for male or female adolescents? • Is access to emergency contraception allowed and facilitated? • Is spousal consent required for female sterilization? Is access to female sterilization restricted by requirements concerning minimum age or number of children? • Under what conditions is abortion permitted? Are there protocols for the management of complications associated with unsafe abortion, and are these protocols applied? • Are providers legally required to report cases of abortion and/or domestic violence?

TABLE 2. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
3. Institutional barriers		
<i>a. Barriers related to health facilities</i>		
<ul style="list-style-type: none"> <i>Geographic barriers</i> 	Primary health care is provided at accessible distances in all parts of the country, including those that are hardest to reach geographically.	<ul style="list-style-type: none"> What is the geographic coverage of health centers and emergency obstetric units, especially in marginal urban and rural areas? Are populations in marginal areas served by health brigades, and do the services offered include sexual and reproductive health services? Is information distributed on how to contact health centers and hospitals in an emergency? Is distance a major obstacle to reaching health centers? What changes have been proposed and are being implemented to address this type of problem?
<ul style="list-style-type: none"> <i>Transportation</i> 	There are mechanisms in place to facilitate timely transportation to health centers, with special priority given to pregnant women and emergency cases.	<ul style="list-style-type: none"> What transportation problems do users experience in traveling to health centers? What means of transportation are available to pregnant women to enable them to reach and give birth in a health service? How are new policies addressing such problems?
<ul style="list-style-type: none"> <i>Infrastructure and availability of drugs</i> 	Strategies have been formulated and are being implemented that ensure local availability of adequate service infrastructure, supplies of drugs and contraceptives, hours of operation, and referral systems geared to the particular needs of women and men in different sociocultural contexts.	<ul style="list-style-type: none"> What proportion of primary health care facilities are in good condition? Average condition? Poor condition? Are there waiting rooms, child care facilities, bathrooms, and private areas for consultations? Will new policies improve the situation? Are infrastructure conditions adequate for obstetric care and uninterrupted provision of essential drugs, including contraceptives? Is the infrastructure adequate for providing care to men? Are there problems with availability of drugs and contraceptives at the local level? What impact do these problems have on users' time and costs? Are there policies that address these problems? Are there government mechanisms that take advantage of economies of scale in the procurement of essential drugs, including antiretrovirals and contraceptives? Have policies on generics been formulated for essential drugs, including HIV/AIDS drugs?
<ul style="list-style-type: none"> <i>Hours of operation</i> 		<ul style="list-style-type: none"> Have local services identified the best hours of operation based on the patterns of paid and unpaid work done by women and men? Is there information available on average waiting times for users to get appointments and be seen at health services? Have those times been reduced? Will policies improve this situation?
<ul style="list-style-type: none"> <i>Referral systems</i> 		<ul style="list-style-type: none"> Do emergency referral systems work efficiently? For example, in obstetric emergencies, what proportions of women at risk arrive at a health care facility in time, late, or not at all?

Issues	Benchmarks for evaluating gender equity in policies	Questions
<ul style="list-style-type: none"> <i>Services offered</i> 	<p>The care offered includes services for women and men that meets both their common and their specific needs throughout the life cycle. In the case of women, these services include, comprehensive care for sexual and reproductive health that goes beyond pregnancy and childbirth. They also include certain non-conventional services—for example, SRH services for adolescents of both sexes, detection and management of domestic and sexual violence, inclusion of men in SRH programs, and support for persons who provide care for the sick and disabled in the home.</p>	<ul style="list-style-type: none"> • Of common services are offered for women and men? • Do the services offered for women go beyond care during pregnancy and childbirth? What other services are offered specifically for women both within and outside the area of reproductive health? • What special services are offered for men? • Are there any SRH programs that include men and are geared towards not only meeting their particular needs but also achieving healthy and equitable couple relationships? Are these programs publicized? • Do policies include the objective of promoting gender equality through the services provided to men? • Are there services for adolescents provided by properly trained personnel? Are these services publicized? Do policies explicitly address the health needs of adolescents? • Are there services for the detection, prevention, and management of domestic and sexual violence provided by properly trained personnel? Are there systems in place for referral and counter-referral to/from other sectors? Are these services publicized? Do policies address this problem? • Are financial and other support services provided for health caregivers in the home? Are the risks for caregivers and patients in the home recognized and managed? Do policies recognize and address the problems associated with caring for the sick and disabled in the home? • Have local health workers been sensitized about the particular needs of women and the men, especially in low-income populations? • Have health workers been sensitized about understanding and respecting generational and cultural differences, sexual preferences, and disability in the user population? • Are there plans to improve their competency in this regard? • Does the user have the option to choose providers of the same sex? • In planning the services and the production of promotional materials, is there recognition of the need to communicate in the language of indigenous populations? • Have the personnel been trained to provide information on health-related rights of users?
<p><i>b. Barriers related to health personnel</i></p>	<p>Policies recognize the importance of providing care with knowledge, sensitivity, and respect for diversity in terms of sex, age, ethnicity, language, sexual preference, and disability. Policies also recognize the importance of providing information on the rights of health service users.</p>	

OBSERVATION FIELD 3: COMPREHENSIVENESS OF BENEFITS

The coverage and content of the benefits offered to the population that uses the health system vary considerably depending on insurance schemes, which in turn depend largely on people's ability to pay and employment status. Whereas the previous chapter dealt with the analysis of gender inequalities in access to the system, this observation field looks at gender inequalities in access to the benefits and services provided within the system.

Segmentation and fragmentation

Three factors within the system account for the restrictions on the coverage of benefits in the Region. The first is the system's architecture—that is, the degree of segmentation and fragmentation. The second is how interventions are organized and resources are distributed. The third is the geographic distribution of the service network. All these factors affect the coverage and quality of health interventions. However, the degree of segmentation and fragmentation is central because it determines how interventions are organized, resources are assigned, and the service network is distributed geographically (OPS, 2002).

Segmentation is the coexistence of several health subsystems with different characteristics in terms of financing, affiliation, and “specialized” mechanisms for providing care for different segments of the population based on their income level and social status. *Fragmentation* is the existence of multiple non-integrated entities and/or agents within the overall system or within a subsystem which do not operate in synergy with one another and indeed often compete among themselves. Gender is a hidden factor in the segmentation of benefits coverage and therefore must be taken into account in any analysis of the comprehensive-

ness of health care. This observation field will look at the role of gender in achieving equitable coverage and comprehensive health care benefits and services.

Different sex-based patterns of work and income result in institutionalized asymmetries in access not only to health insurance but also to the services, benefits, and opportunities needed in order to meet the specific needs of each sex. Hence, given women's greater need for services, especially during their childbearing years, the actuarial logic inherent in certain plans imposes restrictions on benefits and/or higher premiums for women. On the other hand, women's biological role in reproduction, coupled with their lower economic capacity, may make them eligible for some public insurance plans that focus on and are limited to maternal and child health services.

In order to achieve care that responds comprehensively and effectively to the diverse needs of a population, it is essential to implement strategies for interinstitutional coordination and operational integration that address the segmentation and fragmentation of health systems. Interinstitutional and intersectoral coordination requires leadership on the part of the health sector to put in place strategies for the integration of financing and to ensure dialogue among stakeholders, including those who represent the interests and needs of various groups in society. Operational integration (covered in the next chapter, which deals with the quality of care) entails: coordination of health promotion, disease prevention, early diagnosis, timely treatment, and rehabilitation; pre-eminence of promotion and prevention within the primary health care framework; linkage of the primary, secondary, and tertiary levels of care; and a holistic rights-based approach to health care.

Within this context of comprehensive care, the establishment of the priorities for care, a demandable right, should be based on data from **information systems** that are able to capture and monitor the health conditions and the care being provided to different social groups, consulting for that purpose representatives of such groups. The specific content of benefit plans should be formulated within a framework of integrated management of the main health problems, which inevitably include sexual and reproductive health and the provision of drugs (including contraceptives) and diagnostic and other tests.

Setting health care priorities

Progress toward achieving equity in health through priority-setting mechanisms depends to a large extent on the availability and quality of information used for monitoring purposes. There should be a special focus in this context on the type of methodology used to establish health care priorities. One of the most widely used methodologies for prioritizing the content of benefit plans is disability-adjusted life years (DALYs), or potential years of healthy life lost due to premature death or disability. This methodology has been severely criticized for both technical and ethical reasons. The ethical objections have to do with the fact that less weight is assigned to non-productive years in infancy and old age. This methodology also conceals deep gender biases, including the following:

- ✱ The weighting of priorities for the allocation of resources is based on measurement of the disease burden and, thus, on criteria of illness. Since contraception, pregnancy, and uncomplicated childbirth are not illnesses, the care needs associated with these processes are not taken into consideration. This approach underestimates women's needs for care because it does not take account of health promotion and disease prevention interventions, which are the essence of reproductive health care and represent the bulk of services used by women.

- ✱ Failure to account for comorbidity leads to underestimation of women's reproductive health needs; it is essential to consider comorbidity in analyzing the etiology of disease and death during pregnancy and childbirth.
- ✱ Attribution of the disease burden only to the person suffering from the illness fails to take into account the burden of care that the illness creates in the home, a burden which falls mainly on women. Examples are childhood illness or disability in old age, which demand considerable caregiving time and occur in the age groups that carry the least weight in the DALY calculations.
- ✱ The available sources of information on morbidity and disability that provide the evidence base for estimating the burden of disease suffer from major shortcomings in the integrity and quality of the data.
- ✱ The gaps and deficiencies in information systems are filled by the opinions of "experts," while the parties concerned are not consulted.

These examples illustrate the need to undertake a critical examination of the assumptions and procedures underlying the methodologies used to set priorities in order to identify any biases that could lead to gender inequities in the allocation of resources. The problem of underestimating the health needs of women is especially serious for certain sexual and reproductive health conditions, regardless of the method used, either because they are inadequately recognized or diagnosed, or because they are underreported for social or legal reasons. This is the case with maternal mortality, abortion, domestic violence, and rape.

Planning interventions that incorporate a gender equity perspective points up the need to address latent and controversial health problems such as those mentioned in the previous paragraph, as well as issues related to the reproductive health of adolescents and the management of complications of unsafe abortion. It is also necessary to take account of situations that tend to remain invisible for cultural and economic reasons. Important examples are the physical and mental health problems

and the lack of social protection faced by those who assume primary responsibility for health care in the home—most of whom are women.

Importance of primary health care

Actions in the areas of promotion and prevention, with particular attention to actions that are considered essential for public health, are crucial to the quest for gender equity in comprehensive health care. The basis for these actions is primary health care, which is precisely where issues of sexual and reproductive health are addressed. The primary care approach is based on the recognition of health as a right which should guide the

actions of the system and also on recognition of the need to produce health outcomes that are more equitable. Therefore, from the perspective of achieving gender equity in health, the most critical interventions are those that take place in the context of primary health care.

Finally, comprehensive care means that services are organized around a concept of people as whole beings and bodies, not a collection of separate organs and systems. It also means viewing people not just as recipients of care but also as participants in decisions about their own health and that of the community.

□ **TABLE 3: Comprehensiveness of benefits**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Segmentation	Women and men have access to the benefits required to fully meet the health care needs that are common to both sexes and specific to each sex, regardless of their ability to pay and their insurance plan.	<ul style="list-style-type: none"> • Are there different insurance plans? What are the benefits, qualifications for membership, means of financing, and types of coverage provided by each one? What is the total and the sex-disaggregated coverage of each plan? What is the age and sex breakdown of the beneficiary population of the various plans? • Is part of the population excluded from these plans? If so, what is the age and sex composition of this population group? Do those who are excluded have access to health services? If so, what kind? • What differences are there between the public and the private sectors in terms of benefits offered? • Are there inequalities in benefits coverage based on ability to pay? • Are there inequalities in premiums paid based on sex or age? • Are there mechanisms in place to prevent collection of differential premiums based on sex, age, or risk? • Are there differences in the benefits received by the primary beneficiary and dependent beneficiaries? Are dependents guaranteed the same benefits? • Is there a basic package of services guaranteed by the government for the entire population, regardless of ability to pay or affiliation with insurance plans?

TABLE 3. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Determination of benefits		
<i>a) Sexual and reproductive health benefits</i>	Sexual and reproductive health needs are considered basic needs in insurance plans. There is no segmentation in benefit plans based on reproduction-related criteria.	<ul style="list-style-type: none"> • Do basic packages of guaranteed services take into account the reproductive health needs of women and of men? • If so, to what extent do they cover women for (a) preventive care; (b) contraception, including emergency contraception; (c) essential obstetric services; and (d) tertiary care in the event of obstetric complications and emergencies, including complications of unsafe abortion? • Do they include specific provisions for adolescents of both sexes? • Do they include benefits for treatment of HIV infection for women and men? • Do they include benefits for infertility treatment for women and men? • Do benefits they include the prevention, detection, and treatment of cervical, breast, and prostate cancer? • Are private sector insurance plans required to include the reproductive health services guaranteed by the government? Do such benefits generate additional costs for the beneficiary? • If the inclusion of these benefits is required, what monitoring mechanisms does the government have to ensure that they are, in fact, provided? • For the population of reproductive age, are premiums higher for women than for men? • Is there evidence that insurers are limiting access to coverage for women of childbearing age? • With regard to benefits for the population of reproductive age, is there differential treatment in public and private plans based on socioeconomic level?
<i>b) Benefits associated with different stages in the life cycle</i>	Benefit plans respond to the health needs of women and men at the different stages in the life cycle.	<ul style="list-style-type: none"> • Do public and private plans include benefits for women beyond those related to pregnancy and childbirth? What sexual and reproductive health services are covered? • Apart from reproductive conditions, is the coverage the same for women and men? Are chronic conditions such as cardiovascular disease, diabetes mellitus, cancer, arthritis, and osteoporosis covered?
<i>c) Benefits associated with domestic and sexual violence against women</i>	Domestic and sexual violence against women is recognized as a problem that has multiple impacts on health, and treatment-related benefits are included in insurance plans.	<ul style="list-style-type: none"> • Do public and private plans include benefits for addressing domestic and sexual violence? • Does the health sector have treatment protocols/standards or guidelines for dealing with cases of domestic and sexual violence? • Do the care models include actions by other sectors such as justice, education, and forensic medicine? • Do victims of sexual violence have access free of charge to all services?

Issues	Benchmarks for evaluating gender equity in policies	Questions
Methodologies for setting priorities among the benefits offered	<p>The methodologies for setting priorities for service delivery</p> <ul style="list-style-type: none"> – are based on reliable and consistent information systems, – take account of the differential health needs of women and men, – include health promotion, disease prevention, and recovery criteria, – attach special importance to sexual and reproductive health care, – take account of the conditions that require time-intensive care provided in the home, and – provide for consultation of the user population, including women. 	<ul style="list-style-type: none"> • Are there databases with reliable and consistent information on mortality, morbidity, and disability? What measures have been taken to improve quality and to remedy underreporting problems in areas such as maternal mortality and abortion? • Have information systems been created to enable timely priority-setting and to monitor health inequalities by sex, socioeconomic status, ethnicity, and geographic region? Will new policies improve capability for social monitoring? • What methodologies/information sources are used to set priorities for health services? Are these methodologies gender-sensitive? Has the possibility of gender bias been considered in these methodologies—for example, in the case of DALYs? If so, how have such biases been dealt with? • Do benefit plans reflect the main health problems of the population? Which stakeholders participate in setting priorities? Are participatory situation analyses done? Do women participate? • Is weight given to the time-intensive burden of providing health care in the home? • How is the determination of benefits affected by decentralization, particularly with reference to the provision of care for the uninsured population?
Primary health care services	<p>Countries allocate resources from all sources to provide promotion and prevention services to the entire population in the context of primary health care, with planning and execution coordinated at the highest level.</p>	<ul style="list-style-type: none"> • Does the private sector participate in promotion and prevention activities? • To what extent do policies that emphasize health promotion affect the allocation of government resources? • Have there been efforts or pilot experiments aimed at shifting institutional emphasis from a curative to a preventive approach? • Have sexual and reproductive health and the prevention of violence against women been identified as public health issues in the country? • Are resources allocated for addressing these issues? • Do households have access to programs that offer support for women or men who provide health care for their younger or older dependents? • Are there national campaigns that contribute to women's awareness of their rights and to society's awareness of its responsibility to address these issues?

OBSERVATION FIELD 4: QUALITY OF CARE

Some aspects of the quality of health services—considered from the overall perspective of an appropriate and effective response to the health needs of the *population*—have already been covered in the two previous chapters on access. These aspects have to do with the way health services (a) are organized into networks with adequate infrastructure so that they can ensure access for people throughout the life cycle; (b) integrate promotion, prevention, and treatment at the various levels, including referral and counter-referral systems; (c) take the lead in intersectoral action, when appropriate, to ensure continuity of service delivery; (d) identify and address the common and specific needs of women and men, involving them in defining these needs; and (e) build solid information systems to serve as a basis for action.

This section deals with the improvement of services in terms of a broad range of technical and social indicators. The second observation field identified poor quality of care as a barrier to service utilization. Issues related to freedom of choice and informed consent are central to quality of care. Sexual and reproductive health services are emphasized because of their fundamental importance as public health issues and their relevance in determining gender differences in health. Within this context, emphasis is placed on contraceptive services because studies have shown that poor women have fewer options and that procedures for obtaining informed consent are not always followed.

The ultimate objective with regard to quality is to produce optimal health outcomes, within the constraints of available technology, by improving the delivery of services that protect the life and rights of people. The perception of deficiencies in quality often leads to low service use, and failure to seek timely health care ultimately not only leads to negative effects on individual health, but also raises the costs of care associated with treatment of complications.

Improving the quality of care from a gender perspective means identifying, with the participation of users, the particular needs of women and men throughout the life cycle and in different socioeconomic and cultural contexts. It also entails considering these needs within the dimensions of structure, process, and outcomes of care. It should therefore include (a) the design or adaptation of adequately equipped infrastructure; (b) the definition and monitoring of compliance with standards and protocols for technical and organizational processes of service delivery; (c) the creation of conditions and working relationships that enable providers to offer appropriate levels of care, and, of course, (d) the effectiveness of the results of the services provided. Gender considerations should be incorporated in all **technical and interpersonal** dimensions of service delivery so that processes are carried out in accordance not only with scientific and technical health criteria but also with ethical criteria of nondiscrimination and sensitivity and respect for differences. Especially important from the perspective of achieving gender equality and empowerment of women is the need to ensure that health care recognizes women's situation of social and economic subordination and creates conditions that will facilitate autonomous and informed decision-making and promote the exercise of women's rights.

Infrastructure and human resources

From the standpoint of gender equity, the main elements of infrastructure quality would be privacy afforded in the consultation area, existence of child care facilities for women who cannot attend health care services without bringing along the children in their care, and of course, the existence of adequate equipment for providing services, including emergency obstetric care and other services related to sexual and reproductive health.

With regard to human resources, it is important to ascertain the extent to which personnel training and the development of on-site response capacity incorporates consideration and respect for the particular situations and needs of women and men of different ages and from different sociocultural contexts. The latter is especially important when, as a result of administrative and financial decentralization, primary health care services are responsible for local networks. It is also important to find out whether the conduct of personnel in this regard is subject to supervision and monitoring. A gender-equity approach to health care would mean that, in the process of providing health care and reporting health information, providers do not underestimate or fail to perceive the risks posed by certain problems that affect women exclusively or differently. For example, some providers underestimate the probability of cardiovascular disease in women, attribute symptoms to presumed mental health problems, or ignore problems such as violence against women, abortion, and the risk of married women contracting HIV, and therefore fail to adequately inform patients about the risks, consequences, and management of these problems.

In the area of human resources, the gender perspective also calls for examining the link between quality of care and gender inequities as evidenced in working conditions and relationships between providers. In addition, it includes looking at the extent to which providers recognize the health knowledge and abilities of users, especially women.

Two cardinal indicators of quality in the provider-user relationship are the provision of adequate, clear, and timely information by providers, and the opportunity given to patients to give informed consent to a given procedure. Provision of information is a fundamental social task of the health sector which helps raise awareness of rights and empower women, who make up the majority of health system users.

Finally, as mentioned earlier in the context of cultural barriers to access,

it is key to ensure an adequate male:female ratio of personnel to enable the user to choose a provider of the same sex, train staff to interact appropriately with persons of the opposite sex, and prevent the institutionalization of custom-based practices that limit women's autonomy—for example, the requirement to obtain spousal consent to undergo female sterilization or other medical procedures.

Standards and protocols

Integration of the gender perspective into treatment standards and protocols involves the recognition of sex-based differential patterns in roles, risks, diseases, and needs. Defining standards, protocols, and guidelines for care from a gender-based perspective should avoid the kind of arbitrary stereotypical decisions that are often made in the health care process. An example would be the assumption that aspirin has the same preventive effect for cardio- and cerebrovascular diseases in women as it does in men. Despite the fact that these diseases are the leading cause of female deaths in most countries of the Americas, care continues to focus on men while underestimating the risk for women. This bias is reflected in substantial sex differences in the quality of care provided for these conditions (Nechas and Foley, 1994)—differences that could translate into the probability of surviving acute episodes.

Thus, to achieve gender equity in quality of care, it is essential to ensure that the conditions that affect women exclusively, most frequently, or differently are not overlooked in the care delivery process or in health records. Problems that are common to both sexes but affect them differently need special management in terms of detection, prevention, and care. Among these are HIV/AIDS, violence (especially domestic violence and sexual violence), nutritional disorders, cardio- and cerebrovascular diseases, diabetes mellitus, osteoarthritis, cancer, and other chronic diseases. The main problems that affect women exclusively are

those related to contraception, pregnancy, childbirth, maternal mortality, abortion, and cervical cancer. Since contraception is a basic issue affecting the health and empowerment of women, it must be included in standards and protocols for family planning services with all the related quality dimensions, including choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and the appropriate constellation of services (Bruce, 1990).

In this context, special consideration should be given to the abuse of certain technologies, such as the indiscriminate practice of cesarean section and hysterectomy without medical justification, which reflects an undervaluing of the physical integrity of women's bodies.

Organization of services

As mentioned in the previous chapter, from the perspective of gender equity, primary health care services play a key role in integrating health services networks. These services are responsible for the majority of health sector actions relating to sexual and reproductive health, which is a major component of women's lives and a key factor in the differentiation of gender-related needs. Health systems that are organized around health promotion and disease prevention services provide a favorable climate for gender equity, since it is these services that women use most often, not only for themselves but in their role as the guardians of their children's health. From this perspective, the promotion of women's participation in identifying needs for the organization of services is essential to achieving the objectives not only of gender equity but also of service quality and efficiency. These considerations should be integrated into the establishment of minimum quality standards, a reform measure that is being increasingly used in several countries.

Fragmentation of health services delivery and the absence or ineffectiveness of referral and counter-referral systems leads to duplication of services and delays or omissions in the delivery of care. Thus, fragmentation adversely affects health outcomes and wastes the time and money of service users. These negative effects are felt especially by women, first, because they are the principal direct users of services; second, because they are also most often the ones who seek services for their children or other persons for whom they are responsible; and third, because they are the ones whose time and economic resources are most limited because of their domestic responsibilities.

Another requirement not only for promoting gender equity, but also for ensuring favorable health outcomes, is coordination between the formal sphere of services and the informal unpaid care provided in the home, mostly by women. It is important to find out whether care provided in the home is informed and supported by health services and whether such support is intended not only for the benefit of those who are cared for but also to protect the health and well-being of those who provide the care. It is also important to observe the extent to which services reinforce traditional stereotypes that associate the care of children, the sick, and the elderly exclusively with women, or whether an effort is being made to promote and enable the participation of men in providing such care.

Information systems

In order to improve quality, it is indispensable to develop information systems that facilitate timely and appropriate decision-making with regard to priorities and resource allocation, as well as to collect reliable information from all institutional records, including clinical histories, for the various phases of the care process. Another information mechanism that is important, from the gender perspective, for improved decision-making within health services is the creation of advisory committees on specific issues—for example, reduction of maternal mortality. Such

committees might conduct verbal or social autopsies, which has proved to be an effective strategy for producing key information on maternal mortality. Other committees might deal with ethics and research issues, especially clinical trials that affect women differently, and users' interests (user committees/associations).

Ethics and rights

Service quality involves two basic principles that are especially important for women, given their subordinate position, which is reflected in various aspects of their lives, including health. To achieve gender equity, institutions and providers must not only serve as sources of information regarding rights, but also create the conditions to enable informed health decision-making.

The recognition of health as a right also has important implications for

gender equality. The classic view of human rights supports recognition of the particular needs of women and men in the various spheres of their lives, including sexuality and reproduction. The right to life includes the obligation to prevent women's deaths from causes related to pregnancy or other aspects of reproduction, such as abortion performed under unsafe conditions. The right to freedom and safety means that women have control over their sexual and reproductive lives, free from harassment or coercion to undergo procedures such as abortion and sterilization. The right to nondiscrimination includes protection against unfair differentiation based on sex, age, ethnicity, sexual orientation, disability, or other sociocultural variables. The right to privacy requires that sexual and reproductive health services be provided in confidence and includes the possibility of expressing one's sexual orientation in order to be able to enjoy a satisfactory and healthy sexual life. The right not to be subjected to torture or abuse implies the absence of rape, sexual assault, abuse, and harassment, and it also implies the right to humane treatment of the complications of unsafe abortion.

□ **TABLE 4: Quality of care**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Methodologies for improving the quality of care	The design and implementation of methodologies and instruments for improving and monitoring the quality of care take into account the differences between women and men in terms of vulnerabilities, risks, and health needs.	<ul style="list-style-type: none"> • What instruments are being used to strengthen the quality of care (for example, protocols, definition of minimum standards, case conferences)? • Do these instruments take into account the different health needs of women and men? • How is quality measured and regulated to ensure that gender is recognized as a determinant of health?
Infrastructure	Steps are being taken to build or retrofit a sufficient number of properly equipped facilities to take care of the different needs of women and men in different sociocultural contexts.	<ul style="list-style-type: none"> • Do the environment and conditions in health facilities ensure privacy? • Are there enough bathrooms for both male and female service-users? • Are there spaces and equipment for child care while women are waiting to see a provider? • Have minimum capacity and accreditation standards been established for health promotion and disease prevention services? • Are drugs and contraceptives available locally and are there suitable facilities for storing them? • Are there emergency obstetric care units? Are they adequately equipped? Are there arrangements in place to ensure transportation in the event of emergencies?
Human resources	<p>Consideration of the particular situations and needs of women and men of different ages and in different sociocultural contexts is part of the training given for health workers and local health care networks, and supervision and evaluation look at whether it is actually occurring.</p> <p>Health professionals have been trained to provide users with clear information about procedures and request their (informed) consent to perform them, regardless of the user's socioeconomic or educational status.</p>	<ul style="list-style-type: none"> • Do health personnel routinely receive training to develop awareness of the differing situations and needs of women and men in different age and sociocultural groups in order to avoid discriminatory attitudes and treatment? • Do health personnel receive training in offering understandable information, requesting (informed) consent from both female and male users for procedures to be performed, and informing them of their rights? • Is this competency taken into account in supervision and performance evaluation? Are supervisors aware of the importance of these issues as part of the delivery of services? • Have personnel been trained in areas such as management of temporary and permanent contraceptive methods, detection and management of cases of domestic violence, and management of the complications of unsafe abortion?

TABLE 4. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Human resources (cont.)	<p>Health workers have been informed that the State has made a commitment to gender equality and the empowerment of women within the framework of the Millennium Goals and other international agreements on the subject and that reproductive rights are human rights.</p> <p>Principles of gender equality and nondiscrimination exist and are being applied with regard to working conditions, remuneration, and autonomy of personnel.</p>	<ul style="list-style-type: none"> • Do policies explicitly address the inclusion of these subjects as part of human resources training? • Are there health service guidelines regarding users' option to choose a provider of the same sex? • Do health services require spousal consent for female sterilization when it is not required by law? • Are adolescents' decisions regarding their sexual and reproductive health respected? If the information is confidential, who has access to it and under what conditions? • Are there standards that prohibit sex-based discrimination in regard to opportunities for promotion, remuneration, and working conditions? Are they applied? • Are there standards that protect female health care providers against sexual harassment?
Consultation of users	Health services are monitored regularly from the users' perspective, and the perspective of women is explicitly sought.	<ul style="list-style-type: none"> • Are women and men routinely consulted as to whether the information they receive from providers is sufficiently understandable and timely? • Are women and men asked whether providers confirmed their understanding about medical procedures and requested their consent to perform them? • Is the opinion of male and female users sought and is it taken into account regarding elements of infrastructure, health care processes, and the user-provider relationship that might be improved (taking into account the "courtesy bias") and better adapted to people's needs? • Are male and female users asked to what extent referral and counter-referral systems have provided timely and effective responses to the health needs that prompt them to seek care? • Are users, especially women, asked to what extent health care services have provided them with training and support for home care of illness and disability?

Issues	Benchmarks for evaluating gender equity in policies	Questions
<p>Treatment standards and protocols</p>	<p>Consideration of the particular needs of women and men has been incorporated into the mandatory standards and protocols that define behaviors and conditions that apply to priority public health issues.</p> <p>Protocols have been designed and are being applied for the management of conditions that tend to be overlooked and to affect women exclusively or more frequently, such as domestic and sexual violence and complications of abortion.</p> <p>Protocols have been designed for the use of techniques that tend to be overused or inappropriately used and that are more frequently used with women, including cesarean section, hysterectomy, hormone replacement therapy, and the prescription of certain contraceptive methods, and these protocols are being applied</p>	<ul style="list-style-type: none"> • What quality control mechanisms exist for ensuring that differences are taken into account when appropriate, while at the same time avoiding discrimination based on sex, ethnicity, social class, or sexual orientation in the application of medical procedures when such differentiation is not justified? • What type of research is being done—and by whom—to provide the basis for standards and protocols? • Do protocols for heart disease and other chronic diseases take sex differences into account? • Are there standards and protocols for the prevention, detection, and management of cases of domestic and sexual violence? • Are there standards, protocols, and/or guidelines for the provision of comprehensive care for contraception, pregnancy, childbirth, and complications of unsafe abortion? • Does the delivery of contraceptive services ensure: <ul style="list-style-type: none"> — choice of method? — provision of clear information regarding the requirements and risks of the various methods? — technical competency of providers to provide both temporary and permanent methods? — interpersonal relations that are both respectful of and sensitive to sociocultural differences? — mechanisms for follow-up and continuity in the provision of methods? — a constellation of services that is appropriate for different ages, health conditions, and cultural preferences and that is accessible to both women and men? • Do prevention and treatment protocols take into account unequal power relationships and the particular vulnerabilities of women in the management of HIV/AIDS? • Is the use of dual protection encouraged for women who are married or in long-term relationships • What proportion of deliveries are cesarean sections in public- and private-sector institutions? Has the medical necessity of cesarean sections been investigated? What measures have been taken in order to rectify possible abuses? • Has the use of hysterectomies for the management of conditions that could be treated with other techniques been investigated? Has compliance with the relevant protocols been reviewed? • Are tests routinely performed to determine the suitability of different contraceptive methods to the age and health conditions of women?

TABLE 4. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Normas y protocolos de atención (cont.)	Health care providers draw upon the health knowledge and skills of users, especially women, incorporating them into standards for care.	<ul style="list-style-type: none"> Do health care providers take into consideration the health knowledge and skills contributed by women in developing standards for care and in relationships with users
Service networks (See also “Primary health care” in the previous chapter, Observation Field 3, on the comprehensiveness of benefits)	<p>Health services are organized and priorities are set around the primary health care strategy, and the necessary resources for its implementation are available.</p> <p>Health service networks incorporate the various actions and levels of care, the participation of other sectors when necessary, and strategies and resources for informing and supporting women and men in the provision of health care in the home.</p>	<ul style="list-style-type: none"> To what extent do local referral and counter-referral systems function effectively, providing timely and comprehensive responses in health services, for example, in case of emergencies, obstetric emergencies in particular? Have HIV services been incorporated into the rest of sexual and reproductive health programs? Is continuity assured in the provision of contraceptive methods and drugs used in long-term medical care? How is health care organized in the public and private sectors for the diagnosis and management of diseases—for example, cervical cancer? Are health promotion, disease prevention, diagnosis, and treatment included within the responsibility of a single provider? Are actions coordinated with other sectors, as appropriate, in the case of specific health issues—for example, is there coordination with the justice and forensic medicine sectors for the management of cases of domestic and sexual violence? Is appropriate information available on health care rights and the procedure for reporting violations and seeking redress, and is it readily accessible to both women and men? Are there programs that offer training and financial or other support to women and men who provide care in the home?

Issues	Benchmarks for evaluating gender equity in policies	Questions
	<p>The information in institutional records is broken down by sex and includes problems that affect women mainly or exclusively and are often unreported or incorrectly reported. These include information about diseases or injuries associated with care-giving.</p>	<ul style="list-style-type: none"> • Is the information in health records broken down at least by sex and age? • Has the information been collected in a way that would allow, in addition to sex disaggregation, an analysis of differences based on place of residence, ethnicity, etc.? • Are records systematically kept of cesarean sections and hysterectomies and of the reasons for performing them? • Is information on abortion recorded? • Is information on cases of domestic and sexual violence, age of the victim, and relationship to the assailant recorded? • Is information on diseases and injuries associated with health care delivery in both the public and the private sectors recorded? • Who has access to the information, and under what conditions?
Information systems	<p>Information systems serve as a basis for the evaluation of health services, and for this purpose they include information obtained from users, especially women, who are the most frequent users of the health care system.</p>	<ul style="list-style-type: none"> • Have there been efforts to promote the creation of user committees or other bodies to facilitate user participation as a means of improving information on the quality of care? • Are verbal autopsies carried out in cases of maternal mortality? • Are there committees for monitoring maternal mortality? Do they seek to improve information and interventions? Do women participate actively?

OBSERVATION FIELD 5: HEALTH SYSTEM FINANCING

The fundamental principle of equitable financing is that people should have the opportunity to receive benefits based on their needs and should contribute to the health care system in proportion to their ability to pay. This section examines the degree to which national and local health care financing mechanisms either promote or undermine the achievement of greater gender equity in sharing the burden of financing health services. The areas to be examined are: on the one hand, the extent to which the overall financing system promotes justice by reducing the degree of segmentation in access to benefits and, on the other, the relative equity afforded by the various types of financing mechanisms.

Health sector reform programs have sought, in particular, to develop new financing and cost recovery schemes such as fees for services, copayments, and vouchers. In terms of gender equity, these expanded options for health care financing raise the following broad questions:

- ✱ Are women disadvantaged by some payment schemes, or do their circumstances make some modalities more workable than others?
- ✱ Does cost recovery, especially requiring payment at the time of service, have a more adverse impact on health for women than for men?
- ✱ How do the different types of cost recovery affect the sexes differentially in terms of access to services?
- ✱ Who pays for the cost of human reproduction? Is it distributed across society or is it mainly paid by women?
- ✱ To what extent are women assuming the cost of home care which the government “saves” when it cuts public spending on health?

Since measures taken at the macro level are not always reproduced at the local level, decentralization (financial and administrative autonomy)

is also a critical aspect of gender equity in financing. Both these aspects should be considered.

Social distribution of risk

Although financing policies tend to be regarded as gender-neutral, they are actually pivotal to the achievement of gender equity in health. Women have greater need for health services primarily, but not exclusively, because of their reproductive role. This means that when the financing of care is not viewed from a perspective of solidarity, women's health expenditure is much greater than that of men, and the inequality is even greater because of their lesser economic capacity. From the standpoint of equity, therefore, it is essential that social responsibility for reproduction be shared and that it be financed without generating additional contributions or costs for women.

Examples of equitable strategies for the achievement of this objective include the development of collective financing schemes and increased government budget allocations to meet the needs of women. Collective schemes, which may be overall systems or subsystems, involve pooling resources from individuals of both sexes and differing incomes, ages, and health conditions in order to provide comprehensive care for those who have greater needs—for example, women, older adults, and chronically ill patients. One of the purposes of this approach is to avoid discrimination against these groups in insurance systems.

The type of system that most favors equity is one which, through general taxes and/or compulsory contributions from members, creates a collective fund to which contributions are made based on ability to pay, and the funds are then redistributed in the form of health benefits apportioned according to need. Financial contributions to the system that are based

on ability to pay and not on risk eliminate obstacles to access that end up generating higher insurance costs and greater out-of-pocket expenditures through cost recovery schemes such as copayments.

Health care in the home

The unpaid health care that women perform in the community and at home has traditionally been, and continues to be, the principal means by which health care is provided and gaps in social protection are filled, with women bearing most of the brunt of the structural adjustments that are eroding the provision of public services. More than 80% of health care (Durán, 2003) is provided in the home, not in health centers. This figure begins to give an idea of the extent to which underfunded health systems are being subsidized by the unpaid work of women in the home.

There is often an inherent gender bias in apparently neutral concepts such as “cost-cutting,” “efficiency,” and “privatization” because they involve shifting costs from the paid economy to the unpaid economy based on the unremunerated work of women. Thus, the premise that underlies some of the adjustment and reform measures is that the government can reduce expenditures by cutting services—for example, by reducing hospital stays, care for the elderly, institutional care for the mentally ill—on the assumption that these services can be provided by families. Such measures are based on the expectation that women are available, willing, and morally obliged to provide assistance in the home to dependents, the sick, the elderly, and the disabled (Gómez, 2000). However, the “savings” in public spending are nothing more than costs that the government shifts to the community and families, and especially to women in their social role as caregivers.

These savings are not limited to the provision of care per se; they also affect the social welfare benefits of those who perform the work. This is because in systems where insurance is contingent on employment or based on ability to pay, unremunerated health care services provided in the home do not count as work, and those who provide these services lose not only the opportunity to receive income but also the social protection benefits provided under such systems.

Resolution CD46.R16 (2005) adopted by the Member States of PAHO points out the importance of measuring unremunerated work as a key strategy for the promotion of gender equality, and it commits the governments of the Region to include in their national health accounts indicators of the value of unremunerated time devoted by men and women to health care in the home, as a function of the total national expenditure on the country’s health care system (PAHOa, PAHOb, 2005; Gómez, 2007). This commitment is an outgrowth of the work that the countries of the Region have been doing since 2001 with support from the PAHO Gender, Ethnicity, and Health Unit and also its Health Policies and Systems Unit (Gómez, 2007). This work emphasizes that the debate on gender equality in health should take into account *capacities, opportunities, and compensation*, and that an important step toward this equality is the recognition of unpaid work so that it is made visible and counts in the design and evaluation of economic and social development policies. Saying that it “counts” means that it is counted in statistics, accounted for in economic models, and factored into policy-making at both the macro and micro levels.

□ **TABLE 5: Health system financing**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Modalities for financing and social distribution of risk	<p>Society, through government, ensures that women and men receive, through one or another of the country's health subsystems, appropriate treatment for their common and specific needs and contribute to the financing of the system based on their ability to pay.</p> <p>Solidarity in the financing system makes it possible to distribute the differential risks associated with age, sex, and chronic diseases in the different population groups.</p> <p>Collective financing of the general health system and its subsystems explicitly distributes the risks and costs associated with reproduction across society so that they do not fall disproportionately on women.</p>	<ul style="list-style-type: none"> • What are the sources of financing for the health care system, and what proportion of the total is represented by each of these sources (public taxes, social security contributions, private insurance premiums, out-of-pocket expenditure)? Identify in particular the percentage of out-of-pocket expenditure, which is the most regressive indicator. • What are the public, private, and mixed financing schemes under which health care is provided? What percentage of the population is covered by each of them and what is the makeup of this population by age, sex, and income bracket? • Under these schemes, have steps been taken to guard against potential gender asymmetries in access and benefits coverage – for example, restrictions on access to basic services caused by user fees? • Have gender inequalities in service access and coverage under the various schemes been noted? For example: <ul style="list-style-type: none"> – Adverse selection among women, especially those of childbearing age? – Reduced coverage or exclusion of reproductive health benefits? – Higher insurance premiums for women, especially those of childbearing age? – Higher deductibles for women for conditions other than those related to reproductive health? – Higher insurance premiums for women or men in the post-reproductive age range? • Do policies take into consideration the implications of various financing schemes for equity in general and gender equity in particular? • If so, what measures has the government taken to eliminate sex and age discrimination in access and benefits coverage under the various schemes? To what extent does the State monitor and enforce compliance with these measures? • What mechanisms exist to foster solidarity in financing? • What mechanisms exist to distribute the financial burden of the cost of reproduction across society?
Health benefits for workers		<ul style="list-style-type: none"> • Who is covered and how is this coverage related to factors associated with the differential work patterns of women and men? • Do coverage schemes contain discriminatory features such as type of work or a requirement for full-time or uninterrupted employment? • Are women less likely to have access to employment-based health benefits because of their occupational status?

TABLE 5. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Primary and secondary beneficiaries under different insurance schemes		<ul style="list-style-type: none"> • Do the various schemes offer the possibility of insuring dependents? Does the sex of the primary or other beneficiary affect this possibility? • Are there differences in the benefits covered for primary and other beneficiaries? What is the proportion of primary versus other beneficiaries? • What measures are available to ensure health care coverage for beneficiaries in the event of death of, divorce from, or abandonment by a spouse who is the primary beneficiary?
Community-based financing		<ul style="list-style-type: none"> • What groups are covered, what benefits are provided, and what are the requirements? • Are reproductive health needs adequately covered?
Social protection for the poorest population		<ul style="list-style-type: none"> • What schemes exist to provide care for the poorest groups? • How do these schemes differ—if they do—in terms of access to and benefits covered for women and men? • In the case of women, are benefits provided for services other than maternity-related services?
Decentralization	In situations where decentralization has taken place, the delivery of services for the poor is not determined by their ability to pay.	<ul style="list-style-type: none"> • Is it known whether decentralization has exacerbated the exclusion of the most excluded groups? How are women and men in those groups affected? • Is the participation of women in setting health priorities and allocating health resources at the local level encouraged? • Are there mechanisms for monitoring resource allocation at the local level? Do women participate in this monitoring?
Out-of-pocket expenditure	<p>The government has regulatory frameworks that ensure that women, the elderly, and the chronically ill are not required to pay more for insurance based on their relative risk, and compliance with these arrangements is monitored.</p> <p>Services related to sexual and reproductive health are provided free of charge to both women and men.</p>	<ul style="list-style-type: none"> • Has sex-disaggregated information been obtained, through household surveys, on out-of-pocket expenditure on health? • What services account for the largest proportion of out-of-pocket expenditure by women and by men? • Are copayments collected for delivery care? • Are drugs and contraceptives covered by insurance or benefit plans, or are they paid for out of pocket? • Has it been recognized that payment for drugs and diagnostic tests might constitute a barrier to comprehensive care and have an adverse effect on health? • Has consideration been given to exempting the most vulnerable populations (indigenous groups, displaced persons, etc.) from health service cost recovery measures?

Issues	Benchmarks for evaluating gender equity in policies	Questions
Unpaid health care in the home	<p>Collective financing of the overall health system and its subsystems distributes the costs of both the biological and the social aspects of reproduction across society. The latter refers to the care involved in bringing up children, sending them out into society, and maintaining their health and that of other members of society, which is provided without remuneration in the home and also in the community.</p> <p>Steps have been taken to (a) measure and calculate the economic worth of unpaid care provided in the home and the community; (b) support care providers during and after the period devoted to care; and (c) redistribute unremunerated health care across society so that the costs do not continue to be borne mainly by women.</p>	<ul style="list-style-type: none"> • When decisions are made to reduce public health services, what assumptions are made about how they will be provided instead, and by whom? • Has the extent to which this free work is subsidizing the system been calculated? • Do the policies take account of the cost, in terms of money and time, that this burden of care represents for women from the lowest-income groups? What measures are being taken to mitigate these costs? • Does the system provide some form of compensation that facilitates access to insurance for people who provide unpaid health care for members of their households and communities? • Are such benefits as job protection, flextime, and pension coverage continued while this care is being provided? • Do policies envisage financing and operational mechanisms for redistributing the work of unpaid home care among families, the State, and the market? • Is the health sector involved in intersectoral efforts to measure the contribution of unpaid health care through time use surveys, to calculate its economic worth, and to integrate it into satellite accounts linked to the national accounts system?

OBSERVATION FIELD 6: MANAGEMENT OF HUMAN RESOURCES

Many countries are attempting to improve their management of human resources, but the gender dimension of these processes generally receives scant attention. A number of facts can be cited that point up the importance of taking this dimension into account in planning the management of human resources:

- ✱ Women make up more than 80% of the paid work force in the health field.
- ✱ More than 80% of health care services are provided free of charge in homes, mainly by women.
- ✱ While the majority of health sector personnel are women, few of them are found at the highest decision-making levels or in the jobs that are most prestigious or most highly paid.
- ✱ Increased labor market flexibility associated with health sector reforms has affected women's employment more adversely than men's, both quantitatively and qualitatively.
- ✱ Staff and public service cutbacks have a disproportionately greater effect on women in the home, since they have to devote more of their time and resources to make up for reduction in services;
- ✱ A growing trend associated with privatization is the outsourcing of auxiliary functions—for example, cleaning and food service—to companies that pay lower wages and offer fewer benefits. Most of the workers who perform these jobs tend to be women.

Hence, gender equity issues are especially relevant in the management of health personnel, and sex-disaggregated information is essential for the development of human resources policies that are not only equitable but also effective.

This observation field addresses some of the gender factors that affect

the development of skills, the range of opportunities available, and the level of compensation paid to workers in the health system, both in the formal system and in the system of informal unpaid care given in the home and the community.

Working conditions and employment patterns

Women make up a majority of the work force in the health field. However, they are underrepresented in decision-making positions at the national and local level and are concentrated in the health sector jobs with the lowest pay and the least power. This situation is a reflection of social gender constructs which, on the one hand, segment the work force into male and female specialties and competencies, and, on the other, devalue the spheres in which women are concentrated, assigning them less prestige, autonomy, and remuneration. An example of this segmentation is the preponderance of women in the nursing profession. This phenomenon is associated with the idea that “women's jobs” are an extension of the “natural” domestic role of women as caregivers and facilitators of the work of others.

The introduction of flexible labor practices as part of health sector reforms has not been a gender-neutral process. Because women make up the majority of health sector personnel and are concentrated at levels with low status and little bargaining power, they have been proportionately more adversely affected by salary cuts, heavier workloads, loss of social security protection, and layoffs resulting from this trend toward labor market flexibility. Female community health workers who work in the formal sector for very low wages have also felt the effects of this trend, despite their role as the sector's critical link for the provision of health promotion and disease prevention services, especially in most remote and rural areas.

Professional education and training

The curricula of schools of health sciences, as has been pointed out in various international forums, reflect deep gender biases and fail to take into account the web of structural determinants that lead to inequity in health or the impact that unequal power relationships between women and men can have on health-disease patterns in the population. These biases also affect the perception of differential needs of women and men and the way in which the system responds to those needs, thus contributing to the perpetuation of gender inequality in health care. Incorporation of the gender dimension into training programs for health professionals, viewed within the analytical framework of the social determinants of health and the ethical framework of human rights, would enhance the capacity of health personnel for policy formulation and analysis and improve equity and efficiency in professional practice. The gender dimension should also be incorporated into in-service training activities for personnel in public- and private-sector institutions, into the evaluation criteria of universities, and into certification processes. The same applies to continuing education on emerging issues in the sector, such as management of gender violence, including sexual violence.

Unpaid health workers

As has been emphasized in previous chapters, about 80% of health care is informal and provided largely by women in the home. This unpaid dimension of health care, despite its magnitude, is often overlooked in official policies and planning.

Because it is usually women who take on most of the burden associated with the care of sick family members, any illness—for example, when one of the children gets sick—tends to affect women (mothers) more than other adults in the household. The division of labor in the home also tends to place greater burdens on women's time, burdens which in a growing percentage of cases are added to paid jobs outside the home. Evidence from around the world indicates that when both paid and un-

paid working hours are taken into account, women work more hours on average than men. This workload has high opportunity costs for women, who have to seek care for their children or for themselves. Another situation that reflects gender inequity is the non-remuneration of women community leaders who perform informal health care work and the manner in which work in the community is distributed: it is women who do most of the routine work of the community, while it is men who make the decisions.

Because of its magnitude and importance, unpaid health care work in the community and the home, especially the latter, represents an essential component of the health care system that cannot continue to be overlooked in the development of health policies, especially in the context of population aging and growing importance of chronic diseases in the epidemiological profile. Issues such as the elimination of institutional care for the mentally ill and older adults and reductions in the number of hospital beds and length of hospital stays should be looked at not only from a humanitarian angle but also in terms of the feasibility of providing such care in the home and the quality of the care provided.

Nor can policy-makers continue to overlook the fact that unpaid care responsibilities limit women's opportunities to participate in paid work, thus reducing not only their economic ability to access services but also denying them the right to share in the short- and long-term benefits of employment. Because women's employment is often interrupted by the obligation to care for young children, elderly parents, and other sick or disabled household members, they are unable to contribute to social security systems to the same extent as men, and in many cases they fail to complete the minimum length of employment required to make them eligible for retirement benefits and health insurance in old age. Thus a perverse logic operates: those who are covering, without pay, the deficit in public services are precisely the ones who experience the most difficulty in gaining access to care for themselves.

Finally, since unremunerated care provided in the home is not considered “work,” the occupational risks associated with the demanding job

of caring for others go unrecognized and are thus excluded from occupational health and safety schemes.

□ **TABLE 6: Management of human resources**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Policies and management information systems for the development of health human resources	There is a policy in place that supports equal opportunity for women and men in recruitment, training, and promotion in employment. The information system that supports human resources management provides sex-disaggregated information, which facilitates timely decision-making and makes it possible to monitor compliance with the gender equality policy.	<ul style="list-style-type: none"> • Has an explicit sectoral policy been formulated that supports equal opportunity in employment and specifically mentions gender equality? • If so, has an action plan been drawn up to implement this policy which includes a situation assessment, objectives, and indicators of gender equity? • Have responsibilities, resources, and monitoring mechanisms been established within this plan? • How much progress is being made under the plan? • Is information available on the sex breakdown of the health work force, including the areas in which men and women work, the professions and specialties they choose, remuneration levels, representation at decision-making levels, length of employment, etc., at both the national and local levels?
Working conditions and employment patterns	<p>The participation of women in health sector decision-making is encouraged and supported, and affirmative action measures are envisaged for that purpose. For example, there are measures to ensure that women can participate in training programs that will help facilitate their access to higher-paid jobs.</p> <p>Working conditions and terms of employment are “family-friendly” for personnel who have responsibilities for child and elder care, and these conditions apply to both female and male workers</p>	<ul style="list-style-type: none"> • What is the male:female ratio in the various professions, specialties, and spheres of activity? Which professions and specialties have the greatest prestige and the highest remuneration? What is the sex breakdown in these categories? In which categories do there tend to be large concentrations of women and men? • What proportion of women are in supervisory and management positions at the national and local levels of the sector? Why are women underrepresented in these positions? • What sex differences exist with respect to remuneration, job security, working hours and benefits? • Are there differences in the remuneration of women and men for the same work in the public sector? In the private sector? • Are there differences between the private and public sectors with respect to working relations and conditions for women? • What is the average length of time that women and men remain at the same job level before being promoted? Have there been affirmative action measures to encourage the promotion of more women to decision-making positions? If so, what measures? Has their effect been evaluated? • What measures are being taken to facilitate the participation of women in training programs? • To what extent do family responsibilities limit opportunities for training and promotion?

TABLE 6. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Working conditions and employment patterns (cont.)		<ul style="list-style-type: none"> • Have measures been taken or proposed to reconcile domestic responsibilities with those of paid employment for women and men in the sector? • If so, what measures have been taken, for example, to reconcile the care of dependents with the working hours of women? • Have parallel measures been considered to promote male responsibility in the domestic sphere—for example, paternity leave? • Are there infrastructure conditions that favor breast-feeding by women who work in the health sector? • Have policies been developed at the national level and in institutions to prevent sexual harassment in the health sector
Introduction of flexible labor practices and privatization	Reforms take into account the differential effects that labor market flexibility policies may have, and are having, on women and men, and envisage measures to mitigate adverse.	<ul style="list-style-type: none"> • Are new contractual arrangements being introduced in the public and private sectors? • What has the differential effect on women and men been, both in numeric terms and with regard to working conditions? • What is being done to mitigate adverse effects? • Is women's workload increasing in the formal sector? Have there been increases in illness, injury, and absenteeism rates because of the increased workload?
Training	Processes are under way aimed at modifying university curricula and providing in-service training for health service personnel in order to include issues relating to gender inequalities and their impact on health and health care.	<ul style="list-style-type: none"> • Have health professionals received training on emerging issues such as domestic and sexual violence? • Are health professionals aware of international agreements on sexual and reproductive health and other areas of women's health? Are they aware of the human rights approach embodied in these agreements? • Do evaluations for professional certification incorporate criteria related to mainstreaming a gender dimension into knowledge and practices? • Do regular trainings for in-service personnel incorporate aspects related to gender inequalities and their impact on health and health care? If so, how often?

Issues	Benchmarks for evaluating gender equity in policies	Questions
Unpaid health workers	The unpaid health care provided (predominantly) by women in the community and the home is recognized and valued, and those who do this work are supported accordingly.	<ul style="list-style-type: none"> • Are there special services and/or benefits that support the work of caring for sick and disabled people in the home? • Do health care providers take into account women's workload and opportunity costs when they prescribe time-intensive care in the home? What mechanisms are in place to facilitate the provision of such care? • Do policies take into account the consequences for the economic and employment future of those who provide health care in the home? • Have policies for the reduction of public services taken into account the time available to women—or men—to provide additional care in the home? Have support mechanisms been created for this purpose? • Have policies taken into account the financial and occupational (physical and mental) risks associated with the care of chronically ill and disabled persons in the home? What measures have been taken to address these risks? • Do policies on elder care provide for and envisage measures to address the labor shortage that will ensue when the demand for services increases and women enter the work force?

OBSERVATION FIELD 7: PARTICIPATION, ACCOUNTABILITY, AND EMPOWERMENT

This section deals with the degree to which users and citizens can demand accountability from health systems, based on the principle that health systems should provide the population with adequate information and decision-making power and ensure that all components of the system are accountable for the decisions they make regarding the provision of services. It reaffirms the importance of the role played by advocacy and citizen groups in demanding accountability and the development of corrective mechanisms. And finally, it highlights the areas in which attention needs to be paid to gender issues.

Participation

The notion of participation is related to the concept of modern citizenship, one of the characteristics of which is formal equality of rights and the corresponding guarantees regarding the exercise of those rights. From the standpoint of gender equality, participation is inherently related to two elements which at the same time define it—namely, empowerment and accountability. The latter has to do with transparency and information. From this perspective, participation must be rooted in clear, legally established mechanisms, and it must occur at both national and local levels, especially in contexts of decentralization.

The idea of citizenship provides the basis for a type of participation whose central purposes from the gender standpoint have to do with: (a) the characteristics that participation should have in order to be considered equitable (participation *with* equity), and (b) the exercise of participation as a condition for the achievement of equity (participation *for* equity). In this sense participation is not a means for mobilizing support, nor is it a process that occurs exclusively from the top down or that is limited to the performance of tasks by certain groups, particularly women. On the contrary, it is linked to decision-making.

In terms of gender equality, the emphasis on the involvement of women—participation *with* equity—stems from recognition of:

1. The existence of a right, which in the case of women has not been fully exercised.
2. The historical exclusion of women from decision-making in the sector.
3. The obstacles that limit women's participation as a consequence of their excess burden of work in the domestic arena.
4. Women's greater health needs.
5. Women's greater participation as providers of care, both in the formal sphere and in the domestic and community spheres.

These characteristics bear out the importance of involving women in decision-making—first, because women, who have primary responsibility for family and community health, have a clearer perception of basic health needs and of how to prevent diseases that are directly related to living conditions in the home and the community; second, because they are the principal users of health services; and, third, because it is necessary to correct the traditional view of participation by women as “performers of tasks” without decision-making power. This emphasis implies, therefore, that women are involved in making decisions about priorities, resource allocation, and social monitoring of how decisions are implemented.

Participation for gender equity presumes that women's participation takes place under a set of conditions that will truly make it possible to overcome inequities in the area of health. Health systems are responsible for improving the health of the population with equity, including gender equity, and those whose well-being is affected by decisions and policies should be involved in the ultimate conception and oversight of those systems.

These ideas are closely related to the need to provide for participation at both the national and local levels, as decentralization has shifted the bulk of decision-making to the local level. As a result, women need to be involved in health sector decision-making at all levels, including the formulation of local health plans and the development of participatory budgets.

Empowerment

Empowerment, defined as the process by which those who lack power and authority obtain them, poses a challenge for existing power relationships, in which power is exercised by some “over” others with the aim of controlling certain social groups, one of which has historically been women. The “power” in empowerment is conceived of as a highly positive form of power “for”—that is, a power that enables more people to achieve autonomy in processes of transformation. It is also a power “with,” which means that it is built collectively.

The goal of empowerment is to transform structures characterized by gender discrimination and social inequality as part of a process of overcoming gender inequalities, especially, in this particular case, those that are health-related (León, 1997, 1999). Empowerment is seen as an outcome to which participation should contribute, while at the same time determining the form that this participation should take.

The traditional exclusion of women from participation in decision-making has been particularly marked for some subgroups owing to factors linked to their ethnicity, language, race, age, or sexual orientation. Consequently, mechanisms need to be put in place that will guarantee the participation of women in a context of diversity. Another element of crucial importance from the gender standpoint is the identification of mechanisms that will help free up women’s time and lighten their excessive domestic burden

Decentralization has been seen as an opportunity to foster the participation of women because it is at local levels that they have most often been involved in health “tasks” in the community. However, affirmative action is needed in order to encourage and ensure the participation of women, lest decentralization become a mere reflection of the limited participation of civil society at the national level.

Mechanisms and legal frameworks for participation

Mechanisms that enable women to participate in the health sector with voice and decision-making power contribute to their empowerment and thus to gender equality. At the community level, these mechanisms can be strengthened through forms of organization that allow citizen control, such as local health committees and user leagues in which women not only perform tasks but also have a role in decision-making. These forms of organization are founded on the strengthening of civil society.

For participation to be effective, it must be supported by legal provisions. In many countries, this support takes the form of a constitutional mandate that recognizes the importance of participation and promotes it through various mechanisms aimed at consolidating public administration within a framework of participatory democracy. In addition, legal support may be found in the laws and regulations governing the sector and in international commitments signed by most of the governments of the Region which advocate participation and gender equality.

The legal instruments available to citizens for the exercise of social control over government include: (i) mechanisms for obtaining information, such as mandatory public comment periods, public hearings, and freedom of information legislation;¹ (ii) mechanisms that enable people to take action against public authorities in response to threats to their rights, such as injunctions, public interest actions, enforcement actions,

¹ Instrumento para solicitar información a una entidad pública, la cual debe ser respondida dentro de unos plazos estipulados por la ley.

and formal complaints; and (iii) political participation mechanisms, such as public legislative initiatives. All these avenues can be used to improve the quality of participation “with” and “for” gender equality in health.

Accountability

Citizens’ exercise of social control over government as a means of ensuring that actions by the State are truly in the public interest is known as accountability. This notion implies understanding and approaching participation as a political phenomenon that is based in power relations.

An essential requirement for this type of participation is the existence and accessibility of comprehensive information systems that foster transparency and control through accountability. Information should be readily available throughout the policy-making process, including assessment of the differential impact of policies on particular population groups as a result of variables that give rise to inequalities in health outcomes. In other words, information should be disaggregated by sex, age, area of origin, geographic location, socioeconomic level, and race/ethnicity, among other variables, and it should be presented in a format that is easily understandable to a wide audience.

An example of the use of information for accountability is the establishment of national and local citizen observatories such as those that have been set up in several countries of the Region for the purpose of obtaining, analyzing, and disseminating existing information or generating information regarding the health needs of the population and the appropriateness of political and institutional responses. Some of these observatories have focused on issues related to gender equity in health and have succeeded in impacting the formulation of policies.

If gender equality is to be achieved, violations of health rights must be reported (which calls for public information duly disaggregated by sex as a condition for quality) and there must be legal and constitutional mechanisms for submitting formal complaints. Among these violations, the following are particularly important: the practice of forced sterilization, abuse of procedures such as cesarean section, denial of treatment to persons with HIV/AIDS, and the use of radical treatments such as hysterectomy in cases that could be treated by other means—for example, localized cervical neoplasms.

□ **TABLE 7. Participation, accountability, and empowerment**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Citizen participation in decision-making processes	Civil society groups, and women within these groups, have a voice in planning, priority-setting, and allocation of resources.	<ul style="list-style-type: none"> • Have officials and supervisors received training and guidance on consultation processes? • Have women's groups, especially those in low-income brackets, received training in administration and negotiation? • Has the sector invited civil society groups, and specifically women's groups, to participate in priority-setting and policy-making at the national and local levels? • Do existing policies foster and strengthen this participation, especially at the local level? • Have community mechanisms been developed to enable women to delegate child care so that they can participate in decision-making processes?
Legal frameworks for participation	<p>Social and legal frameworks have been created that ensure the participation and representation of traditionally excluded groups such as the poor, indigenous populations, and women in health sector decision-making bodies.</p> <p>This legal framework goes beyond quotas and includes the imperative to build leadership and negotiating skills among these groups, especially at local levels.</p>	<ul style="list-style-type: none"> • What participation mechanisms have created by health sector policies? • Has a legal framework been established to support these mechanisms? • Is this participation limited to consultation, or are concerned groups represented in decision-making processes? Are women, in particular, included in these groups? • How is participation ensured for the most excluded groups? • Does the law provide for the creation of training mechanisms and resources for excluded groups with a view to empowering them to participate? • Does the law provide for the creation of mechanisms that free women from their domestic duties and enable them to take part in social participation activities?
Composition of the formal bodies responsible for health decision-making and monitoring in both the formal system and the community	Civil society and women's groups within it have voice and vote in health sector governing and advisory bodies, as well as in community-level bodies responsible for formulating and monitoring policies.	<ul style="list-style-type: none"> • Is civil society represented on health sector governing and/or advisory bodies at the national, local, and institutional levels? • What advisory committees exist at the national level? For what issues? • Are there user leagues and/or associations at the level of provider institutions? • What is the proportion of women on these committees, councils, and associations? Do they have voice and vote? • Are there national and/or local entities that monitor health policies on behalf of civil society? Do they include issues related to gender equity in health care? What is the proportion of women in these entities? • Is there official monitoring of the consistency of health sector actions with international treaties on the health of women and children? • Do these processes allow room for the participation of civil society? Does the women's movement participate in monitoring agreements regarding the health of women?

Issues	Benchmarks for evaluating gender equity in policies	Questions
Availability and flow of information to citizens	The health sector routinely produces information, and makes it accessible to the various interested groups, with regard to (a) the health status of the population, broken down by sex and other socioeconomic variables, and (b) political, financial, and organizational responses to the health needs of various subgroups of the population.	<ul style="list-style-type: none"> • Does the sector maintain up-to-date public information databases on the health status of the population and the public and private institutional response to the needs of the various subgroups? Are these databases easily accessible and understandable to a wide audience of citizens? • Is information about health sector policies and actions actively disseminated through appropriate communications media (for example, the mass media)? • Is this information disseminated to health professionals? • How does this dissemination take place at the local level? • How are needs for information regarding provider and treatment options met for poor populations, especially the needs of women as the principal users of the health services?
Transparency in the allocation and use of resources	<p>The allocation of resources for health has taken into account prior consultation of the population groups concerned and responds to criteria that are transparent and can be monitored by the respective public entities and civil society.</p> <p>The pertinent information is accessible and is sufficiently broken down to allow monitoring of the budgetary response to the shared and specific needs of women and men; there are participatory mechanisms for carrying out this monitoring; and women participate actively in the process.</p>	<ul style="list-style-type: none"> • Are there formulas for the allocation of health resources, and how are they affected by decentralization? • Is this information accessible to the public? If so, in what form? • Are there mechanisms for internal monitoring of the use of public resources in the health sector? Is a distinction made between primary health care, including sexual and reproductive health, and other relevant areas from a gender perspective? • What means are available for the community and women's groups to discuss and dispute the allocation of resources? • Have there been initiatives to develop participatory budgets in general and gender budgets in particular? • Have there been initiatives to integrate the gender dimension into national accounts? • Have these initiatives allowed for the participation of civil society?
Rights of citizens to competent and equitable care and prevention of malpractice	Formal mechanisms are available to ensure quality and equity in the treatment of male and female users, and emphasis is placed on ensuring access to these mechanisms for the most excluded groups, including women, especially poor women.	<ul style="list-style-type: none"> • Is there a charter or declaration of users' rights and is it displayed in health centers and disseminated via the communications media? • What efforts have been made to ensure that the most excluded groups, including poor women, are aware of their rights with regard to health care, especially care for sexual and reproductive health needs? • Is appropriate information available to women and men about their health care rights and how to report violations and seek redress? Is this information readily accessible? • Have complaints been filed regarding preventable maternal deaths; denial of care, including care for complications by unsafe abortion; abuses with regard to contraception; or violation of other rights? • Have these complaints led to policy changes? If so, what changes? • Are social audits or autopsies conducted in cases of maternal mortality?

TABLE 7. (cont.)

Issues	Benchmarks for evaluating gender equity in policies	Questions
Rights of citizens to competent and equitable care and prevention of malpractice (cont.)		<ul style="list-style-type: none">• Does the definition of quality standards for institutions include aspects relating to women's rights?• Are there maternal mortality committees at local levels, and do women participate in them?• Are there national committees on HIV/aids that have incidence on policy?

OBSERVATION FIELD 8: FULFILLMENT OF INTERNATIONAL COMMITMENTS

International agreements concerning the rights of women and children are extremely useful instruments for supporting demands for accountability from national governments for their actions in support of these groups. This observation field has to do with the extent to which such international commitments have been met through national and local entities, as well as with the way in which various civil society groups that advocate for gender equality have been included in this process.

The following instruments and events have been milestones in terms of generating international agreements to move towards achievement of the goals of gender equity and empowerment of women, with explicit reference to health: the Convention on the Elimination of All Forms of Discrimination against Women (1979); the World Conference on Human Rights (Vienna, 1993); the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Convention of Belém do Pará, 1994); the International Conference on Population and Development (Cairo, 1994); and the Fourth World Conference on Women (Beijing, 1995); the gender equality goals included in the Declaration of the Third Summit of the Americas (Quebec, 1992); and the United Nations Millennium Declaration (2000), which set eight goals, one of which was specifically to promote gender equality and empower women.

For the purposes of this guide, it is therefore very important to determine to what extent the agreements signed by governments have been effectively incorporated into reform and “counter reform” policies in the health sector and whether any decisions have been taken that run counter to the spirit of these agreements. It can be affirmed a priori that the scarce interaction that has taken place between gender equality advocacy groups and the national and international entities responsible for pro-

Principal international commitments on gender equality and health

- Convention on the Elimination of All Forms of Discrimination Against Women, 1979
- World Conference on Human Rights, Vienna, 1993
- Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women, Belém do Pará, 1994
- International Conference on Population and Development, Cairo, 1994
- Fourth World Conference on Women, Beijing, 1995
- Millennium Development Goals, 2000
- Declaration of the Third Summit of the Americas, Quebec, 2002

cesses of change in the health sector has been a limiting factor in the advancement of these commitments within the context of health policies.

Listed below are some of the main areas in which international commitments relating to health exist. These areas should, as a result, permeate all health sector policy reforms. Although some of these topics have been dealt with in greater detail in previous chapters, they are mentioned again here in order to highlight the fact that their implementation is an obligation on the part of governments and, therefore, something that the public can demand. The focus in this observation field is on the conduct of governments with respect to formal endorsement of these agreements

and the development of plans for their implementation within the health sector, as well as the participation of civil society in the development of such plans where they exist. For a more detailed examination of the consonance between policies and these areas of commitment, the reader is referred to the respective chapters.

Primary health care and access to services

(See mainly Observation Field 2: Access to the Health System; Observation Field 3: Comprehensiveness of benefits; and Observation Field 4: Quality of care, in particular the section on service networks.)

Although great strides have been made in public health in all countries over the last 30 years, many population groups continue to bear a disproportionate burden of preventable morbidity and mortality which is associated with the extreme socioeconomic inequality that prevails in Latin America. Maternal mortality, which is an emblematic indicator of social inequity, continues to be a public health problem of enormous proportions in certain socioeconomic, geographic, and ethnic groups. With a view to addressing this situation, an international commitment was made to consolidate health systems based on primary care—health promotion and disease prevention—the achievement of which requires that sufficient resources be allocated and distributed according to the differing needs of different groups.

Within the context of the broader mandate of promoting gender equality and women's empowerment, these instruments recognize health as a right that entails access to services and underline the strategic importance of sexual and reproductive health as one of the spheres of human life that is crucial to the attainment of gender equality. Reproductive autonomy is seen as an aspect of women's empowerment that is of fundamental importance for the exercise of their other rights. Similarly, the physical and social burden that

falls on women's shoulders as a result of their role in reproduction makes sexual and reproductive rights the area in which the sharpest differences occur between men and women with regard to the need for health care. It is also the area that generates the greatest demand for services. These facts, coupled with the critical importance of healthy reproduction not only for women, but for society as a whole and for future generations, means that sexual and reproductive health deserves special consideration in the analysis of health policies and reform processes.

Any conflicts that arise between these commitments and health sector reform decisions—such as cost recovery and privatization schemes that create sometimes insurmountable barriers to women's access to sexual and reproductive health services—should be the focus of attention by the sector. It should also be noted that commitments acquired at the national level are not necessarily reflected in the implementation of sexual and reproductive health programs at the local level. Issues such as the sexual rights of women, male and female adolescents' access to contraception, emergency contraception, humane treatment of the complications of unsafe abortions, and the prevention and management of domestic and sexual violence, are ignored when priorities are established, or else they are explicitly excluded in response to the conservative attitudes of local authorities. With regard to abortion, which is the most controversial of these issues, it is worth noting that two basic aspects have been addressed by international instruments: guaranteed provision of service in contexts where abortion is legal and, in all contexts, management of the complications of unsafe abortion.

Information systems

(This is a topic that cuts across all observation fields, but it is especially

important in the following: No. 1, Intersectoral action, in the section on statistical information; No.3, Comprehensiveness of benefits, in the section on setting health care priorities; and No. 7, Participation, accountability, and empowerment, in the section on availability and flow of information to citizens).

As the generation of reliable information is crucial to the formulation and monitoring of policies, another of the most important commitments emanating from the above-mentioned conferences is to compile, analyze, and disseminate information disaggregated by sex and other variables for purposes of decision-making, planning and policy evaluation. This task calls for joint effort by a variety of actors—including government, non-governmental organizations, and research organizations and centers—in order to develop suitable indicators and research methods for gender analysis.

Promotion of participation

(This, too, is a topic that cuts across all observation fields, but is especially important in No. 7, Participation, accountability, and empowerment, in the section concerning availability and flow of information to citizens).

The foregoing commitments not only constitute specific objectives for attaining gender equality, but also lay out a broad agenda for action that aims at consolidating public policies reinforced by the participation of civil society. Achieving such objectives requires political will at the highest levels, expressed through the creation of opportunities for broad and effective participation by the population and the establishment of conditions in which such participation is oriented not towards carrying out tasks prescribed by others, but rather towards developing health policy agendas and exercising social control over their implementation. For this reason, the topics and parameters identified in this observation field are closely related to participation and empowerment processes and are essential to the fulfillment of international commitments. The creation of institutes

or offices for the promotion of equal opportunities for women and men has been identified as a critical strategy for achieving these results. It is generally agreed that these entities should be located at the highest levels of government and should have administrative and financial autonomy. Coordination between the health sector and these entities is of crucial importance for the inclusion of gender equity in policy debate and development processes.

Education

(See especially: the section on education in Observation field 1: Intersectoral action, and the section on training in Observation field 6: Management of human resources).

An important aspect of these commitments is recognition of the disadvantages faced by women as a result of the perpetuation of gender stereotypes in education, from the primary to the university level, and, consequently, of the need to make changes to educational curricula in order to: (a) expand knowledge about the impact of cultural gender constructs and unequal power relations between the sexes in terms of access to resources and services, women's autonomy with respect to health, and the well-being of the community; (b) improve equity and efficiency in professional practice in the area of health research and health care; and (c) contribute to a more equitable distribution of the sector's human resources by identifying and addressing the unequal opportunities and obstacles faced by men and women in their professional careers.

Unpaid Work

(This is also a cross-cutting issue in all the observation fields, but it is most closely related to the following: 1. Intersectoral approach, section on statistical information; 5. Health system financing, section on unpaid health care in the home; and 6. Management of human resources, section on unpaid health workers).

Recognizing the economic and social importance of the contribution of

unpaid health care provided in homes and communities, but especially in homes, governments have committed themselves to developing appropriate methods for: (a) measuring and calculating the economic value of this unpaid work, and (b) accurately reflecting that value in satellite accounts or other official accounts linked to national accounts. In the case of the health sector, this commitment is especially important, given the high proportion and the importance of the health care provided in the home, mainly by women, and the “occupational” risks for health associated with caring for sick and disabled persons in the home and with the double workload of domestic and paid work.

Mainstreaming a gender perspective

(By definition the guiding principle for the analysis in all observation fields.)

This area of commitment involves all sectors of government and is aimed

at implementing processes for weighing the implications for women and men of any planned action, including legislation, policies, or programs, in any area and at all levels. This strategy is designed to ensure that the interests and experiences of both men and women become an integral dimension in the design, implementation, monitoring, and evaluation of policies and programs in the political, economic, and social arenas in order to avoid perpetuating the inequality between women and men. The ultimate goal is to achieve gender equality. This commitment was reaffirmed by PAHO Member States when they adopted the Gender Equality Policy (PAHO, 2005), whereby the States and the Secretariat commit to incorporating a gender perspective in all technical cooperation activities and in the development of policies and programs in the countries. WHO is currently in the process of designing a plan of action for implementing the WHO strategy for integrating gender analysis and actions into the work of WHO, adopted by Member States in 2007.

□ **TABLE 8: Fulfillment of international commitments**

Issues	Benchmarks for evaluating gender equity in policies	Questions
Signing of agreements	Governments have signed and ratified the international agreements on gender equality and health.	<ul style="list-style-type: none"> • Has the government signed the principal international agreements on gender equality and health (listed in the box above)? • Are there national (or state in federal systems) laws, policies, plans, or programs based on the content of these instruments? What are they? Do they include a health dimension? • Have staff in the health sector been instructed about their role in fulfilling these agreements?
Procedures for implementing agreements	Plans of action and/or procedures have been developed to implement the international agreements signed by governments specifically in the field of health and in the context of sectoral policies.	<ul style="list-style-type: none"> • What efforts have been made and what procedures have been established for incorporating the health issues addressed in these agreements into health policy? • Is there an entity under the ministry of health that is responsible for following up on these agreements? • Is specific mention made of these agreements in the text of some health policies? Which agreements and in which policies? • Is a comprehensive approach to sexual and reproductive health taken, as proposed at the Cairo conference? • Are these agreements born in mind in the formulation of health sector reform policies? • What progress (or setbacks) in the formulation, implementation, and monitoring of sectoral policies have there been with regard to specific areas covered by these agreements?
Civil society participation in implementing agreements	The health sector has the support of civil society groups with knowledge and expertise in gender equality and health issues for decision-making and the drafting of plans for carrying out the international agreements signed by governments.	<ul style="list-style-type: none"> • Has the health sector enlisted the support of NGOs and academic and research institutions with recognized expertise in gender and health issues in order to develop plans and/or procedures for carrying out these international agreements? • Have these civil society organizations participated in some or all stages of the formulation, implementation, and monitoring of these plans and procedures?
Intersectoral coordination	The health sector has coordinated with the appropriate sectors (e.g., statistics, education, social security) and especially with the ministries or offices in charge of matters relating to the advancement of women and gender equality.	<ul style="list-style-type: none"> • Has the health sector coordinated activities with other sectors in order to carry out international agreements in specific areas? With which sectors? In connection with which objectives? • Is there coordination between the health sector and offices of women's affairs to develop plans and procedures for carrying out international agreements? What type of coordination?

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