Monitoring PAHO's Gender Equality Plan of Action: Interim Report 2009-2011

March 2013

Gender Equality…

…easier said than done!

INTRODUCTION

In September 2005, the Member States of the Pan American Health Organization (PAHO) approved its Gender Equality Policy (GEP)[1] through a PAHO Directing Council resolution (DC 46.R16). The resolution called on PAHO's Director to "develop an action plan for the implementation of the [GEP], including a performance monitoring and accountability system."[2] In 2009, PAHO approved its Plan of Action (PoA) for implementing the GEP. Since then the PoA has been widely disseminated throughout the Americas region.

The PoA was developed through extensive consultations with PAHO Member States, United Nations (UN) agencies, and regional civil society organizations (CSOs) to provide a framework for technical collaboration with Member States for operationalization of PAHO's commitment to include a gender perspective in planning, implementation, and monitoring and evaluation of health policies, programs, projects, and research. It incorporates PAHO's Health Agenda of the Americas and is implemented within the context of PAHO's Strategic Plan 2008–2012.

As set out in a related PAHO Directing Council resolution (DC 49.R12), the PoA also 1) provides a "roadmap" for the development and use of GEP monitoring indicators by PAHO's Member States and Secretariat (the Pan American Sanitary Bureau, PASB); 2) guarantees ownership of gender equality considerations within PAHO; and 3) designates PAHO leadership responsible for achieving equity in health as part of the "Health for All" (HfA) goal set out at the 30th World Health Assembly of the World Health Organization (WHO) in May 1977.

Resolution DC 49.R12

Resolution DC 49.R12 calls on the PAHO Director to:

(a) *ensure the implementation of the Plan of Action and support Member States to progress in the implementation of national plans for integrating gender equality in health systems;*

(b) provide knowledge on advances and best practices for achieving gender equality in health, as well as on threats to reaching it;

(c) facilitate monitoring the progress of implementation of the Plan of Action in the Secretariat's work and technical collaboration;

(d) rely on the support of a technical advisory group and other internal and external mechanisms that include civil society participation for implementing and monitoring the Plan of Action; and

(e) promote and strengthen partnerships with other United Nations agencies and other organizations to support the implementation of the Plan of Action.

[1] www.paho.org/English/ad/ge/PAHOGenderEqualityPolicy2005.pdf

[2] Resolution DC 46.R16.

PURPOSE

As stipulated in the PoA, PAHO's Director is responsible for providing PAHO's Directing Council with biennial reports assessing progress by PAHO and its Member States in implementing the PoA goals described above. This report is the initial assessment and covers the year 2009 (when the PoA was first approved) through PAHO's 2010–2011 Biennial Work Plan (BWP) period. It also includes recommendations from participants in consultations organized by PAHO on improving the integration of gender equality in Ministries of Health (MoHs) and PAHO to achieve better health outcomes for women, men, and children in the Americas region.

As per the Director's request, PASB's Office of Gender, Diversity and Human Rights (GDR) coordinated the collection and analysis of information for assessing this progress. Based on the recommendation of the Director's Technical Advisory Group (TAG) on Gender Equality and Health (GEH), the monitoring process included representatives from the Americas region MoHs, Ministries of Women (MoWs), and CSOs. The TAG/GEH consists of representatives and gender experts from PAHO Member States, MoHs and MoWs, UN agencies, and CSOs, and has been instrumental in providing recommendations and other input on the PoA, its monitoring framework, and the draft of this report.

MONITORING STRATEGY AND METHODOLOGY

GDR developed a framework for monitoring progress in implementing the PoA by its own staff as well as that of PASB technical areas and PAHO Country Offices, and Member States. In 2011, the framework was presented to the participants of three sub-regional PAHO Managers' Meetings as well as the TAG/GEH, PAHO's Gender Focal Point (GFP) network, and other partners. Three instruments were designed by the PAHO Gender Office to obtain information to help guide the implementation of the four main strategies of the GEP (Strategic Areas 1–4).

Gender PoA Strategic Areas 1-4

Strategic Area 1: Strengthen the capacity of PAHO and its Member States to produce, analyze, and use information disaggregated by sex and other relevant variables

Strategic Area 2: Develop tools for and increase the capabilities of PAHO and its Member States for integrating a gender equality perspective in the development, implementation, and monitoring and evaluation of policies and programs

Strategic Area 3: Increase and strengthen civil society participation, especially among women's groups and other gender-equality advocates, in identifying priorities, formulating policies, and monitoring policies and programs at local, national, and regional levels

Strategic Area 4: In line with results-based management methodologies, institutionalize

gender-responsive policies, as well as monitoring mechanisms that track specific mainstreaming results, and evaluate the effectiveness of gender interventions on health outcomes

At the regional level, GDR provided information about progress on indicators related to its work, and facilitated consultations with PASB technical areas for the collection of information about gender integration in their work. At the country level, GDR encouraged PAHO Country Offices to coordinate with each Member State's MoH, other government sectors, UN agencies, and CSOs to obtain information on gender integration in country-level activities. Information about the PoA, and a monitoring questionnaire, were provided to 26 Country Offices, including the Office of Barbados and the Eastern Caribbean Countries (ECC), which represents 10 island countries and territories.

Based on information obtained through consultation with the GFP network, partners, TAG/GEH members, and Member States of the Executive Committee of PAHO's Directing Council, the information collected was analyzed in a draft report by GDR. Comments were compiled and included in the final report, which was presented to the Executive Committee and to the Pan American Sanitary Conference (PASC) in September 2012.

MONITORING RESULTS

Considering the challenges of the ongoing process of mainstreaming gender equality within PAHO and its Member States, the impressive and comprehensive results documented in this report are a tribute to the uncompromising commitment to equity and gender equality in health by PAHO's former Director and Assistant Director Dr. Mirta Roses and Dr. Socorro Gross.

All four technical areas and GDR responded to the PoA questionnaire. Of the 36 PAHO countries/territories contacted, only four did not respond (Haiti, Jamaica, Puerto Rico, and the United States). Of the 26 country consultations that were held (25 in individual Member States and one with the ECC), eight included all partner groups (CSOs, MoHs and other ministries, the PASB, and the UN); 11 included only MoHs and PAHO; and four included only non-health ministries and UN agencies. All but two of the countries/territories that responded to the questionnaire participated in a PoA consultation. Annex 2 provides details about the consultation processes undertaken by each respondent.

The text below summarizes the responses generated by PAHO and its Member States (GDR, PASB technical areas, and the 36 countries/territories). The results are presented by the GEP Strategic Areas, their Objectives, and their PoA indicators. The report concludes with recommendations from the participants for improving the integration of gender in PAHO. The annexes and footnotes provide additional information.

Strategic Area 1: Strengthen the capacity of PAHO and its Member States to produce, analyze, and use information disaggregated by sex and other relevant variables

Objective 1.1
PASB incorporates gender-sensitive indicators, disaggregated by age and sex, in developing plans, programs, technical collaboration, and other initiatives

Baselines/indicators
Flagship publication Health in the Americas • Baseline: WHO 2008 assessment of *Health in the Americas* 2007 edition • Indicator: *Health in the Americas* 2012 edition includes gender analysis in regional chapters and all country/territory chapters using the WHO analysis tool *Country Cooperation Strategies (CCS)* • Baseline: Proportion of 2008 CCS includes analysis of data disaggregated by sex and age, using WHO analysis tool • Indicator: By 2010, all new CCS include analysis based on data disaggregated by sex and age, and strategies to address differences *Strategy for strengthening vital and health statistics in the countries of the Americas* • Indicator: By 2009, guidelines call for disaggregation of data by sex and age for all information systems *Health analysis publications* • Indicator: By 2013, all health analysis publications include analysis based on data disaggregated by sex and age

GDR collaborates closely with the PASB technical areas, especially the Health Analysis and Statistics (HA) unit, to better integrate gender in health information systems, tools, and guidelines, and to strengthen the capacities of the PASB, governments, and CSOs for equitable decision-making, advocacy, and monitoring.

***Health in the Americas*.** The PAHO publication *Health in the Americas* was completed in 2012 and launched during the 2012 Pan American Sanitary Conference (PASC). GDR was part of the writing team and applied PAHO/WHO gender tools in the development of and consultations on both the regional and country/territory chapters of the publication. An analysis of this flagship publication will be carried out in 2013.

Country Cooperation Strategies (CCS). Since 2009, GDR has included gender indicators in the situation analysis and development of CCS, the basis for WHO/PAHO collaboration with Member States. In 2009, GDR incorporated gender, human rights, and cultural diversity directives, and a checklist for their review, in the WHO guidelines for developing CCS.[3] These tools were used to analyze the 14 CCS developed from 2005 to 2008, prior to GDR's engagement in the CCS process. According to the analysis, none of

[3] The WHO checklist was adapted and used to identify CCS (developed from 2005–2008), that incorporated gender and/or ethnicity in their report content (for use as baseline comparison tools). The guidelines are available at: http://bit.ly/mainstreaming-gdr

the 14 CCS demonstrated strong integration of gender (corresponding to the highest score of 7–9); 13 attained a medium score (4–6), and one obtained a low score (1–3) (Annex 1).

Since 2009, 10 CCS have been developed or completed, and GDR has participated in the development of seven of them. Starting in 2012, the post-2009 CCSs were reviewed using the WHO checklist. The results of these reviews will be compared to the analysis of the 2005–2008 CCS to determine if integration of gender in CCS has benefited from GDR's involvement.

Disaggregating health information in guidelines and publications. The GEP calls for all health information produced by PAHO and its Member States to be desaggregated by sex and age, and to be analyzed from a gender perspective. Tables 1 and 2 provide self-reported information on guidelines and publications with data disaggregated by sex, age, and ethnicity produced by PASB's four technical areas: Sustainable Development and Environmental Health (SDE), Family and Community Health (FCH), Health Surveillance and Disease Prevention and Control (HSD), and Health Systems based on Primary Health Care (HSS).

Table 1. Number and percentage of guidelines with data disaggregated by sex, age, and ethnicity produced by PASB technical areas, 2005–2010

Project	Total Guidelines	Disaggregated by:					
		Sex		Age		Ethnicity	
		Number	%	Number	%	Number	%
SDE	9	9	100%	8	89%	3	33%
FCH	20	14	70%	16	80%	6	30%
HSD	13	11	85%	10	77%	9	69%
HSS	8	5	63%	6	75%	4	50%
TOTAL	**50**	**39**	78%	**40**	80%	**22**	44%

Source: PAHO/GDR consolidated data.

Table 2. Number and percentage of publications with data disaggregated by sex, age, and ethnicity produced by PASB technical areas, 2005–2010

Project	Total Publications	Disaggregated by:					
		Sex		Age		Ethnicity	
		Number	%	Number	%	Number	%
SDE	15	11	73%	11	73%	5	33%
FCH	15	12	80%	13	87%	4	27%
HSD	28	23	82%	25	89%	6	21%
HSS	7	5	71%	4	57%	4	57%
TOTAL	**67**	**49**	**73%**	**48**	**72%**	**15**	**22%**

Source: PAHO/GDR consolidated data.

Between 63% and 100% of the guidelines and other publications produced by PASB technical areas disaggregated information by sex, but considerably fewer did so by ethnicity. Disaggregation is a necessary step for identifying health disparities, but it alone

is not sufficient for understanding why these disparities exist. A gender and equity analysis can complement disaggregated information by indicating how to address inequalities in health. The technical area addressing surveillance and disease (HSD) consistently disaggregated its information in its guidelines but did not always apply a gender and ethnicity perspective in its publications. The guidelines and documents for the technical area aimed at improving health systems and services (HSS) were less likely to disaggregate information by sex, thus missing an opportunity to address the different needs of women and men seeking these services.

Objective 1.2
National and local producers and users of health statistics have the capacity to produce, analyze, and use gender-sensitive information for decision-making, advocacy, monitoring, and evaluation

Baselines/indicators
Tools for gender and health analysis
• Indicator: Several tools for gender and health analysis available and accessed from gender and health knowledge platform
National health profiles on women and men
• Baseline: Several existing health profiles
• Indicator: By 2014, trained producers and users of information in 10 countries/territories develop or improve national health profiles on women and men and use them for planning and advocacy (survey of workshop participants)
Contribution of unpaid home-based health care to national health expenditure
• Indicator: By 2013, three countries/territories have quantified unpaid home-based health care provided by women and men as a contribution to total national health expenditures
National mechanisms for analysis and monitoring of gender equity in health
• Baseline: Several health or gender observatories that have received PAHO support to include gender and health indicators
• Indicator: By 2013, three national or local observatories on gender have integrated health/gender indicators and published issue papers on advances in gender equality in health

Tools for gender analysis in health

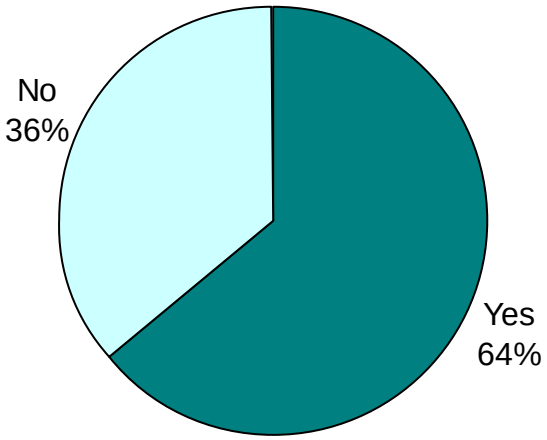
Gender, Diversity and Human Rights Office. GDR has developed a number of tools for training health information producers and users on integrating a gender and intercultural perspective in health information system development and use. It has also produced a number of gender and health evidence publications (see *Objective 1.3*). Since 2009, and in collaboration with the HSD/HA Offices and country-based GFPs, GDR has carried out capacity-building workshops with participants from MoHs, national women's machineries (NWMs), national statistics offices, and CSOs from seven countries (the Andean Community of Nations (*Comunidad Andina de Naciones*, CAN) plus Guatemala, Paraguay, and Suriname). The four Andean countries subsequently developed a set of

gender and health indicators that will be incorporated into the health information system promoted by the Andean integration entity CAN.

PAHO Country Offices and Member States. The information collected from Member States was self-reported and quite varied. Some countries/territories included guidelines and publications produced only by PAHO and the MoHs, while the majority included information on gender produced by other partners, including CSOs, MoWs, and UN agencies.

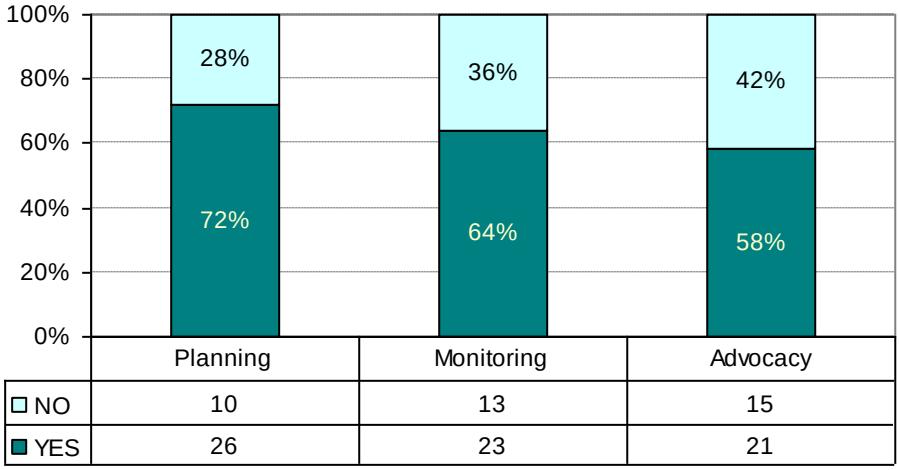
The number of guidelines (per country/territory) that incorporated gender equality in health information, policies, and programming ranged from 1 to 19 (Bolivia), and the number of other types of publications that incorporated gender ranged from 1 to 20 (Peru and Uruguay). Most countries/territories that reported disaggregating information by sex said they had carried out a gender analysis. Most of the countries/territories producing this type of information said it was used for decision-making, advocacy, monitoring, and training. Most of the publications dealt with violence against women (VAW), HIV and sexual and reproductive health, and health situation analysis. Only two countries (Argentina and Nicaragua) reported incorporating gender equality in publications on communicable diseases.

Figure 1 Percentage of countries/territories with publications that include data disaggregated by sex and age, 2005–2010



Source: PAHO/GDR, Self-administered survey of 36 countries/territories.

Figure 2 Percentage of countries/territories that use their gender-sensitive health publications for planning, monitoring, and advocacy, 2005–2010

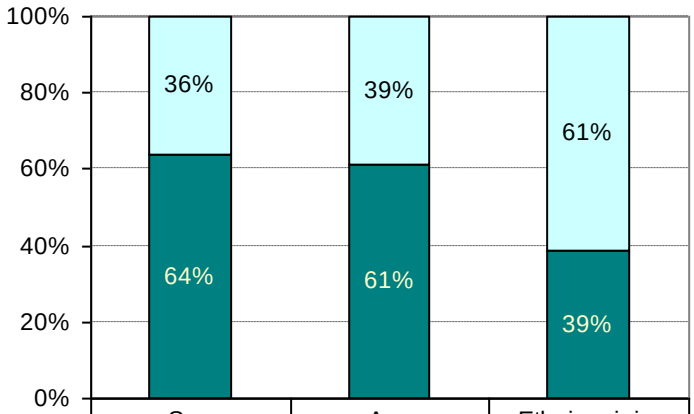


	Planning	Monitoring	Advocacy
NO	10	13	15
YES	26	23	21

Source: PAHO/GDR, Self-administered survey of 36 countries/territories.

Nineteen countries/territories reported having gender-sensitive guidelines for health analysis, programming, and monitoring.[4] As illustrated in Figure 3, the majority of the guidelines disaggregated the information by sex, but less than half disaggregated it by ethnicity.

Figure 3 Percentage of countries/territories with data disaggregated by sex, age, and ethnicity, 2005–2010



	Sex	Age	Ethnic origin
No	13	14	22
Yes	23	22	14

Source: PAHO/GDR, Self-administered survey of 36 countries/territories.

[4] No information on guidelines was provided by Bahamas, Costa Rica, Guyana, Suriname, or Trinidad and Tobago.

National health profiles on women and men. The following countries reported having published gender and health profiles during 2005–2010: Bolivia, Costa Rica, Honduras, Mexico, Panama, Peru, and Uruguay. Colombia, Nicaragua, and Trinidad and Tobago reported that gender analysis was included in their country's health situation reports.

Unpaid home-based health care and national health expenditures. The PAHO GEP calls for recognizing the importance of home-based health care that is predominantly provided by women and is unpaid. With PASB advocacy, Colombia, Costa Rica, Ecuador, Peru, and Uruguay have included this type of care in time use surveys. Costa Rica is publishing the analysis of unpaid care. Colombia, Ecuador, and Mexico are developing satellite health accounts that quantify this contribution within the framework of national accounts. In addition, Chile, Costa Rica, Mexico, and Peru reported policies and/or publications on unpaid health care and gender (Objective 1.3).

National mechanisms for analysis and monitoring of gender equity in health. Observatories are made up of CSOs and academics, and are key partners for using and producing gender and health information for analysis, advocacy, and monitoring of equality. GDR has set up a network of 35 observatories in Latin America and the Caribbean (LAC) that address gender and health and established an electronic discussion list ("listserv") with more than 70 participants, including GFPs, for the exchange of publications and other information. In 2009, GDR, the MoH of Chile, and the Chilean Observatory on Gender Equality in Health (*Observatorio de Equidad de Género en Salud*) brought together representatives of eight observatories and their health sector counterparts to identify ways to strengthen collaboration and support.[5]

During the PoA monitoring consultations participating countries/territories reported existing observatories that address gender and health and other types of observatories related to health for which gender analysis might be relevant (e.g., observatories on violence) (Table 1). In Chile, Guatemala, and Uruguay, the PASB provides technical collaboration (TC) to observatories on human resources and violence and on gender and health.

Table 3 Existing observatories relevant to gender and health and other areas of health reported by country participants in gender-integration monitoring survey, Americas region, 2011

Country/territory	Observatories on gender and health	Other observatories related to health
Argentina	Observatory on sexual and reproductive health (CSOs)	
Bolivia	Observatory on gender and equity (CSOs, MoH)	

[5] The PAHO website on gender and health observatories in the Americas, their publications, and minutes and recommendations from their meetings with MoHs can be found at: http://bit.ly/observatories

Brazil	Observatory on gender equality (CSOs)	
Colombia	National observatory on gender issues (NWMs)	
Ecuador	Observatory on sexual and reproductive health under construction (CSOs)	Observatory on children and adolescents
El Salvador		Observatories on violence (one each in three cities) that address gender-based violence (CSOs, MoH, NWM / ISDEMU[a])
Guatemala	Observatory on sexual and reproductive health (CSOs, MoH)	Observatory on violence; observatory on human resources
Honduras		Four observatories on human resources and one observatory on violence
Mexico	Observatory on maternal mortality (CSOs, MoH, UN)	Observatories on violence in all states
Paraguay		Observatory on external causes (injuries)
Peru	Four women's observatories (in Ayacucho, Apurímac, Piura, and Puno)	Three observatories (one on quality, one on cultural diversity, and one on human resources)
Uruguay	Observatory on sexual and reproductive rights (CSOs)	
U.S.-Mexico Border		Observatory on violence

[a] Salvadoran Institute for Women's Development.

Objective 1.3
Inter-agency collaboration strengthened to fulfill international commitments of PAHO Member States related to gender indicators and statistics

Indicators
Inter-agency regional observatory on gender parity
• Health indicators included and monitored in Regional Observatory on Gender Parity,

and support provided in training national partners in their application
Evidence on regional situation of women and men in Latin America and the Caribbean
• By 2009, one regional health profile on women and men published with the UN Development Fund for Women (UNIFEM), the UN Population Fund (UNFPA), and UNICEF, and widely disseminated
• By 2014, two biennial statistics brochures on gender and health published with UNIFEM and UNFPA, and widely disseminated
New and existing international and regional monitoring mechanisms on MDGs
• Inter-agency collaboration on monitoring of MDGs includes gender and health
• By 2011, two sub-regional profiles on women and men's health (Central America and Andean countries) developed by sub-regional coalitions of NWMs (Council of Women's Ministers [COMMCA], and Andean Group of Women Ministers) to provide evidence for advocacy of the inclusion of indicators for the gender integration processes in sub-regional health agendas
• Indicator: By 2011, gender indicators included in Phase III of the Caribbean Cooperation in Health (CCH) Initiative
Regional statistical conferences promote time-use studies
• Indicator: By 2013, three national time-use studies related to unpaid work include health care

Regional Observatory on Gender Equality. GDR has joined its sister agencies in contributing health information to the inter-agency Regional Observatory on Gender Equality coordinated by the UN Economic Commission for Latin America and Caribbean (ECLAC), which provides evidence for advancing gender equality to NWMs and other constituencies.[6]

Regional situation of women and men in LAC. To strengthen country/territory capacities on producing, analyzing, and using health information that includes gender indicators, GDR produced the following publications with UN partner agencies: the third biennial statistics brochure *Gender, Health and Development in the Americas, Basic Indicators 2009*; *Health of Women and Men in the Americas, Profile 2009*; and three case studies (*A Gender and Ethnicity Analysis of Cancer in Manitoba, Canada; A Gender-Based Analysis of Body Weight in Guatemala*; and *Homicide in Brazil: A Gender and Diversity Analysis*).[7]

Regional mechanisms for monitoring MDGs. The PASB is a part of the inter-agency ECLAC-led initiative on monitoring the achievements of the Millennium Development Goals (MDGs). In 2005, this initiative produced a comprehensive five-year interagency report on advances in achieving the MDGs. It also released adjunct reports on specific MDGs, including a 2007 report on gender equality and women empowerment (MDG 3); a 2008 report on the health-related MDGs (4, 5, and 6); and a 2009 report on MDG 8 related to sustainable development. GDR has collaborated with the gender integration in all of these reports.

[6] www.cepal.org/oig/
[7] All publications available at www.paho.org/gdr/publications

Sub-regional profiles on gender and health. In 2010, the PASB and COMMCA launched "gender and health for Central America," a sub-regional profile on gender and health. In 2011, the PASB and the Network of Women's Ministers of the Andes (*Red de Ministras de la Mujer Andinas*, REMMA) published the same type of profile for the Andean countries. These profiles provide health evidence to health networks and ministers to support the inclusion of gender in the agendas of all involved countries/territories and sub-regions.

Caribbean Cooperation in Health (CCH). Phase III of the Caribbean Community (CARICOM) health plan (2010–2015) (CCH-III) forms the basis for PASB cooperation with Caribbean Member States and includes gender indicators for sexual and reproductive health, adolescent health, and gender-based violence on which countries are requested to report. In collaboration with UN agencies, GDR and PASB's Office of Caribbean Program Coordination (OCPC) are supporting CARICOM and women's bureaus in its member countries in the production of the organization's first health profile for women and men in the Caribbean.

Regional statistical conferences promote time-use studies. (See *Objective 1.2*.)

Strategic Area 2: Develop tools and increase capabilities within PAHO and its Member States for integrating a gender-equality perspective in the development, implementation, and monitoring and evaluation of policies and programs

Objective 2.1
Capacity and commitment of the PASB and the Member States strengthened to support PAHO and the health sector in integrating gender analysis with a human rights–based approach in policies, programming, monitoring, and research

Baselines/indicators
Collaboration plans for integrating gender in technical areas and country offices developed and implemented • Baseline: Several collaboration plans developed • Indicator: Several PASB Offices reporting on advances of collaboration plans as part of the annual reporting process *Training PASB staff on gender and health* • Baseline: 2008 WHO baseline survey on knowledge and capacity of PASB staff and managers • Indicator: By 2010, WHO mid-term assessment shows 50% increase in number of staff and managers reporting that they have received training in gender equality and are applying the concepts in their work • Indicator: By 2013 evaluation, 75% of staff applying concepts in work plans *PAHO technical gender networks functioning to support implementation of PoA and national gender and health plans* • Indicator: By 2009, Internal Gender Working Group (IGWG) of designated representatives of the PASB technical areas and sub-regional GFPs trained and

supporting the technical areas and PWRs on implementing and monitoring the PoA
• Indicator: By 2009, the TAG/GEH has a work plan that guides PAHO's Director on gender mainstreaming and progress reports
• Indicator: By 2009, sub-regional gender networks of PAHO-trained GFPs and other partners, coordinated by the regional GEH advisor and providing technical support to countries in the region for developing and implementing plans for integrating gender in the health sector
Integrating gender equality in the health sector
• Baseline: Several preliminary gender and health plans developed in 2008–2009 by participating country teams during the gender and health training workshops
• Indicator: Proportion of national gender and health strategies defined during workshops developed and implemented with national partners
• Indicator: Several inter-sectoral TAGs formed after workshop that support the PWR and MoH in developing, implementing, and monitoring gender and health plans in the national health sector

Collaboration plans. GDR organizes its support to Member States in gender collaboration plans — agreements based on the BWPs and developed by the GFP, MoH counterparts, and CSOs. These plans are the basis for PASB technical and financial cooperation on mainstreaming and monitoring of gender in MoHs. Collaboration plans and their indicators were developed for seven priority and three non-priority countries.[8] The plans provide details on how countries intend to incorporate gender considerations into different areas (e.g., health information, institutional adoption of gender equality, non-communicable diseases (NCDs) in Guyana, maternal care in Bolivia, gender-based violence in Nicaragua and Peru, and HIV in Honduras). These plans were developed during the 2010–2011 planning period and will be incorporated into the 2012–2013 BWPs.

PASB staff training on gender and health. The WHO Mid-term Gender Assessment carried out in 2010 did not include in-depth staff questionnaires and therefore collected sparse information on WHO and PAHO managers' skills and political commitment to gender.[9] As a result, little is currently known about the overall training needs of PASB staff in gender.

Nevertheless, the GDR Coordinator sits on the PAHO management team that determines staff training opportunities. PASB managers are invited to all gender training sessions for GFPs and are trained specifically to incorporate gender in BWPs and Governing Body technical documents. PASB managers also are required to take the virtual course on gender and health developed by GDR (Annexes 3 and 6). In addition, PASB has included

[8] Priority countries: Bolivia, Guatemala, Guyana, Honduras, Nicaragua, Paraguay, and Suriname. Non-priority countries with developed plans: Colombia, Ecuador, and Peru.
[9] *Gender mainstreaming in WHO: what is next? Report of the mid-term review of the WHO Gender Strategy*, available at www.who.int. The review is the second phase of the WHO global evaluation of the Gender Strategy for mainstreaming gender in WHO, to be completed with a final evaluation in 2013. The 2008 baseline involved questionnaires sent to all WHO staff, and interviews with managers. PAHO had an 85% response rate and the highest level of awareness of gender policy, although only one-third of responding staff said they routinely applied gender concepts to their work (see Objective 4.1).

discussion of gender in the staff orientation course, and gender is a mandatory competence in the staff evaluation tool.

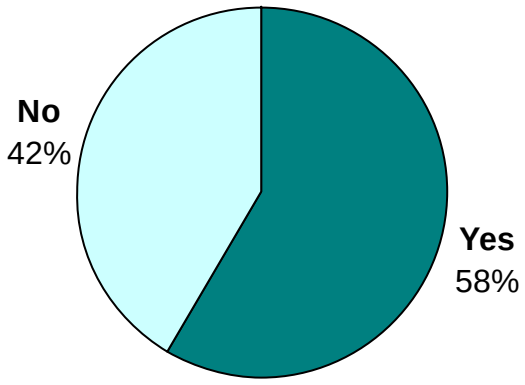
PAHO technical gender networks. GDR coordinates a network of GFPs from each PAHO Country Office and PASB technical area. In 2008 and 2009, GDR trained most of these focal points, the MoHs and partners from the NWM, and the CSOs, during sub-regional, four-day workshops, resulting in training for more than 100 people at the country level plus 30 PAHO headquarters staff. Since then, GDR developed a training course (*Gender and Health Virtual Course with a Human Rights and Cultural Diversity Perspective*) for training inter-sectoral country teams. During 2011, 58 persons (including 16 PAHO staff) from five priority countries were trained.[10] This virtual training allowed PAHO to build capacity at the country level and form technical groups that support MoHs in advancing integration of gender. In 2012 the course was translated into English and adapted for the Caribbean countries and territories and other partners.

PAHO has also translated a short WHO training course (*Virtual Course on Gender and Health*) and made it available on its VCPH. GDR intends to designate this and two other courses (*Basic e-Learning Course on Human Rights and Health*[11] and *Ethnicity and Health*[12]) as mandatory staff learning courses. Along with their PASB colleagues, the country-level GFP received short, targeted virtual training on integrating gender in their BWPs in 2010 and 2011.

Gender and health training in Member States. More than half of PAHO Member States said they had received training on gender for implementation of their national plans on gender and health (Figure 4). It was commonly noted that this training should be more consistent and focused on specific health issues. Training was often provided by the country's MoH, as in the case of Mexico, whose MoH gender trainers provide ongoing capacity-building and offer a Gender and Health diploma course to health workers. The MoHs in Uruguay and Chile train staff in all regions of both countries. In the case of Argentina and Colombia, a gender CSO provided training to MoH health staff in different regions and provinces.

[10] Bolivia, Guatemala, Honduras, Nicaragua, and Paraguay.
[11] www.paho.org/hr-ecourse-e/index.html
[12] http://devserver.paho.org/virtualcampus/moodle/course/view.php?id=39

Figure 4 Percentage of countries/territories that received training and support for implementing their action plans for gender and health, 2005–2010



Source: PAHO/GDR, Self-administered survey of 36 countries/territories.

Technical Advisory Group on Gender and Health. TAG/GEH consists of gender experts and representatives of UN sister agencies, government (MoH leaders or gender offices), and regional CSOs that promote gender equality in health. The TAG/GEH has met three times from 2008 to 2011 to assist the Director and PAHO with concrete recommendations in the development, consultation, and implementation of the GEP PoA and its monitoring framework.

Integrating gender equality in the health sector. Virtually every country/territory in the Americas has ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), an international human rights treaty that calls for all government offices, including MoHs, to end gender disparities and assign appropriate budgets to gender-transforming activities. Most countries/territories have passed national gender equality or equal opportunity laws that also apply to the health sector. As shown in Table 2, results of the monitoring questionnaire indicated nine countries/territories had specific health and gender policies and eight had units to address gender-related issues. Only Honduras, Mexico, Peru, and Venezuela reported gender and health budgets designated by law. Many respondents noted that their gender activities were mostly donor supported. Many respondents — including the eight countries/territories that engage in gender budgeting with CSO partners — said they did not have sufficient funds to carry out their gender plans.

Table 4 Countries reporting national policy, plan, or unit related to gender equality in health, Americas region, 2011

Type	Country/description
MoH gender policy	Brazil: National Policy for Integrated Care of Women Chile: Policy on Gender Equity and Health Costa Rica: Social Security: Policy and Plan of Gender Equality and Equity Ecuador: National Gender Plan (MoH) Guatemala: Strategy and Plan for Equality in Health of Men and Women Mexico: Special Action Program for Gender Equality in Health Paraguay: Plan/policy/national strategy for incorporating a gender perspective (in process) Peru: Technical Norm for mainstreaming gender, diversity, and human rights Uruguay: Plan for mainstreaming, with gender mechanisms in all departments
MoH gender regulation	Bolivia: Gender guidelines in National Health Plan of the 4 Peoples Nicaragua: Joint Gender Program with Ministry of Labor Venezuela: Integrated in National Health Plan and Constitution
National gender-equality plan that applies to MoH	Brazil: National Plan of Women's Policies for Gender and Health, National Lesbian, Gay, Bisexual, and Transgender (LGBT) plan El Salvador: ISDEMU has Council of Ministers Guyana: National Commission on Gender Equity and Equality ECC: Four countries/territories include health in gender policies Honduras: Equality Plan includes health
Gender and health unit or department	Chile: Gender and Health Office and Commission in each region Guatemala: Gender and Health Unit Honduras: Gender Unit Mexico: National Center for Gender Equality and Reproductive Health (presence in 32 states) Nicaragua: Gender commissions in 15 municipalities Panama: Women, Gender and Health Section in Health Promotion Department Peru: Technical Unit for Gender and Human Rights in Health Uruguay: Mainstreaming Unit for gender in health
Addresses men or masculinity	Bahamas: Male health program Brazil: National Policy for Men's Health Cuba: Emphasize men's participation Uruguay: Men's Health Program
Addresses gender in MoH or national budgets	Belize; Bolivia; Dominican Republic; Ecuador with the participation of the women's movement); Guatemala has a gender marker in the health budget); Mexico; Peru; Uruguay (with CSOs)
No specific policy/plan/unit	Argentina; Cuba (conforms to PAHO policy); El Salvador; Suriname; Trinidad and Tobago

Objective 2.2
Support PASB and Member States in including gender in the formulation and review of policies and processes related to staffing

Baselines/indicators
Human resource policies attain gender parity and positive work environments that promote gender equality in the workplace • Baseline: 2008 Human Resources staff report and WHO baseline • Indicator: By 2013, WHO evaluation, parity reached at all staff levels, especially in PAHO Country Offices • Indicator: By 2013, Work/Life Balance Policy approved and operational within PAHO • Indicator: By 2010, gender competency included in corporate competencies and in staff assessment tools • Indicator: By 2014, at least five countries support the incorporation of equal opportunity rules in their health sector human resources policy

Gender parity in the PASB. PAHO's GEP calls on the Director to "strive for parity between sexes in matters of recruitment, career development, and employment in decision-making within the Secretariat."[13] As part of the WHO Monitoring and Evaluation Framework on Gender Mainstreaming, the PASB analyzed the sex parity of its staffing in 2008 and in 2010, and found little change over this period. PAHO has achieved sex parity in all professional level positions at headquarters. In PAHO Country Offices, men slightly dominate higher professional posts, while women dominate in the lower (P2 and P3) positions (Annex 4). This highlights the urgency to recruit more women for P4 positions who can take on higher leadership.

The PASB Office of Human Resources (HR) has a strong commitment, although no stated policy, to ensure sex parity in PAHO positions. PASB has included gender, through staff orientation and a staff e-learning course, as a mandatory competence in its staff evaluation tool, although accountability and monitoring are still in process. As a result, PAHO has a remarkable record in achieving sex balance in professional positions. PAHO has been recognized by the former UN Division on the Status of Women (DAW) as one of the top UN agencies for advancing sex parity in its human resources.[14]

Gender parity in PAHO Member State MoHs. PAHO's GEP also calls on Member States to attain sex parity in their work force. With the exception of Cuba, no country/territory reported having specific MoH human resource policy on sex parity, although most countries reported having national equal opportunity laws that apply to all sectors (Figure 5). In addition, several countries/territories reported national commitments to international human rights conventions that require equal opportunities for both sexes in the health work force.

[13] PAHO Resolution DC 46.R16.
[14] *Improvement of the status of women in the United Nations system*, Report to Secretary General, UN general Assembly, Sixty Fifth Session. Available at: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/500/50/PDF/N1050050.pdf?OpenElement

Figure 5 Percentage of countries/territories that reported having national equal-opportunity laws for women and men in their MoH system, 2011

Source: PAHO/GDR, Self-administered survey of 36 countries/territories.

Objective 2.3
Knowledge platform on gender and health is established and accessible for PASB, PAHO Member States, and CSOs to support implementation of the GEP and the PoA

Indicators
Knowledge platform on gender, ethnicity, and health set up to support Country Offices, Technical Areas, and partners
• By 2010, knowledge platform set up and fully operational (accessed by at least 1 000 users/month) on gender and health as part of PAHO's information strategy and includes training tools and information packets, database of experts, best practices, and links to networks
• Two best practices on integrating gender in health awarded yearly (one internal and one external) during International Women's Day celebration and virtual forum, and included in PAHO database of best practices on gender and health
Access and contribute to gender and health knowledge platform
• Half of all contributions to knowledge platform provided by Member States and other partners (CSOs and UN agencies).

Knowledge platform on gender, ethnicity and health. The GDR knowledge platform includes a Sharepoint[15]-based webpage, a blog, and databases on best practices, partners, and experts in Gender and Health. The platform has been operational since 2012.

[15] Microsoft server for browser-based collaboration and document management.

Currently, GDR manages a 75-member listserv of gender and health observatories and GenSalud, a gender and health listserv with more than 800 registered members.

Best Practices Competition. In partnership with the Organization of American States (OAS), GDR conducts an annual competition on best practices in gender and health (*Best Practices That Integrate Equality and Fairness in Gender and Interculturalism in Health*). Winners are recognized during PAHO's International Women's Day celebration and receive technical support, a certificate, publication in English and Spanish, and financial prizes to help finance 1) investment to strengthen the best practice and 2) the award ceremony in the winners' country. Since 2008, GDR has awarded and helped develop thirteen best practices in partnership with other PAHO Offices and UN agencies[16] (Annex 5).

Strategic Area 3: Increase and strengthen CSO participation, especially among women's groups and other gender-equality advocates, in identifying priorities, formulating policies, and monitoring policies and programs at local, national, and regional levels

Objective 3.1
Leaders of regional CSOs, especially women's organizations and gender-equality advocate groups, serve as members of TAG/GEH and advise on the implementation of the GEP within PAHO and its Member States

Indicators
CSOs actively participate and support PAHO's GEP and PoA
• By 2009, TAG/GEH includes three CSO members from women's groups or gender-equality advocate groups
• By 2010–2011, BWPs with the Latin American and Caribbean Women's Health Network (LACWHN) developed, implemented, and monitored, with progress reported to the Executive Committee
• Number of CSOs consulted in the development of the PoA

Participation of CSOs in PAHO's GEP. CSOs participated in the TAG/GEH and in the reviews of the PoA at four sub-regional Gender and Health training workshops. The website of the LACWHN, a CSO association of more than 600 groups, provides information about a collaboration plan developed with PAHO that produces biennial reports.[17]

[16] Additional information and a list of past winners are available at: http://www.paho.org/gdr/bestpractices
[17] www.reddesalud.org

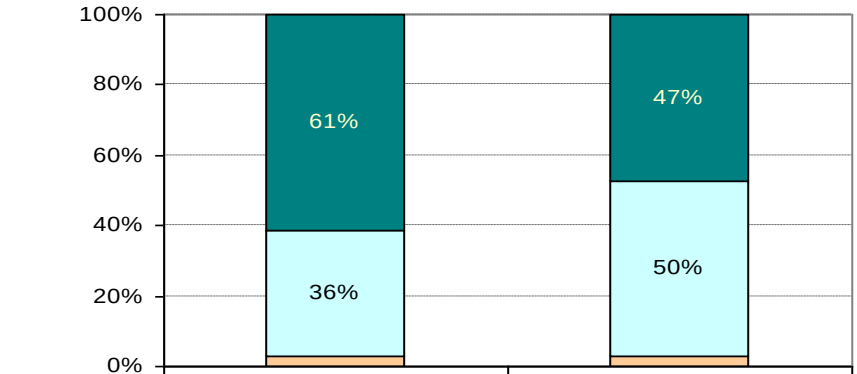
Objective 3.2
CSOs (dealing with women, men, ethnic groups, human rights, etc.) empowered to participate in national multi-sectoral teams to support the MoHs in implementing, monitoring, and evaluating gender equality in health policies and programs

Indicators
CSOs participate in national health policy-making and monitoring processes • Several CSOs participating in national advisory groups for developing and implementing the national gender equality health plans developed during the sub-regional training workshops • By 2013, processes supported, facilitated, and documented in three countries that have included CSO participation and resulted in the allocation of health budgets to better address gender inequalities

Inter-sectoral participation in MoH advisory groups. The participation of many different stakeholders in integrating gender in health is vital because trained partners can support their MoH's efforts with respect to gender. PAHO has included the participation of diverse sectors as a priority in its GEP. Representatives from NWMs and CSOs are included in sub-regional MoH training workshops and as participants in the *Virtual Course on Gender and Health*.

Eight individual-country consultations on the GEP PoA monitoring included participants from CSOs. As shown in Figure 6, most countries reported that their MoH worked with inter-sectoral committees or advisory groups to address gender-related issues, including VAW, reproductive health, and HIV. For example, Chile's MoH works with an advisory group of CSOs, and Costa Rica involves CSO partners in social monitoring of policy and program implementation.

Figure 6 Percentage of countries/territories that have technical groups with CSO participation to support gender-related health initiatives, Americas region, 2011



	Technical groups to support initiatives on gender and health	Civil society participation in state gender and health initiatives
Yes	22	17
No	13	18
No answer	1	1

Source: PAHO/GDR, Self-administered survey of countries/territories.

Objective 3.3
Increased knowledge and capacity on gender-related health issues and advocacy among CSOs working to promote gender equality

Indicators
Advocacy campaigns implemented to increase awareness on gender equality in health
• Annually, regional information campaign carried out on Women's Health Day
• By 2009, Plan of Action widely disseminated and accessible to CSOs for comments

Increasing awareness on gender equality and health. PASB actively promotes women's rights campaigns together with its colleagues and constituents (e.g., the UNiTE to End Violence against Women campaign ("UN UNITE") launched in 2008, and International Women's Day). It also participated on numerous panels promoting health and gender equity issues during other regional and international events. During the 11th Regional Conference on Women in Latin American and the Caribbean in 2010 in Brazil, the PASB, with UNFPA, the LACWHN, and the Rockefeller Foundation organized a panel on universal health coverage for women. During the 2009 UN Commission on the Status of Women (CSW), with UN and Member State partners, PAHO participated in a high-level panel presenting primary health care as a women's priority. For CSW 2010, PAHO launched a publication (*Health of Women and Men in the Americas*), and for CSW 2011 it organized a panel on gender and non-communicable disease. PAHO organized similar panels during the 2011 UN High-level Meeting on NCDs, and since then has disseminated related information through GenSalud and the LACWHN. As a result of advocacy by the PASB and its partners, clear references to gender were incorporated in the 2011 UN Declaration on NCDs.

Future activities will include the launch of awareness-raising campaigns with civil society for Women's Health Day.

Note: The knowledge platform section of Objective 2.3 provides information on other indicators for Objective 3.3 reviewed in the PoA monitoring consultations.

Strategic Area 4: In line with results-based management methodologies, institutionalize gender-responsive policies, as well as monitoring mechanisms that track specific mainstreaming results and evaluate the effectiveness of gender interventions on health outcomes

Objective 4.1
Ensure PAHO's alignment with WHO's approach to monitoring and evaluating gender mainstreaming for developing appropriate capacity-building and gender-analysis strategies based on the results

Baseline/indicator
• Baseline: 2008 WHO Gender Strategy monitoring and evaluation exercise • Indicator: By 2013, results of WHO's evaluation of its Gender Strategy reported to PAHO staff and Executive Committee to help guide the development and implementation of PAHO's gender mainstreaming strategy

Applying WHO Gender Strategy evaluation results. The PASB has been an active partner in activities related to the WHO Monitoring and Evaluation Framework for implementing the WHO Gender Strategy. Compared to WHO headquarters and other WHO Regional Offices, PAHO had the highest staff response rate to the 2009 WHO baseline survey and the highest level of participation in the 2010 WHO Mid-term Gender Assessment.[18] Results of the baseline study[19] were widely disseminated among PASB executives and staff, and taken into consideration in the development of GDR's work plan and indicators. In addition, the WHO monitoring and evaluation instruments were adapted as PASB gender mainstreaming assessment tools.

Objective 4.2
PASB has systems in place for implementing and monitoring the GEP and PoA

Baselines/indicators
Strategies presented to PAHO Governing Bodies • Baseline: Several strategies and action plans presented to PAHO Governing Bodies in 2008, some of which comprised a gender analysis • Indicator: By 2010, all presented strategies and action plans include gender in the situation analysis and differential interventions

[19] Results of the WHO Gender Strategy monitoring and evaluation exercise are available at: http://bit.ly/mainstreaming-who.

Planning and reporting process include gender marker
• Baseline: 2009 analysis of BWP reporting and budgets, using gender marker
• Indicator: By 2013, reporting from all PASB offices on gender marker and budget allocations in BWPs that include gender collaboration strategies, and implementation of national plans for integrating gender in the health sector
• Indicator: By 2013, 75% of BWPs include gender indicators
• Indicator: Director reports to Governing Bodies on progress of PoA implementation in 2011 and 2013

Integrating gender in PAHO policy documents and PASB BWPs. The PASB has developed and implemented gender tools and checklists for reviewing BWPs, CCS, and Governing Body documents and resolutions. These tools, which also measure integration of human rights and cultural diversity, have been included in the organization's operation, planning, and training manuals.

The PASB has developed a mandatory system for indicating the planned products and services that will integrate gender, ethnicity, and human rights. If used properly, this system will allow the PASB to determine budget allocations and construct a gender budget. Unfortunately, six reviews of the BWPs (once in 2009, twice in 2010, twice in 2011, and once for 2012–2013 planning) demonstrate a continued lack of understanding about how to develop clear health outputs that also include a gender component. Additional refinement is required for the BWP system before a gender budget can be developed.

To ensure the integration of gender, diversity, and human rights in PAHO Governing Body documents, various procedures and checklists were included in the training materials and training sessions provided to the document authors. GDR has reviewed every draft of each technical document presented to the Governing Bodies in 2010 and 2011 and shared its recommendations with the authors. Most final documents have included GDR's recommendations, resulting in an improvement in gender mainstreaming in the corresponding policies. GDR is now assisting with the development of the PAHO e-manual to ensure that all policy documents are included.

Objective 4.3
Mechanisms for monitoring Member State advances in implementing the GEP and PoA agreed to and in place at PASB

Indicator
Member States progress in implementing the GEP and PoA
The PASB reports to PAHO Governing Bodies in 2011 and 2013 on Member States' progress in developing, implementing, and monitoring gender equality plans in the health sector

Reporting progress. The Director presented the first progress report on the implementation of the GEP and the PoA at PAHO's 51st Directing Council meeting in 2012. The next report will be presented in 2014.

Objective 4.4
Special gender integration initiatives implemented with the PASB technical areas that bring together the four GEP Strategic Areas — evidence, capacity-building, civil society participation, and evaluation — to increase ownership and demonstrate concrete lessons

Indicator
Special gender mainstreaming programs developed with the PASB technical areas By 2013, GEH and three technical areas will develop innovative programs to include gender; the programs will be funded and evaluated; and lessons learned will be documented and widely disseminated as best practices in gender mainstreaming in health

Collaborations with PASB technical areas focused on integration of gender into varied health programs. GDR has worked with various technical area offices and Country Offices to develop and implement the following gender-sensitivity integration projects:

- With PAHO's Child and Adolescent Health Unit, an assessment of the attitudes and practices of adolescent indigenous girls and boys in four countries/territories regarding sexuality, risk behaviors, and protection related to HIV. Based on the project's results, PASB is developing a course for providers of health services for culturally diverse adolescent women and men.
- With PAHO's Peru Office and colleagues from PAHO's Tuberculosis unit , an innovative study regarding behaviors and access to services among women and men with multi-drug-resistant tuberculosis (MDR-TB). Results were reported in Peru, Argentina, and Canada, and will be published in collaboration with the University of Montreal.
- With PAHO's Nicaragua Office, a study on girls' access and right to physical exercise and sport. Results were presented in Nicaragua at the UN HLM on NCDs, and in Canada.
- With PAHO's Trinidad and Tobago Office and U.S.-Mexico Border Office, a collaboration on a diabetes campaign tailored for both women and men developed by Mexico's MoH. Outcomes of the project include an intervention to integrate gender approaches in the management of diabetes and other NCDs with a strong component of monitoring and evaluation.
- With the Health Information & Analysis Area, a study of the national health information system of Bolivia, an Andean/Canadian gender indicator initiative, and the establishment of RELACSIS (a regional network of health information systems)
- With the Health Systems Strengthening Area, a virtual course on workers' health based on a GDR publication (*The Invisible Economy and Gender Inequalities: the Importance of Measuring and Valuing Unpaid Work*).

OBSTACLES AND RECOMMENDATIONS

The PoA monitoring questionnaire included a section that requested that the Country Offices and Member States report obstacles to integrating gender in health programs and policies at the national level. The most commonly identified obstacles included the following:

- Resistance to change due to adherence to a biomedical and patriarchal model of health
- Lack of political will resulting in insufficient or no designation of funding and training of human resources
- Scarcity of knowledge about best practices and tools that facilitate the exchange of information regarding the integration of gender in health policies, programs, and systems
- Lack of coordination between health managers, stakeholders, and/or sectors and donors that leads to duplication, inefficient use of resources, and unfocused strategies
- Lack of training and indicators that would assist analysis of disaggregated health information with an equity perspective
- Constant rotation of trained health staff, contributing to irregular and scarce availability of trained resources.

Given these challenges, the monitoring questionnaire respondents recommended several ways in which the PASB and GDR could support improved gender mainstreaming at the country level. The most common recommendation was that MoHs clearly position the integration of gender in their national health plans, and the national health plans contain a specific gender policy and PoA that includes indicators, a designated budget, and trained staff. Many countries recommended that the MoH create a coordinating unit to carry out this responsibility. Two countries mentioned that national policies should be aligned with PAHO's GEP and PoA.

Other recommendations from the questionnaire respondents included the following:

- Surveillance systems should be put in place, ideally with the participation of CSOs, to monitor the operations and implementation of the Gender Coordinator and the PoA. One country suggested that achievements related to gender in health be awarded.
- MoHs should coordinate and train networks of focal points at the national and decentralized level to synchronize and reinforce the integration of gender at all levels.
- Regional and national systems for sharing research, advances, and best practices on integrating gender in health should be strengthened and used for training and improving policies.
- Availability and quality of, access to, and capacity for analysis of gender and health data should continue to be improved at the regional, national, and local levels, for use by decision-makers and CSOs, to improve policies, advocacy, and monitoring systems.

- The participation of other sectors, especially CSOs, should be strengthened at all levels, particularly in information exchange, staff training, and monitoring of the GEP and PoA.
- The support of donors should be better coordinated. Some countries identified UN Gender Theme Groups as potential facilitators of donor coordination.
- The GEP should include other important components related to gender equality and health, such as perceptions of masculinity, and male involvement; conciliation between work and care; unpaid health care, and equal compensation of health workers; the participation of women in leadership positions; and sexual harassment policies.

CONCLUSION

The interest of PAHO and its Member States in addressing gender equality in health is demonstrated by their willingness to participate in this monitoring exercise and consult with MoHs and other stakeholders. The results of this monitoring exercise provide a baseline for measuring further progress in implementing the PoA.

The PASB technical areas and PAHO Country Offices, and Member States are in general agreement that understanding the causes of women and men's health disparities requires an equity and social determinant perspective. Yet as noted in many of the PoA questionnaire responses, the greatest challenge to gender integration in health is insufficient political support. Lack of will is reflected in resistance to change and an insufficient investment in gender mainstreaming, training, and staffing.

PASB and country-level guidelines and publications indicate considerable advances have been made in identifying, analyzing, and addressing gender inequalities in health. Yet only three-quarters of the health information produced by PAHO technical areas is disaggregated by sex — despite the inclusion of this requirement in PAHO's GEP — and less than that is analyzed with a gender perspective. Challenges in obtaining, analyzing, and accessing sex-disaggregated health information were also reported by the Member States.

The PoA monitoring exercise also showed that PAHO's contribution to gender mainstreaming varied among countries and was absent in some. Most support for gender integration in health continues to be provided by donors and UN agencies. Country-level respondents report impressive levels of participation by CSOs, as partners in gender mainstreaming, including participation in advisory groups for defining and monitoring health policy. The involvement of CSOs in efforts related to gender and health is largely determined by the Member State's commitment to foster this type of involvement.

Even with these challenges, the results of the PoA monitoring exercise show progress in the implementation of the GEP and PoA. This positive trend can be attributed to former PAHO Director Dr. Mirtes Roses's strong commitment and designation of gender equity as a priority within PAHO. Despite GDR's limited budget, gender equality was given a high political profile at PAHO. With the recent change in PAHO's leadership it is hoped that the legacy in mainstreaming gender at PAHO will continue.

ABBREVIATIONS

BWP	Biennial Work Plan
CAN	Andean Community of Nations (*Comunidad Andina de Naciones*)
CARICOM	Caribbean Community
CCH	Caribbean Cooperation in Health
CCS	Country Cooperation Strategy
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CELADE	Latin American and Caribbean Centre for Demographics
COMMCA	Council of Ministers of Women of Central America (*Consejo de Ministras de la Mujer de Centroamérica y República Dominicana*)
CPC	Caribbean Program Coordination
CSO	Civil society organization
ECC	Barbados and the Eastern Caribbean Countries
FCH	Family and Community Health
FEP	U.S.-Mexico Border Office El Paso, Texas, USA
FONASA	National Health Fund (Chile)
GDR	Gender, Diversity and Human Rights
GEH	Gender, Equality, and Health
GenSalud	Gender and Health Information Gateway (listserv)
GEP	Gender Equality Policy
GFP	Gender Focal Point
GWH	Gender, Women and Health Department (WHO)
HA	Health Information & Analysis
HSD	Health Surveillance and Disease Prevention and Control
HSS	Health Systems Strengthening

IGWG	Internal Gender Working Group
IP	Intervention proposal
ISDEMU	Salvadoran Institute for Women's Development (*Instituto Salvadoreño para el Desarrollo de la Mujer*)
LAC	Latin America and the Caribbean
LACWHN	Latin American and Caribbean Women's Health Network
LGBT	Lesbian, gay, bisexual, and transgender
M&E	Monitoring & Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR	Multi-drug-resistant
MoH	Ministry of Health
MoW	Ministry of Women
NCD	Non-communicable disease
NGO	Nongovernmental organization
OAS	Organization of American States
OCPC	Office of Caribbean Program Coordination
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PASC	Pan American Sanitary Conference
PoA	Plan of Action
PWR	PAHO/WHO Representative
REDLACSIS	Latin American and Caribbean Network for Strengthening Health Information Systems (*Red Latinoamericana y Caribeña para el Fortalecimiento de los Sistemas de Información de Salud*)
REMMA	Network of Women's Ministers of the Andes (*Red de Ministras de la Mujer Andinas*)

RSMLAC	Latin American and Caribbean Women's Health Network (*Red de Salud de las Mujeres Latinoamericanas y el Caribe*)
SAE	Serious Adverse Event
SDE	Sustainable Development and Environmental Health
SRH	Sexual and Reproductive Health
TAG	Technical Advisory Group
TB	Tuberculosis
TC	Technical cooperation
UN	United Nations
UNCSW	United Nations Commission on the Status of Women
UNDAW	United Nations Division on the Status of Women
UNECLAC	United Nations Economic Commission for Latin America and the Caribbean
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VAW	Violence against women
VCGH	Virtual Course on Gender and Health
VCPH	Virtual Campus for Public Health
WHO	World Health Organization

Annex 1: Country Cooperation Strategies (CCS)

Process

1. Development of tools

   a. GDR adapted the PAHO CCS checklist from the WHO instrument used for evaluating CCS as part of the global project for evaluating the implementation of WHO Gender Strategy; WHO checklist used for scoring integration of gender sensitivity (high score, 7–9; medium, 4–6; low, 1–3)
   b. GDR developed guidelines for integrating gender, diversity, and human rights based on WHO guidelines for developing CCS

2. Baseline evaluation of the 14 CCS developed during 2005–2008

3. Evaluation of the 10 CCS developed after 2009

   a. GDR revised and commented on seven CCS
   b. GDR participated in regional Missions to develop CCS, which included:

      - Participating in national discussions and interviews
      - Collecting data
      - Revising the draft documents.

Results

1. CCS developed during 2005–2008

   a. Rating for gender sensitivity

      - None of the 14 CCS categorized as having strongly integrated gender
      - 13 CCS categorized as having a medium score for integrating gender
      - One CCS categorized as having a low score for integrating gender.

   b. Content related to gender sensitivity

      - Thirteen CCS include one or more statements/references to gender equality or gender equity
      - Six CCS mention consultation/partnerships with women's groups
      - Seven CCCs refer to consultation/partnerships with MoWs or Ministries of Gender Affairs
      - Nine CCS recommend the use of sex-disaggregated data
      - Ten CCS use some sex-disaggregated data but only four CCS use sex-disaggregated data consistently
      - Ten CCS sometimes analyze/interpret the differences between women and men's outcomes (i.e., conduct gender analysis of sex-disaggregated data)

- None of the 14 CCS analyze or interpret the differences between women and men's outcomes consistently
- Thirteen CCS specify actions to address gender.

2. CCS developed after 2009

a. Completed steps

- GDR reviewed and provided comments on the CCS of Costa Rica and Ecuador that were incorporated
- GDR participated in five team Missions to develop the CCS of Mexico (2009), Paraguay (2009), Suriname, Uruguay, and El Salvador (2011), and to assist with integration of gender, ethnicity, and human rights

b. Future steps

- All CCS developed since 2009 will be reviewed again using checklists for the next monitoring phase (2012).

Annex 2: Summary of results from surveys of MoHs, the PASB, other UN agencies, and CSOs on the integration of gender equality in health, Americas region, 2011.

Country/ territory	Survey participants[a]	MoH has national gender and health plan	Number of plans/strategies that address gender (specific areas[b])	Has equal opportunity law related to MoH parity staffing	Has national law for gender budgets (specific areas[b])	CSOs participate in budgeting	MoH collaborates with CSOs/ inter-sectoral groups (specific areas[b])	Has observatories on gender/ health	Self-reported support provided by various agencies
Argentina	1	No	3 (1, 3, 4)	No	Yes (1, 3)	Yes	Yes (3, 6)	Yes	Responses focused on sexual and reproductive health (SHR)
Bahamas	2	No	1 (2)	No	–[c]	–	No	No	Technical cooperation (TC) and financial support from PASB
Belize	3	No	5 (1–5)	No	Yes (3)	Yes	No	No	TC from PASB
Bolivia[d,f]	4	No (guide-lines)	6 (1–6)	No	No	Yes	Yes	Yes	TC from PASB on design and implementation of GBV docs
Brazil[d]	2	No (Y, MoWomen)	5 (1–4)	Yes (national plan; national women's	Yes (1)	Yes	Yes (6)	Yes	Collaboration and analysis from UN

				policy)					
Canada[d]	4	Yes	8 (1–8)	Yes	Yes	–	Yes	Yes	No direct support from PASB or UN
Chile [d,f]	2	Yes	7 (1, 3–6)	Yes	Yes	No	Yes	Yes	TC, training, UN, and CSO participation
Colombia[f]	2	Yes	5 (1, 2, 4, 5, 8)	No	Yes	No	Yes	No (but in PASB database)	Support from PASB in documentation and indicators but not publications
Costa Rica	3	Yes (guide-lines)	11 (1, 3, 4, 7, 8)	No	Yes	No	Yes	No	TC and publications
Cuba[e]	4	Yes	13 (1–6, 8)	Yes	No	No	Yes	No	TC, doc, local support
Dominican Republic	2	Yes	2 (1, 3)	No	No	No	Yes	No	TC, publications and training
Ecuador	2	Yes	11 (1, 3–8)	Yes	Yes	Yes	Yes	No	TC communication plan, health information laws/policies
U.S.-Mexico Border[e]	4	Yes	5 (1–5)	Yes (1)	No	No	Yes	Yes	TC VAW studies and observatory, Gender mainstreaming in municipality
El Salvador	3	No	5 (1–5)	Yes	No	No	Yes	Yes	TC, training, pubs
ECC/	4	xx	xx	No	Yes	No	Yes	No	------

OCPC								
Guyana	2		4 (1–4)	Yes	Yes	No	Yes	Yes	TC, training
Guatemala[d]	4	Yes	6 (1, 2, 3, 6–8)	Yes	Yes	Yes	Yes	Yes	TC, health information, guidelines, M&E
Honduras[e]	4	No	11 (1–5, 8)	No	Yes	No	Yes	Yes	TC and $ support
Mexico	2	Yes	4 (1–4)	Yes	Yes	Yes	Yes	Yes	PASB support limited to Best Practices
Nicaragua	2+	No	4 (1, 3, 4)	Yes	No	No	Yes	No	TC, training at national and local levels
Panama	2+	Yes	7 (1–7)	No	No	No	Yes	Yes	TC, health profile collaboration plan with MoH
Paraguay[e]	4+	Yes	7 (1, 3, 4, 5)	Yes	No	Yes	Yes	Yes	TC, training, doc
Peru	3	No	13 (1–8)	Yes	Yes	Yes	Yes	Yes	TC to ministries, training
Suriname	2	No	5 (2, 3, 4, 5, 8)	No	No	No	No	No	TC, training
Trinidad and Tobago	1	No	3 (1, 3, 4)	Yes	No	No	Yes	No	United Nations
Uruguay[d]	4+	Yes	6 (1, 3, 4, 5)	Yes	Yes	Yes	Yes	Yes	TC, M&E model of care
Venezuela	2	Yes	10 (1–8)	Yes	Yes	No	Yes	Yes	TC health information/EPI Bulletin

[a] 1) PASB; 2) PASB and MoH); 3) PASB, MoH, and UN; and 4) PASB, MoH, and CSOs.

[b] 1) VAW; 2) NCDs; 3) SRH; adolescent/maternal mortality; 4) HIV; 5) mental health; 6) gender, general; 7) information systems; and 8) other.
[c] Provided excellent, thorough reports in strategic consultation with representatives of MoH, other sectors, UN (except Canada), and CSOs.
[d] Held participative consultations with representatives of the MoH, other sectors, the UN, and CSOs.
[e] Received minimal financial support from GDR to carry out the consultations.

Annex 2: Summary of response results (continued)

	Guidelines for producing and/or analyzing health information Number, area, and variable disaggregated*				Publications/profiles on health situation analysis Number, by disaggregation (S, A, Eth, geographic area), area and use			
Country/ territory	Number and specific area(s)	Sex	Age	Ethnicity	Production, number by specific area(s)	Advocacy	Planning	Monitoring
Argentina	Yes, 6 (SRH)	Yes	Yes	Yes	Yes, 6 – SEG (VAW, NCD, SRH, HIV)	No	Yes	Yes
Bahamas	------	------	-------	--------	Yes, 1- SA (VAW)	Yes	Yes	No
Belize	Yes, 1 (gender/general)	Yes	Yes	Yes	Yes, 5 – SAE (HIV, mental health)	Yes	Yes	Yes
Bolivia	Yes, 16+	Yes	Yes	Yes	Yes, 3 – SAE (gender)	Yes	Yes	Yes
Brazil	Yes, 2 (health information/black people, LGBTI)	Yes	No	Yes	Yes, 5 SAE (health situation 2005-2009 not include gender analysis)	-----	Yes	Yes
Canada	Yes, 6 (gender analysis tools that use most relevant gender variables)	Yes	------ Not ticked but included	------- Not ticked but included	Yes, 5 (sex included in some; no gender analysis)	-------	Yes	Yes
Chile	Yes, 4 (VAW, SRH, HIV)	Yes	Yes	Yes	Yes, 8 –SA (not all), HIV and gender	Yes	Yes	Yes
Colombia	Yes, 8 (health information, other)	Yes	Yes	Yes	Yes, 5 (VAW, SRH)	Yes	Yes	Yes
Costa Rica	No	-----	-----	-------	Yes, 2, SA (VAW, gender)	Yes	Yes	------
Cuba	Yes, 1 (health information)	Yes	No	No	Yes, 11 (SRH, gender)	No	Yes	Yes
Dominican Republic	Yes, 9 (VAW, SRH/cancer)	Yes	Yes	No	Yes, 5 (SRH, gender)	No	Yes	Yes
Ecuador	Yes, 11 (VAW, SRH, other)	Yes	Yes	No	11 (VAW, SRH)	No	Yes	No
El Salvador	Yes, (SRH, gender,	Yes	Yes	No	Yes, 8 (SRH, HIV, other)	Yes	Yes	Yes

	health information)							
ECC/ OCPC	Yes, 3 (SRH, gender, health information)	Yes	Yes	No	No	-----	----	----
Guyana	------	-------	------	------	Yes 5, (SRH, health information)	Yes	Yes	Yes
Guatemala	Yes, 4 (SRH, gender, health information)	Yes	Yes	Yes	Yes, 6 (NCD, SRH, HIV, health information)	Yes	Yes	Yes
Haiti	------	------	----	-------	----	-------	------	-------
Honduras	Yes, 10 (VAW, SRH, gender, health information, other)	Yes	Yes	Yes	Yes, 14 (VAW, SRH, gender, health information, other)	Yes	Yes	Yes
Jamaica	------	------	-------	------	-------	------	------	------
Mexico	Yes, 8 (VAW, SRH, HIV, gender, other)	Yes	Yes	Yes	Yes, 8+ (VAW, SRH, health information); all include gender analysis	No	Yes	Yes
Nicaragua	Yes, 4 (VAW, NCD, SRH)	Yes	Yes	Yes	Yes, 5 (health information); none include gender analysis	Yes	Yes	Yes
Panama	Yes, 1 (SRH)	Yes	Yes	Yes	Yes, 1 (gender profile)	Yes	Yes	Yes
Paraguay	Yes, 2 (VAW, health information)	Yes	Yes	Yes	Yes, 2 (SRH, mental health)	Yes	Yes	Yes
Peru	Yes, 6 (VAW, SRH, gender, other)	Yes	Yes	Yes	Yes, 20 (VAW, SRH, HIV, gender, health information)	Yes	Yes	Yes
Suriname	------	-----	-----	------	No	-----	-----	-----
Trinidad and Tobago	------	------	------	------	Yes, 7 (health information, gender)	No	Yes	Yes
Uruguay	Yes, 8 (VAW, SRH)	Yes	Yes	No	Yes, 20 (VAW, SRH, gender, health information, other)	-----	Yes	___
U.S./Mexico Border	Yes, 21 (Red Cross, PASB/FCH), (SRH, HIV, EPI)	Yes (most)	Yes (all)	Yes (few)	Yes, 15 (Red Cross, PASB/FCH), (HIV, health information, SRH, MCH,	Yes	Yes	----

					nutrition, immunization)			
Venezuela	Yes, 5 (VAW, SRH)	Yes	Yes	Yes	Yes, 6 (SRH, health information)	Yes	Yes	Yes

* “Yes" means most but not necessarily all guidelines and publications included this variable.

Annex 3: Gender and health virtual course with human rights and cultural diversity perspective

Executive summary

In March 2011, GDR) launched the first edition of the *Virtual Course on Gender and Health (VCGH): in the framework of diversity and human rights*, which is offered through PAHO's VCPH (Virtual Campus for Public Health) and based on the guidelines established by the GEP (2005) and the PoA (2009). This course is a technical cooperation strategy that strengthens the capacity for integration of a gender and equality perspective within the work of inter-sectoral teams and in the health sector of PAHO's Member States.

Duration and content

- The course consisted of 136 contact hours over 19 weeks.
- High-level experts from the Americas and Spain formed the team of six tutors and lecturers. Using a constructivist pedagogical approach, the course was divided into four modules: 1) *Gender conceptual framework*; 2) *Gender equality with a human rights and intercultural approach*; 3) *Sex/gender analysis*; and 4) *Design of policies and programs with a gender, diversity, and human rights–based approach*.
- The course included an overall course outline, module syllabi, four basic lectures, 10 learning resources (video conferences and practice exercises), and a selection of case studies and further readings.

Participants

The course was disseminated to PAHO staff and their MoH colleagues in five priority countries (Bolivia, Guatemala, Honduras, Nicaragua, and Paraguay) to form inter-sectoral teams in each country. Selected participants represented a wide range of actors such as health services, MoHs, Offices of Women's Affairs; NGOs (working with indigenous people, women, sexual diversity, and persons with disabilities); research centers; and universities. Also included were members of regional mechanisms (Council of Ministries of Health in Central America and the Dominican Republic, and Council of Ministers of Women from Central America and the Dominican Republic) and international organizations (IPPF, PAHO/WHO, UNICEF, and USAID). The participants came from various areas of professional training including anthropology, business administration, communications, education, journalism, law, medicine, nursing, program management, psychology, public health, social work, and sociology.

Results

The academic success of this course is demonstrated by the high completion rate (85%) and the participants' final assessment of key aspects of the learning objectives. Of the 65 participants that enrolled in the course, 55 (85%) passed it. Of these 55 participants, 16 (29%) were PAHO staff, 14 (25%) were from the health sector, eight (15%) were from

civil society, eight (15%) were from national offices for women's issues, six (11%) were from academia, and three (5%) were from other international agencies.

Regarding the overall evaluation of the course, it is noteworthy that 94% of the participants considered the lectures and materials to have greatly facilitated their familiarization with the content, and 87% indicated that the activities were conducive to facilitating their learning.

The concepts learned that the participants identified as key contents of the course are (in descending order: steps to perform sex/gender analysis; gender continuum; formulation of gender-sensitive actions; gender and health concepts; and gender and human rights concepts. This demonstrates the relevance of these new topics to the emerging regional agenda on gender and health.

The participants also identified the activities most conducive to learning (in descending order): participation in the forum, development of the intervention proposals (IPs), and reading the core material, as well as the activities and tasks assigned by the tutors, the group work, and the Elluminate[20] sessions.

Follow-up

Once the participants completed the coursework they were invited to join a Practice Community to facilitate the exchange of resources and ideas. The aim is to strengthen the design of the IPs developed during the course, ensure their viability and sustainability, and support the design of a sound monitoring and evaluation system.

Challenges

- The composition of the group was very diverse in terms of participants' profiles and affiliate institutions, providing for a challenging yet beneficial environment. There was also a diverse mix of skill levels in analysis, programming, and written communication.
- Offer more training on the use of Moodle[21] at the beginning of the course to level the playing field
- Increase the availability of VCPH staff to support the use of technology throughout the course.
- The participants also requested continued access to tutoring sessions or more advanced course sessions.

[20] Real-time (synchronous) web conferencing tool.
[21] Modular Object-Oriented Dynamic Learning Environment (free source e-learning software platform).

Annex 4: Gender parity in Pan American Health Organization professional positions at the regional and country level

Exhibit 1 Women as percentage of total grade staff, by grade, total (Headquarters and Country Offices), 2005 and 2011

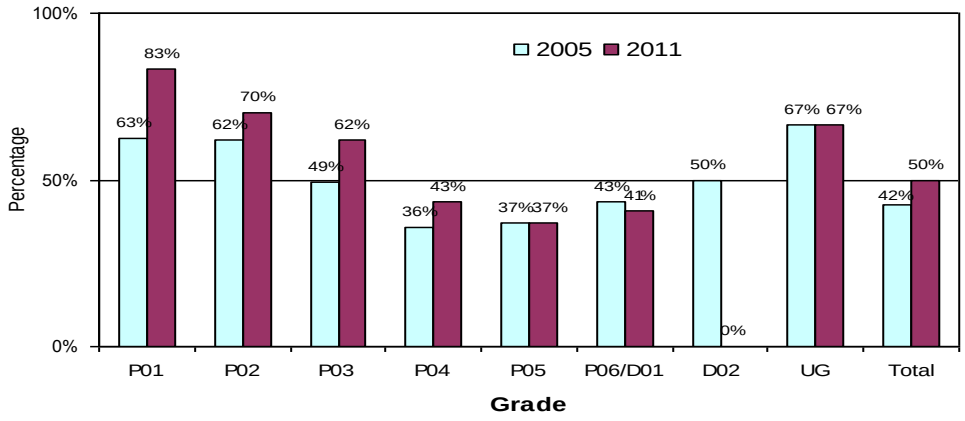


Exhibit 2 Women as percentage of total grade staff, by grade (Headquarters office), 2005 and 2011

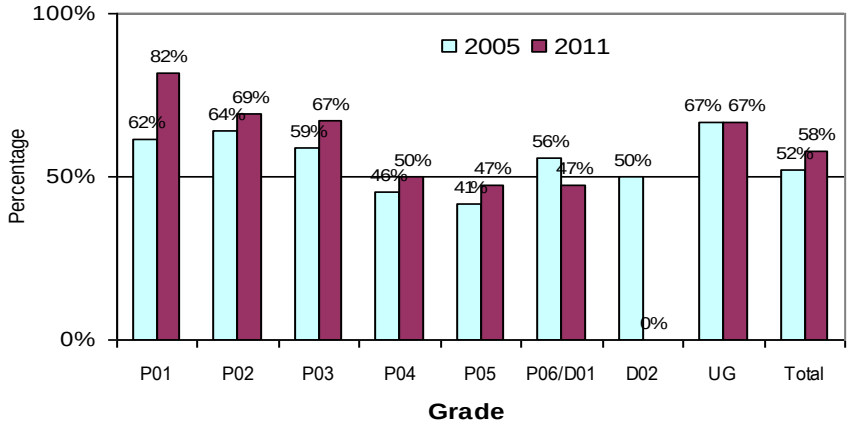
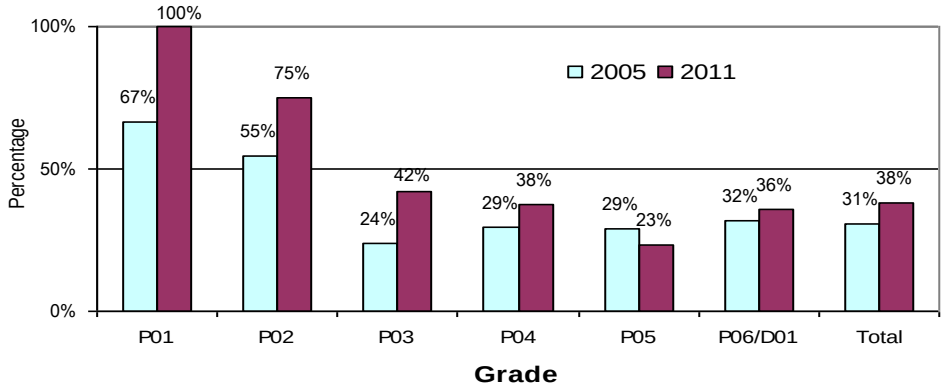


Exhibit 3 Women as percentage of total grade staff, by grade (Country Offices), 2005 and 2011



Annex 5: Pan American Health Organization competition on best practices in gender and health, 2008–2011

From 2008 to 2011, the annual Best Practices Competition received a yearly average of 50 entries from 19 countries/territories. Applications were blind-reviewed by teams of reviewers using the same scoring instrument. Top-score recipients and past Best Practice winners are listed below:

Argentina—2011: ***Promotion of sexual and reproductive health and HIV prevention for adolescents and youth living in marginal areas of Buenos Aires*** **(Fundación Huésped)**

This program was implemented in marginal areas of Buenos Aires to develop an integrated program that actively engaged key youth groups, including HIV-positive youth, those living in poverty, migrants, and indigenous groups. The program was based on qualitative evidence highlighting inequalities between women and men. The program began with the transformation of attitudes and practices to improve the quality of life of women and men by enabling them to exercise their right to sexual and reproductive health. As a result, there was a significant increase in the number of appointments, particularly by boys, as well as in the use of condoms. The project led to the formation of the Network of United Latin American Youth in Response to HIV, which comprises six countries in the Americas and approximately 100 organizations.

Trinidad and Tobago—2011: ***Prevention between discordant heterosexual HIV positive couples*** **(Tobago Health Promotion Clinic, with support from PAHO)**

This program was developed in Tobago to address the needs of discordant heterosexual couples. In the absence of plans to support their needs, this program helped 100 discordant heterosexual HIV-positive couples reduce the number of separations, and the level of domestic violence related to the HIV status, and to train participants in conflict resolution techniques. Those strategies were successful in helping decrease the level of anxiety related to HIV status disclosure, especially when coupled with pregnancy. This program was expanded around the country to include HIV-positive mothers, while obtaining support from local medical practitioners, the community, and some church leaders on issues related to HIV.

Argentina—2010: ***Reducing the risks and dangers in reproductive and sexual health in the context of comprehensive care of adolescents*** **(Agudos Cosme Argerich General Hospital; Foundation for Adolescent Health 2000)**

Developed in Buenos Aires, this initiative responded to the high rates of teen pregnancy, the lack of prevention in sexual and reproductive health, and the number of medical referrals due to induced abortions. It was developed to benefit 15% of migrant adolescents, women, and men. The comprehensive program transformed waiting rooms into workshops that advised teens on sexuality, gender, and rights, and that addressed the daily life situations of adolescents. Results included an increase in the number of offered

workshops, an increase in the number of adolescent boys and girls who participated and sought advice, and a marked decrease in complications related to pregnancy.

Brazil—2010: ***Programs H and M: Engaging young men and empowering young women to promote gender equity and health*** **(Promundo)**

The experience was developed in Rio de Janeiro and aimed to engage low-income youth of that city in critical reflections on the gender norms and their relation with sexual and reproductive health, gender-based violence, and other health issues. The activities included group education and a radio soap opera for youth to address unplanned pregnancy, condom use, and adolescent parenthood. Evaluation impact studies showed that after participating in the program young men showed greater acceptance of domestic work, higher rates of condom use, and lower rates of violence against women.

El Salvador—2010: ***Reducing maternal and neonatal mortality among youth and adolescents*** **(Ministry of Public Health and Social Welfare; PAHO)**

This initiative was implemented in the Nahuizalco municipality to address the great inequalities in maternal and neonatal health among adolescent women. As part of this initiative, several workshops on control and self-care of pregnant women were organized, counting on the participation not only of women but also men. These workshops focused on providing women with the basic knowledge and understanding about human rights, specifically about sexual and reproductive rights. By training health workers from different levels on communication strategies, this experience contributed to improve the quality of health services. Those efforts resulted in improved prenatal controls, and more institutionalized births, as well as a reduced number of infant mortality.

Bolivia—2009: ***Primary health care with a gender approach (Star Health Services)*** **(Ministry of Health and Sports, La Paz Departmental Health Services; PAHO)**

This experience was developed in the urban areas of La Paz as a response to the low level of attention to and participation of women in health care and prevention. Based on a qualitative study, this experience identified key problems in the provision of health services, from the perspective of women and health personnel, and led to the integration of gender considerations in the primary health care structure. Having established a better coordination between women (users of services) and service providers, health services in general were in a better position to provide care with an intercultural and gender perspective. By overcoming the limitations in the services and the barriers in the population, this intervention represents a great contribution to improving the quality of life of those populations in situations of vulnerability.

Brazil—2009: ***Empowering families to face domestic violence*** **(Federal University of Sao Carlos, School Health Unit, Analytical Laboratory of Violence Prevention)**

This program was developed in the police stations of the city of Sao Carlos and started with the setting up of a counseling service for women and victims of violence. This

service provided counseling to parents on strategies to prevent and deal with violence in the families as well as in the communities. By proving counseling to more than 800 beneficiaries of the city, this experience led to a considerable reduction of violent relations as well as more trained staff on early detection and tackling of cases of violence. The success of this experience made it possible to include it as part of the national health system as well as the in the school health units.

Bolivia—2008: ***Building bridges between the community and health services with a gender and intercultural approach*** **(Program for Comprehensive Health Coordination)**

The initiative was developed in Calamarca and Morochata, two rural municipalities in Bolivia. Through its focus on women's empowerment and community participation, and a cultural and gender perspective, it helped reduce maternal and infant mortality. The project demonstrated the possibility of achieving a significant reduction in maternal mortality among indigenous women using a gender and intercultural approach that considers all issues related to access to health services. At the same time, it showed that a gender approach focused on women's empowerment is not an expensive exercise that can be easily implemented in collaboration with community-based and women's organizations. By ensuring the participation of men in this process, it was possible to increase support for the demands and rights of women.

Mexico—2008: ***Incorporation of the gender perspective into the national program for prevention and control of diabetes mellitus*** **(National Center for Gender Equity and Reproductive Health, Secretariat of Health, Mexico)**

This best practice, implemented throughout the country, focused on effective information dissemination and improved methods to manage the differences in the way men and women with diabetes behave, and the way they are affected by the disease. The initiative was part of the national campaign "Men and women are taking measures," which included the dissemination of gender-specific information for men and women users as well as for health personnel, to improve health care coverage for this disease. The experience highlighted the collaborative work of health authorities to achieve the incorporation of a gender equality perspective in health.

Annex 6: Capacity-building for gender-based analysis, 2009–2011

Country/workshop	Date	Participants	Results
National level:			
Chile *Course-workshop on gender equity in health*	August 24–28, 2009	Regional officers from the MoH and directors of health services (all regions) 60 people	Raising awareness among people in leadership positions on gender and health
Bolivia *Analysis of gender in health statistics: helping to reduce inequities in health*	September 14–15, 2009	MoH (various areas from national level and four departments), Police (various units); National Statistics Institute; academia, and civil registry 25 people	Capacity-building for implementation of the collaboration plan
Guatemala *Training course on gender-sensitive statistics, health module*	November 20, 2009	Representatives from the National Office of Statistics, the Presidential Secretariat for Women, and Universidad Rafael Landívar 25 people	Virtual course developed by UN Women; includes health module
Chile *Dialogue on policies to strengthen evidence to benefit women's health using gender and health statistics*	April 4–5, 2011	Representatives of the MoH (statistics and gender); National Secretariat of Women; Gender Equity Observatory of the Mapuche People; Human Rights Institute; INE; ECLAC; CELADE; Superintendent of Health, School of Public Health, FONASA; and Center for Women's Studies 30 people	Opportunity for continuing work on the collection of data disaggregated by sex, ethnic villages, age, and other variables, and the mechanisms for sharing this information
Guatemala *Analysis of gender and ethnicity in health statistics*	June 27–28, 2011	Various areas of MINSA (MoH), representatives from INE, academia, Presidential Secretariat for Women, RSMLAC, Observatory on Reproductive Health, and	Improved capacities for aligning the gender plan for the health sector with the national strategy on health systems

		civil society (*Instancia por la Salud y el Desarrollo de las Mujeres*) 25 people	and services, where gender and multiculturalism are cross-cutting
Paraguay *Analysis of gender and ethnicity in health statistics*	November 14–15, 2011	Representatives from the health sector, women's groups, national statistics offices, and civil society 20 people	Collaboration plan in process. Agreement on the development of a national profile for gender and health
International level: Andean countries *Gender and health: indicators and analysis*	October 14–16, 2009	Bolivia, Chile, Colombia, Ecuador, Peru, Venezuela Representatives from public health ministries, NWMs, statistics offices, and other institutions (Bolivian police, Chile's MIDEPLAN [Ministry of Planning and Cooperation]). Also includes participants from most focal points of Andean country GDR and HA, and one representative each from WHO/Gender, Women, and Health, and CAN (Andean Community of Nations) 40 people	National working groups involved in defining gender and health indicators for the Andean countries. Basic consensus on gender and health indicators for the Andean countries; coordination of this and other initiatives that involve CAN
Mercosur countries *Workshop on health indicators with a focus on gender*	November 16–17, 2011	Argentina, Brazil, Paraguay, Uruguay Representatives from the health sector, civil society, and statistics offices from Mercosur entities 40 people	Basic indicators discussed and selected for review in national workshops

PASB acknowledges the contributions and transparency of all countries and technical staff in the process to monitor their advances in gender equality in health.

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