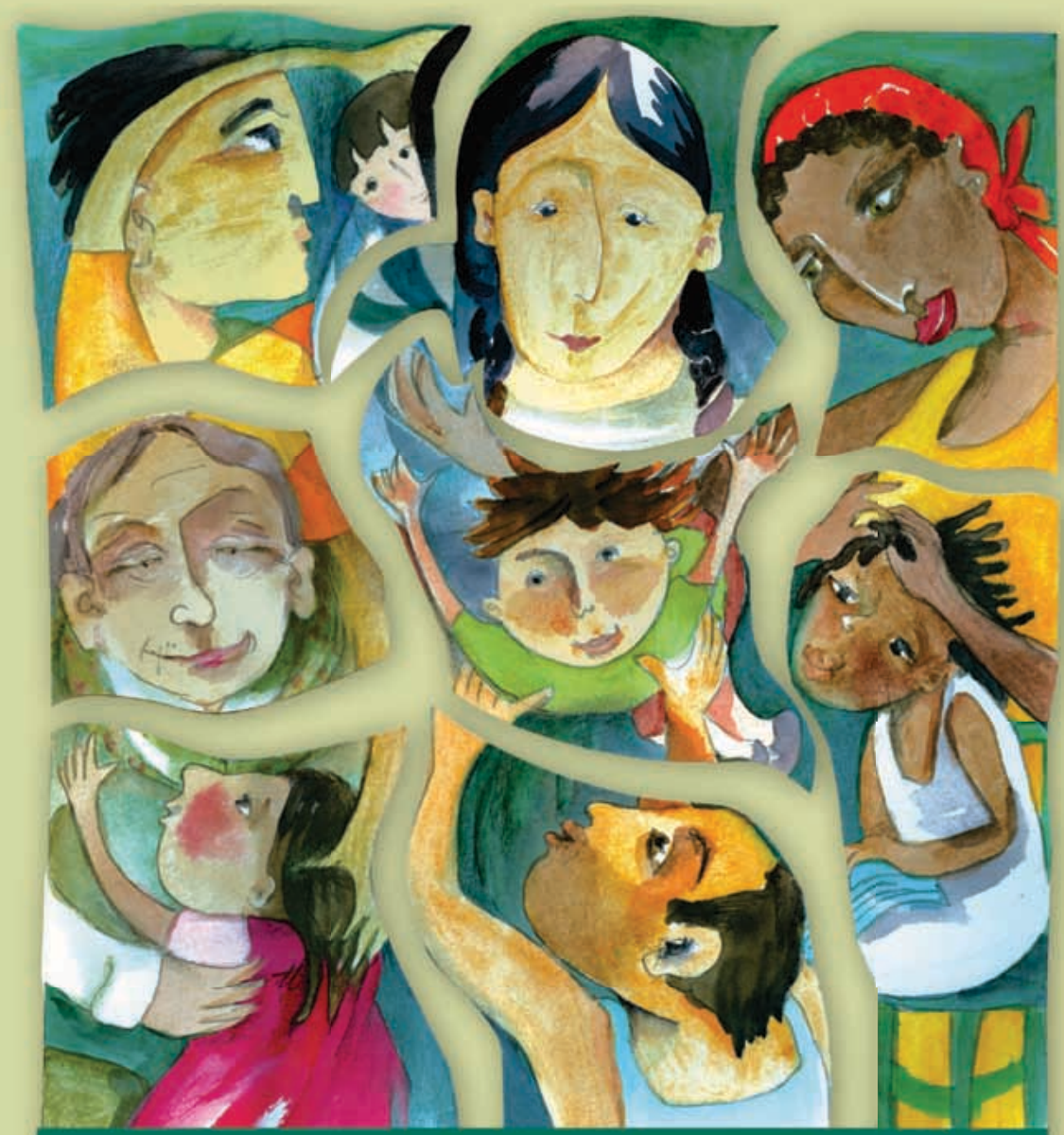

HEALTH OF WOMEN AND MEN IN THE AMERICAS

PROFILE 2009

Pan American Health Organization
Regional office of the World Health Organization

United Nations ECLAC

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Pan American Health Organization

Regional Office of the
World Health Organization

Gender, Ethnicity, and Health Office
Health Information and Analysis Project
Regional Health Program of Indigenous Peoples of the Americas

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Note to Readers

Whenever possible, this document has included a breakdown by sex of health-related indicators for people of different ethnic origins (including indigenous and Afro-descendent populations).

The statistical annex to this document includes tables with data supporting a number of the figures contained in this profile.

Cover illustration: Lápiz y Papel

C o n t e n t

PREFACE

The development of a health profile of women and men in the Americas reflects the commitment of the Pan American Health Organization (PAHO) and other sister organizations of the United Nations system to shed light on the inequalities between women and men vis-à-vis resources and power, and to show how these inequalities affect state of health, access to health services, and contribution to health care.

It is important to have quantitative and qualitative information that will make it possible to examine the roots of the health differences between social groups and the mechanisms in place for identifying the causes that give rise to inequities in health, and to define where and how to intervene in order to close the gap. This is a priority that was identified in the Health Agenda for the Americas 2008-2017. Policies that are based on information about gender-based inequalities and how these inequalities overlap other determining social factors will be more equitable, inclusive, efficient, and effective. In order to ensure fulfillment of the commitments made by the United Nations Member States, it will be necessary to measure attainment of the goals more specifically in terms of data disaggregated by sex, age, area of residence, ethnic origin, and other pertinent variables. This will make it possible to analyze the information from a perspective of gender equality and ethnic equity and to apply this knowledge to policy decisions and the actions of other organized groups of society.

The information presented in this document shows that inequalities persist throughout the entire Region of the Americas—and that they are more profound in the most vulnerable groups. Despite gaps in the information available, this profile points up the areas in which health inequalities between women and men are evident, especially in terms of a number of priorities set in the Program of Action of the International Conference on Population and Development (Cairo, 1994), the Platform for Action of the Fourth World Conference on Women (Beijing, 1995), the Millennium Development Goals (2001), and the PAHO Gender Equality Policy (2005).

PAHO—in collaboration with the Economic Commission for Latin America and the Caribbean (ECLAC), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Development Fund for Women (UNIFEM), and the United Nations International Research and Training Institute for the Advancement of Women (INSTRAW)—is pleased to place this publication at the disposal of governments, civil society, universities, and cooperation agencies, and we hope that it will contribute to the achievement of better health for all people in the Region of the Americas.

Mirta Roses Periago
Director

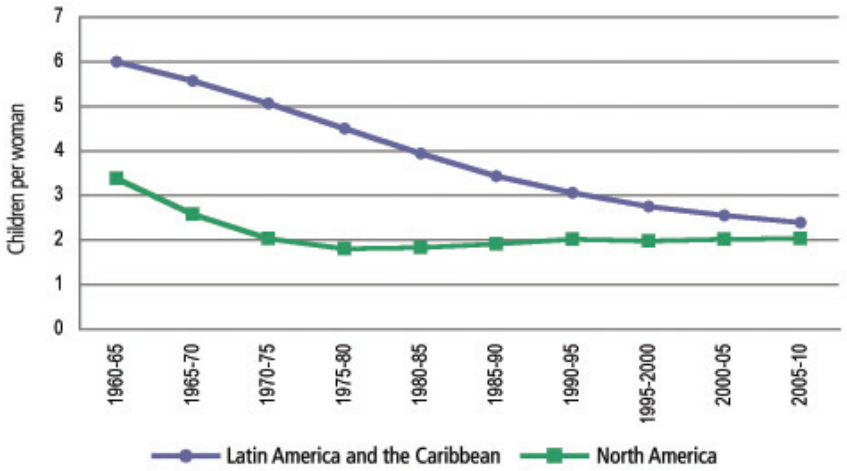
I. DEMOGRAPHIC CONTEXT

At the beginning of the twenty-first century the demographic situation in the American Hemisphere is in a state of transition, with slow population growth and low fertility rates, declining mortality, and rapid urban growth. However, these general trends conceal significant differences between and within the countries—difference that are associated with profound socioeconomic inequalities.

According to United Nations estimates, in 2010 the population of the Americas will be 2.2 times greater than it was in 1960, up from 424 million inhabitants in 1960 to 942 million in 2010. Of the latter number, 594 million live in Latin America and the Caribbean and 348 million in North America. Despite this increase, the population growth rate has declined significantly in the last 30 years in Latin America and the Caribbean, from an annual average of 2.7% in the middle of the twentieth century, to approximately 1.5% today, ranging from 0.3% in Cuba to 2.5% in Honduras (*1*).

By the end of 2005, fertility rates were down and mortality was stable in most of the countries. In terms of population growth, the Region was in full demographic transition. Total fertility rates (TFR) for Latin America and the Caribbean, which had been among the highest in the world 40 years earlier, had declined impressively, and today they are close to levels seen in North America (Figure 1). Nevertheless, significant differences continue to exist between countries: for example, in 2008 the TFR in the Region ranged from 4.1 in Guatemala and 1.5 in Barbados, Canada, and Cuba (*2*).

Figure 1. **Total fertility rate, North America and Latin America and the Caribbean, by five-year periods. 1960-1965 to 2005-2010**

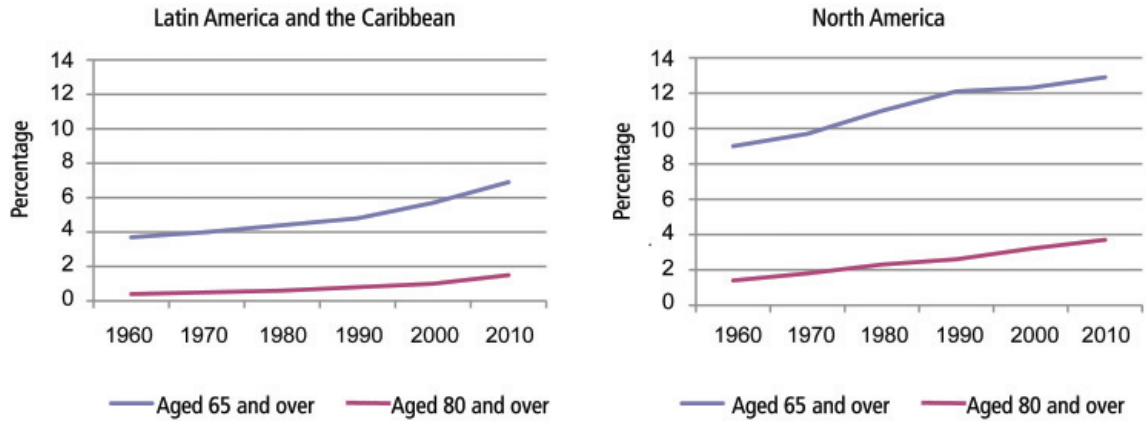


Source: United Nations Population Division. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp/. Accessed on 29 August 2008.

In 2008, 79.7% of the population of the Region of the Americas as a whole resided in urban areas. In North America that proportion was 81.6% and in Latin America and the Caribbean it was 78.4%. More detailed disaggregated data for Latin America and the Caribbean shows the following percentages in descending order: Southern Cone, 88.1%; Brazil, 85.6%; Mexico, 77.2%; Andean Area, 76.4%; Latin Caribbean, 69.1%; Central American Isthmus, 55.2%; and Non-Latin Caribbean, 46.2% (*3*).

As a result of the changes in fertility, mortality, and life expectancy at birth, the distribution of the population has undergone major shifts in terms of the relative weight of the age groups, since the growth rates for each group are different. Take, for example, the aging of the population—i.e., the increase of the proportion of the population over 65 years of age: the characteristics of aging in North America are quite different from the trends in Latin America and the Caribbean (Figure 2).

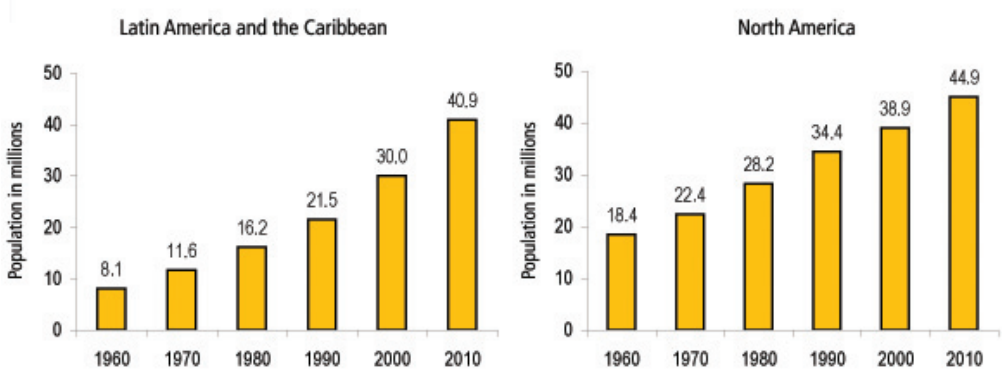
Figure 2. **Population aged 65 and over and 80 and over as a proportion of total population, Latin America and the Caribbean and North America, 1960 to 2010**



Source: United Nations Population Division. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp/. Accessed on 5 February 2009.

Although in absolute numbers the size of the population aged 65 and over in North America is larger than its counterpart in Latin America and the Caribbean (Figure 2), this age group is growing faster in the latter subregion. In fact, the number of inhabitants aged 65 and over in Latin America and the Caribbean almost quadrupled between 1960 and 2000, and it will have quintupled by 2010. By contrast, the population aged 65 and over in North America merely doubled (by a factor of 2.1) between 1960 and 2000, and it will be 2.4 times larger in 2010 (Figure 3).

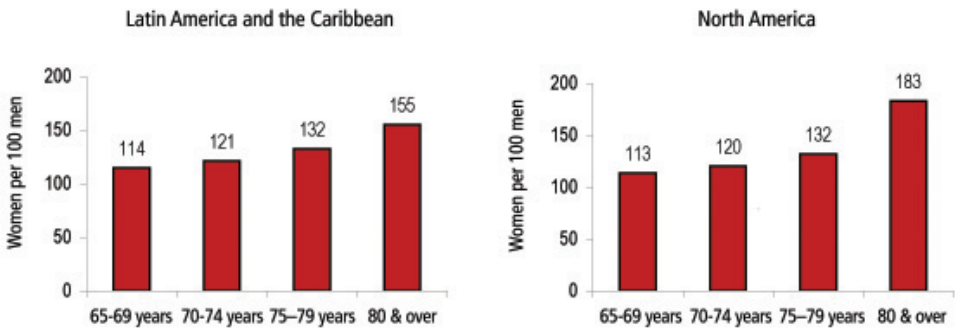
Figure 3. **Population aged 65 and over (in millions) in Latin America and the Caribbean and in North America, 1960 to 2010**



Source: United Nations Population Division. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp/. Accessed on 5 February 2009.

Since life expectancy at birth is higher for women than it is for men, women represent the largest proportion of adults aged 65 and over (Figure 4). Both in Latin America and the Caribbean and in North America, that difference increases with age, reaching a ratio of 2 women for every man in the population aged 80 and over in North America.

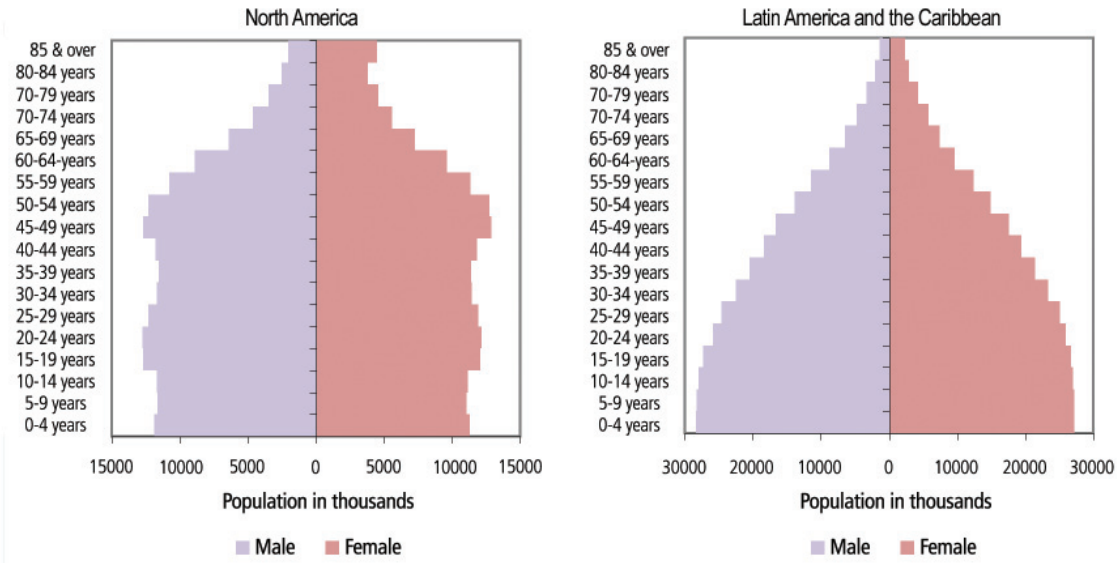
Figure 4. **Estimated number of women per 100 men, population aged 65 and over, by age group, Latin America and the Caribbean and North America, 2010**



Source: United Nations Population Division. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp/. Accessed on 5 February 2009.

A notable difference between the population of North America and that of Latin America and the Caribbean is the distribution by sex and age, which for 2010 is reflected in a relatively triangular shape for Latin America and the Caribbean compared with a more rectangular shape for North America (Figure 5), reflecting the younger population in the first-mentioned subregion. It is also noted that women make up approximately 51% of the total population of the Americas, but the proportion of males is smaller in the younger age brackets. Since more boys are born than girls (approximately 105 per 100), males predominate up to the age of 40 in North America, but only up to age 19 in Latin America and the Caribbean. This difference between the regions could be due to greater exposure to fatal risks (for example, violence, accidents) among young adult men in Latin America and the Caribbean.

Figure 5. **Population of North America and Latin America and the Caribbean (in thousands) by age and sex, 2010**



Source: United Nations Population Division. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp/. Accessed on 14 February 2009.

The rapid increase in the over-60 population and the predominance of women in that age group point to the urgent need for equity and sound social protection systems, both for the population receiving the benefits and for the providers of health care services. Gender considerations are fundamental in this age group. Due to their greater longevity, disabilities, and lack of social protection, women are more vulnerable both physically and economically. In short, with families having fewer children and the older adult population increasing, steps should be taken to readjust resources to meet the demands of this new distribution of the population. Such action should take into account the challenges posed by poverty indexes and limited social security coverage.

The next chapter will show how women are disproportionately excluded from social security systems in both the short and long term because these schemes are tied to remunerated employment. As a result, women at the end of life have less access to, and receive significantly less protection than men. Moreover, the sustainability of elder care, which historically has been part of the unpaid care that women provide in the home, is seriously threatened because of the growing integration of women into the paid workforce outside the home. This reduction in the supply of unpaid care is inversely proportional to the increase in the demand for health care associated with an aging population and the higher prevalence of chronic diseases characteristic of longevity.

II. SOCIOECONOMIC CONTEXT

The definition of health as a *state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity* (*4*) means that it is not an exclusive responsibility of the health sector. Furthermore, the World Health Organization (WHO) has demonstrated that there are social factors that have profound effects on the health of individuals and the community (*5*).

Traditionally, income and education have been considered determinants of the health of populations. Today gender, ethnic origin, and sexual orientation are also recognized as social factors that generate differences in exposure and risk, which in turn compromise the health status of men and women at every stage of life (*6*). In addition, gender interacts with other social determinants of health, including economic inequality and ethnic or racial hierarchy.

In general, women have less access to resources to support them in the development of their capabilities. They also have fewer opportunities in the form of housing, land ownership, work with decent remuneration, income, and participation in policy- and decision-making. This chapter shows that women's progress in education and access to the labor market do not go hand-in-hand with other opportunities. For example, larger proportions of women have poorly paid informal occupations and less access to insurance plans, and unemployment affects women in most countries. At the same time, in almost all societies women carry a greater unpaid workload in the form of care for other people in their own home and in the community, and their contribution to human development goes unrecognized and unvalued.

In order to respond to the specific health needs of women and men, it is fundamental to understand the interaction between their biological differences, as well as the inequalities in gender roles and standards in specific contexts. [1]

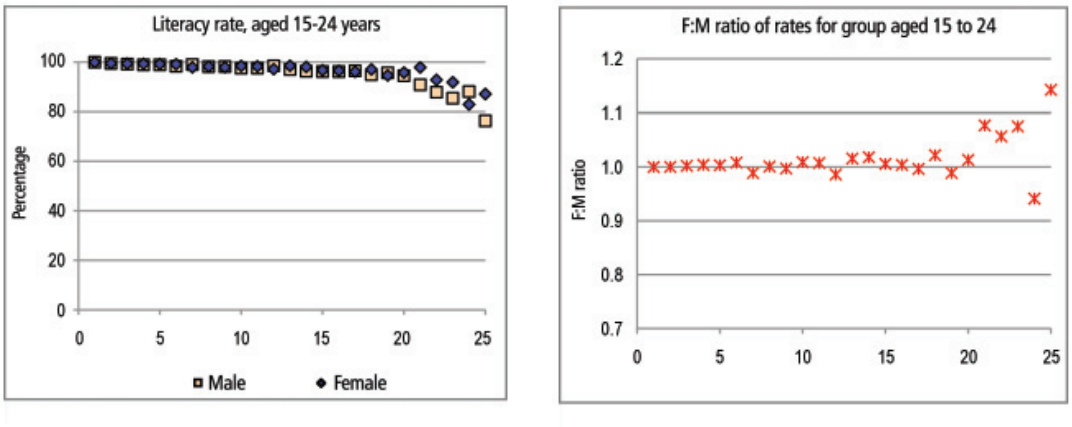
EDUCATION

Education is essential for achieving gender equality and empowerment of women, a fact that was recognized by the Member States of the United Nations when it was included as one of the indicators for the attainment of Goal 3 of the Millennium Development Goals.

The literacy rate of the young population reflects the progress that has been made in education. In 2007 the literacy rate for the population aged 15 to 24, both sexes, was between 82% and 100% in the group of 25 countries Latin American and Caribbean countries studied (Figure 6). The lowest rates were in Haiti, Guatemala, Nicaragua, and Honduras, in that order, both for men and women. Among women the lowest rate was 83% and among men, 76%. In 20 countries the literacy rate for women and men was almost equal (female:male ratio close to 1), even in cases where the literacy rate for both sexes was low. However, in the five countries with the lowest literacy rates for both sexes, the female:male ratio tends to be unequal; this indicator shows an advantage for women in Jamaica, Honduras, Nicaragua, and Haiti (a ratio of >1), but in Guatemala women continue to be at a disadvantage.

[1] Because the data are collected for men and women, the indicators are presented for these two groups, while recognizing that there are additional groups that do not conform to with these categories.

Figure 6. **Literacy rates for women and men aged 15 to 24 and female:male ratio, 25 countries of the Americas, 2007**



Countries			
1 Cuba	8 Netherlands Antilles	15 Ecuador	22 Honduras
2 Trinidad and Tobago	9 Mexico	16 Paraguay	23 Nicaragua
3 Aruba	10 Costa Rica	17 Panama	24 Guatemala
4 Argentina	11 Colombia	18 Dominican Republic	25 Haiti
5 Chile	12 Peru	19 Suriname	
6 Uruguay	13 Brazil	20 El Salvador	
7 Bolivia	14 Venezuela (1991 data)	21 Jamaica	

Note: Countries in descending order of % for both sexes combined.
Source: http://www.uis.unesco.org. Accessed on 29 September 2008.

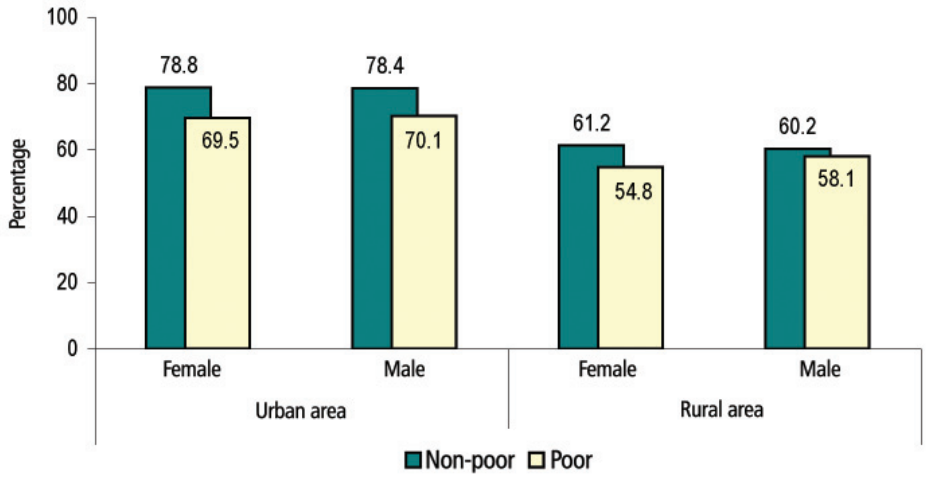
The gaps in access to education that have favored men in the past are now much narrower, and in some countries the balance has shifted in favor of women. With each higher rung on the educational ladder, enrollment declines drastically for both females and males and the female:male ratio rises. In 2005 the gross enrollment rate[2] for both sexes was 117.5% for primary education (35 countries), 87.6% for secondary education (35 countries), and 30.1% for tertiary education (18 countries) (*7*). The female:male enrollment ratio favors women mainly in tertiary education.

However, the apparent equality in the national averages conceals sizeable differences between different population groups within the countries. The poorest, indigenous, and Afro-descendent populations, especially the women in those groups, do not have the same opportunities to access education or the possibility of completing academic programs that will open doors to a better future.

In Latin America the school attendance rate for the poor population aged 13 to 19 (Figure 7) is lower than the rate for non-poor groups the same age, especially in rural areas, where they are at the greatest disadvantage. An analysis of illiteracy rates for indigenous populations in five countries of the Region (Bolivia, Brazil, Ecuador, Guatemala, and Panama) shows that these rates are higher for females than their male peers (Figure 8).

[2] Gross enrollment rate: students enrolled at each educational level, regardless of their age, as a proportion of the population in the theoretical age group for that level of education.

Figure 7. **Population aged 13 to 19 enrolled in school (%), by sex and poverty status, Latin America,[a] circa 2002**

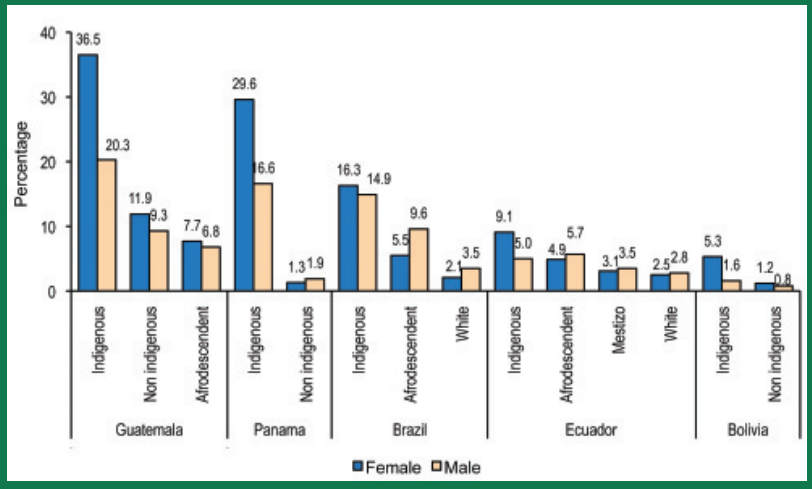


[a] Average for urban areas in Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru and Uruguay. Average for rural areas includes data from Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, and Peru.
Source: ECLAC. Cuaderno No. 92. Estadísticas para la equidad de género: magnitudes y tendencias en América Latina. Santiago, 2007.

Maybe women like me can also be like men: it's just that we haven't been to school and things like that.

Women from the 16 de Julio Health Area, El Alto, Bolivia
Source: PAHO. Winning experience in the Best Practices Competition 2009.
Bolivia: Gender-focused Primary Health Care ("Estrella" Health Services).

Figure 8. **Illiteracy rate in the population aged 15 to 24 (%), by sex and ethnic origin, five countries of Latin America, circa 2000**



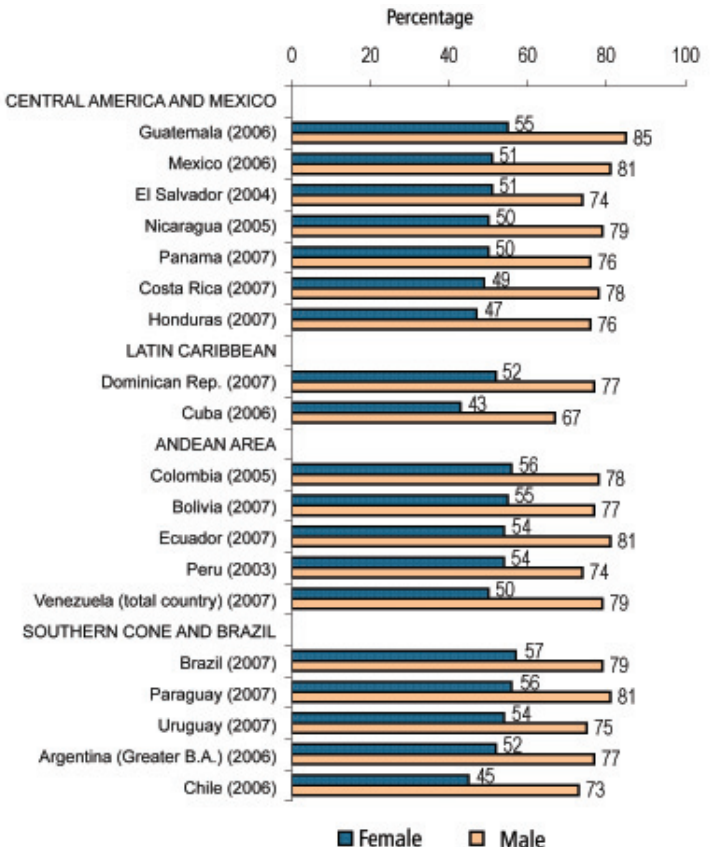
Source: ECLAC. Cuaderno No. 92. Estadísticas para la equidad de género: magnitudes y tendencias en América Latina. Santiago, 2007.

WORK AND INCOME

According to the traditional division of labor, men have assumed the main responsibility of working at a paid job while women do unpaid work in the household and the community. Because of the domestic role that society has assigned to women, the work women do, both paid and unpaid, is given less value.

Although women are being integrated into the labor market at a growing pace, there has been no substantial change in the distribution of domestic responsibilities between women and men. The premise has been that women are responsible for doing most of the work in the home, which limits their time and availability to participate in the labor market. Furthermore, when women do join the workforce, they tend to choose more flexible jobs that offer fewer opportunities to improve their income and do not provide the social security benefits associated with formal employment. The proportion of women in the labor market has been rising significantly in recent decades. Their rate of participation in economic activity, estimated as the weighted average for urban areas in 18 countries, rose from 43.0% in 1990 to 54.2% in 2006, while the rate of male participation has remained almost constant (79.8% in 1990 and 78.9% in 2006) (*8*). However, despite the increases, female participation in the workforce was still 25 points lower than the proportion of males in the urban areas analyzed. In 2007, women's participation in the labor market ranged between 50% and 60% in the urban areas of 15 of the 19 countries for which information was available; the four exceptions were Chile, Costa Rica, Cuba, and Honduras, with rates of 45%, 49%, 43%, and 47%, respectively (Figure 9). Men, on the other hand, had at least 70% participation in all the countries except Cuba. The largest proportion was 85% in Guatemala.

Figure 9. **Economic activity rates (%), by sex, urban areas of 19 countries of the Americas, circa 2007**

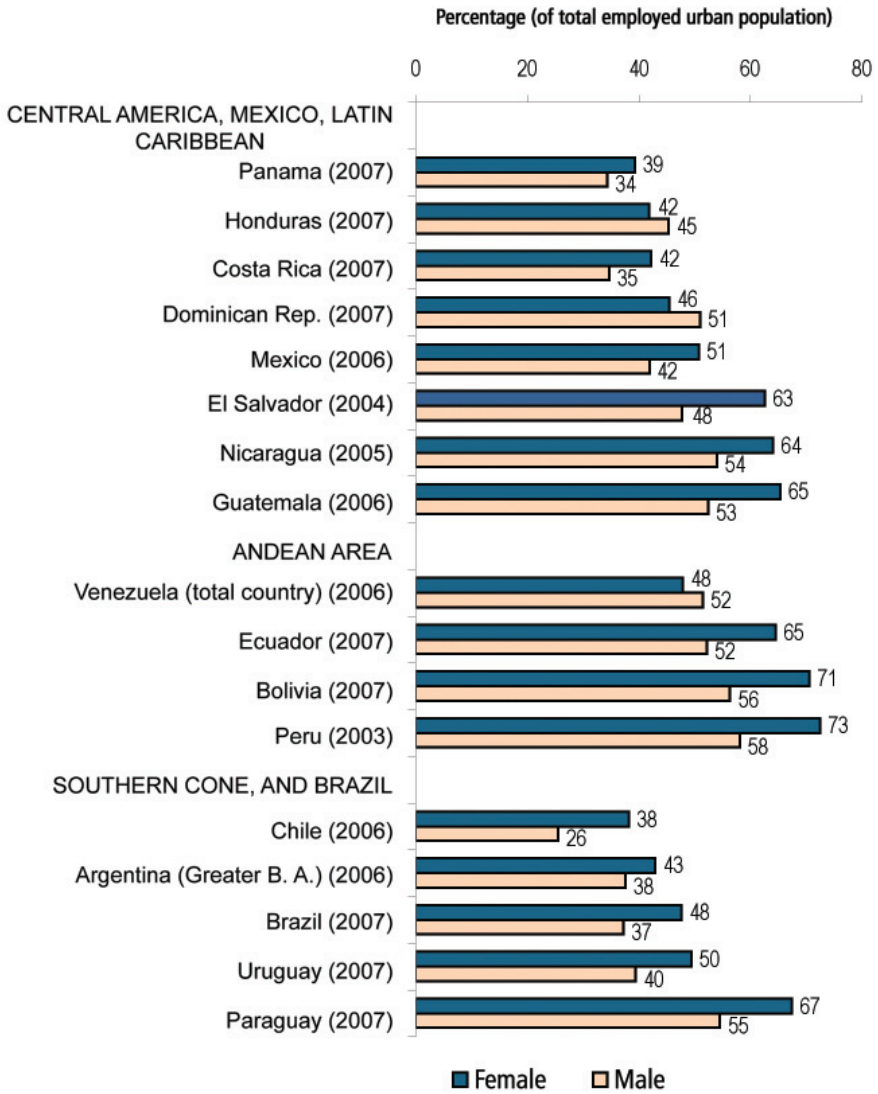


Note: Within each subregion the countries are shown in descending order of female rates.
Source: ECLAC. Social Panorama of Latin America 2008. Statistical Annex.

Employment in Low-Productivity Sectors

A high percentage of the employed urban population continues to work in low-productivity sectors, usually without access to social security or retirement. As of 2006 or thereabouts, 57% of women and 49% of men were working in low-productivity sectors in the group of 17 Latin American countries for which information was available. These figures were somewhat lower than for 1990, when they stood at 60% for women and 53% for men (*8*). As shown in Figure 10, in 14 of the 17 countries the percentage of women employed in low-productivity sectors was higher than it was for men. In seven countries, 60% to 80% of employed women were working in low-productivity sectors. On the other hand, none of the countries had more than the 60% of employed men working in these sectors.

Figure 10. **Urban population employed in low-productivity sectors (%), by sex, 17 countries of the Americas, circa 2007**

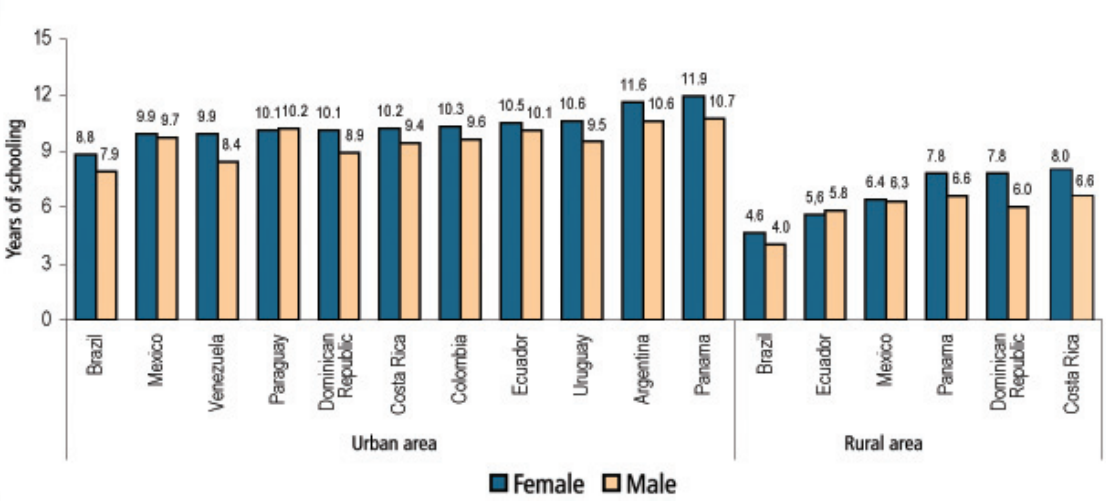


Note: Within each subregion the countries are shown in ascending order of female rates.
Source: ECLAC. Social Panorama of Latin America 2008. Statistical Annex.

Years of Schooling of the Economically Active Population

In both urban and rural areas, women participating in the labor market were found to have more years of schooling than their male peers with only two exceptions: the urban area of Paraguay and the rural area of Ecuador, where men on average have had slightly more years of schooling than women (Figure 11).

Figure 11. **Average years of schooling of the economically active population aged 15 and over, by sex, Latin America, 2005**

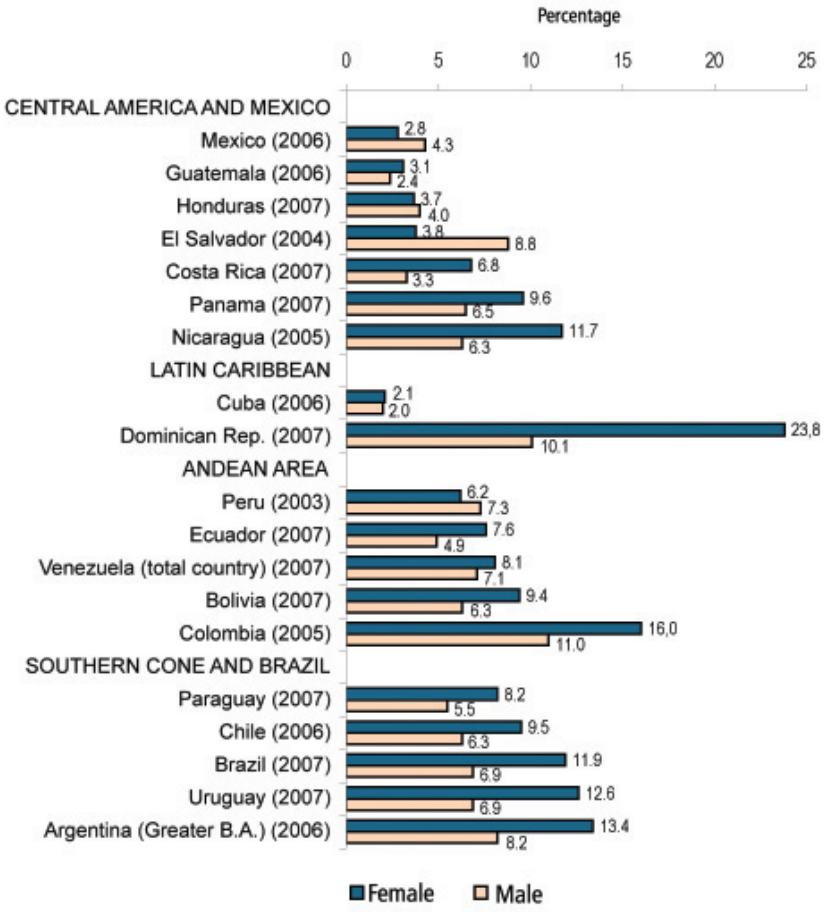


Note: Within each area of residence the countries are shown in ascending order by women's number of years of schooling.
Source: ECLAC, http://www.eclac.cl/mujer/. Accessed on 26 March 2009.

Unemployment

In urban areas the unemployment rate was on average higher for women. In 18 countries female unemployment rose 51% between 1990 and 2006 (from 6.9% to 10.4%), while male unemployment increased only 22% (from 5.8% in 1990 to 7.1% in 2006) (*8*). Although women's participation in the labor market is smaller, their open unemployment rate was higher in 15 of the 19 countries for which information is available (Figure 12). The widest gap between men and women was in the Dominican Republic, where in 2007 the unemployment rate was 10% for men and 24% for women. In the four countries that had higher male unemployment, the difference between the sexes was low except in El Salvador, where unemployment was 9% for men and 4% for women. In Cuba, which had the lowest rates of participation in the workforce, i.e., 43% for women and 67% for men (Figure 9), open unemployment for both women and men was 2%.

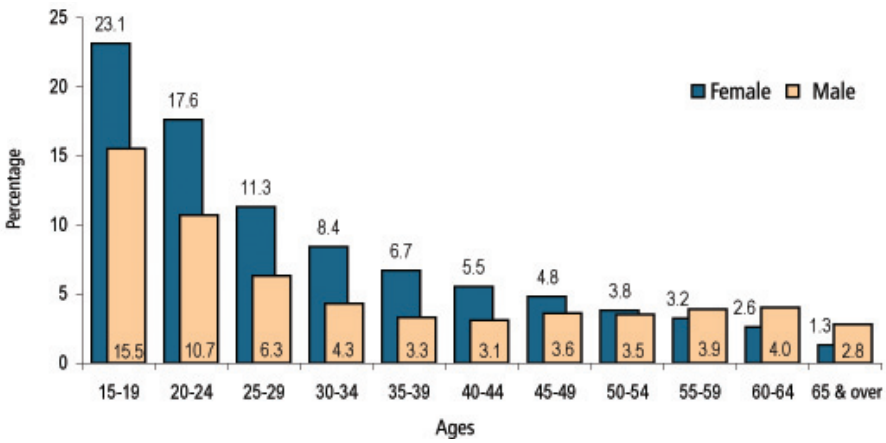
Figure 12. **Open unemployment rates (%), by sex, 19 countries of the Americas, circa 2007**



Note: Within each subregion the countries are shown in ascending order of women's unemployment rate.
Source: ECLAC. Social Panorama of Latin America 2008. Statistical Annex.

Figure 13 shows that in Latin America unemployment affects women more than men throughout most of their productive life. The highest unemployment rates are seen in the group aged 15 to 19, in which 23% of women and 16% men are unemployed.

Figure 13. **Unemployment rates (%), by sex and age group, 11 countries of the Americas, circa 2006**



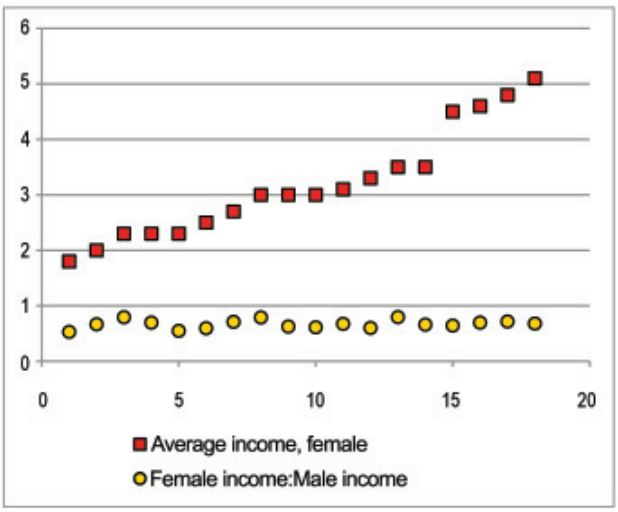
Source: ECLAC. Social Panorama of Latin America 2008.

Remuneration for Work

Gender-based inequality in the insertion of women in the labor market is also reflected in their pay, which is always lower than what men receive. In 18 countries of the Region the weighted average income and wages of employed women in urban areas was 64% of the amount received by men, ranging from a low of 53% in Guatemala to a high of 79% in Venezuela (*8*).

Figure 14 points out major differences between countries with respect to the average income of an employed urban woman, measured in multiples of the per capita poverty line in the respective countries. The highest values were recorded in Chile, Panama, Costa Rica, and Argentina (Greater Buenos Aires), in that order.

Figure 14. **Average income of employed women and female:male ratio of average income,[a] urban areas in 18 countries of the Americas, circa 2007**

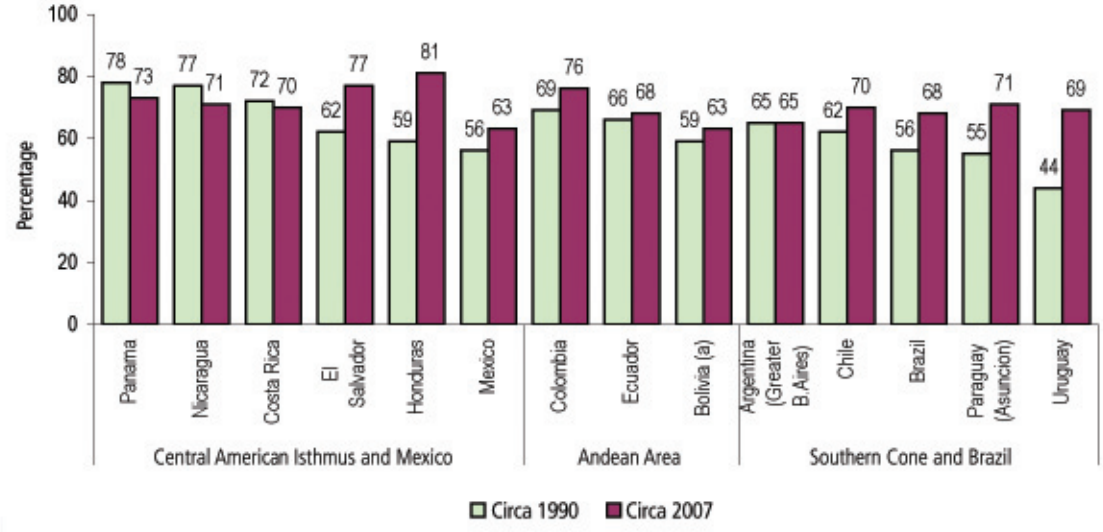


	Countries
1	Peru (2003)
2	Paraguay (2007)
3	Honduras (2007)
4	Nicaragua (2005)
5	Guatemala (2006)
6	Bolivia (2007)
7	Colombia (2005)
8	El Salvador (2004)
9	Ecuador (2007)
10	Mexico (2006)
11	Uruguay (2007)
12	Dominican Republic (2007)
13	Venezuela (total country) (2007)
14	Brazil (2007)
15	Argentina (Greater B.A.) (2006)
16	Costa Rica (2007)
17	Panama (2007)
18	Chile (2006)

[a] Average income expressed in multiples of the per capita poverty line in the respective countries.
Note: The countries are shown in ascending order of average female income.
Source: ECLAC. Social Panorama of Latin America 2008. Statistical Annex.

Between 1990 and 2007, the ratio of women's income relative to that of men improved in the urban areas of 10 of the 14 countries for which information was available (Figure 15); in Argentina (Greater Buenos Aires) the ratio remained unchanged; and in Nicaragua, Panama, and Costa Rica women's income declined compared to men. The narrowest gap (circa 2007) was in Honduras, where the average female income represented 81% of the comparable figure for men.

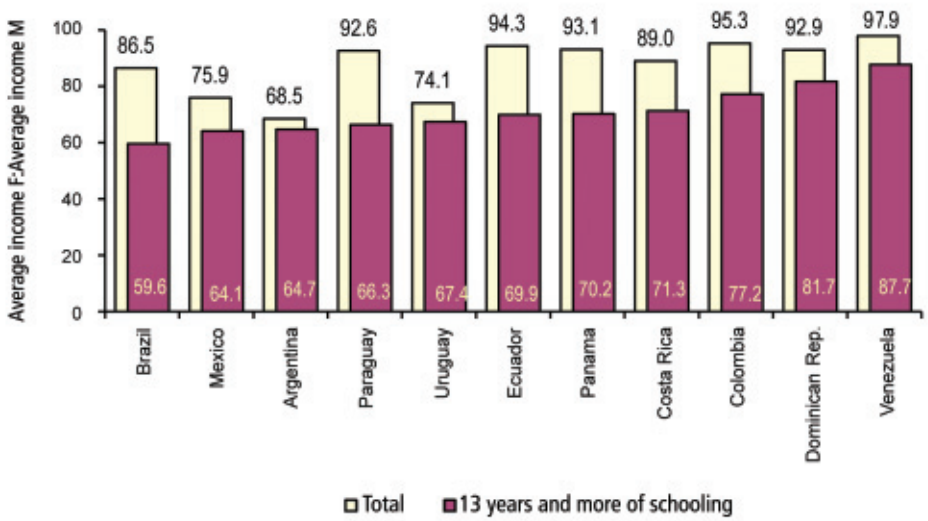
Figure 15. **Trend in average income of women as a percentage of average income of men, urban areas in 14 countries of the Americas, circa 1990 and 2007**



(a) Figure for Bolivia includes eight departmental capitals and El Alto.
Note: Within each subregion the countries are shown in descending order of percentage of average income in 1990.
Source: ECLAC. Social Panorama of Latin America 2008. Statistical Annex.

In terms of earned income only, the inequality gap has been getting wider in the Region, even though the educational status of women has risen. The salary gaps between women and men who have 13 or more years of schooling were greater than the total gap for all women in the countries. The largest difference was in Brazil (Figure 16).

Figure 16. **Difference between average income of salaried women and men, by years of schooling, urban areas in 11 countries of the Americas, 2005**



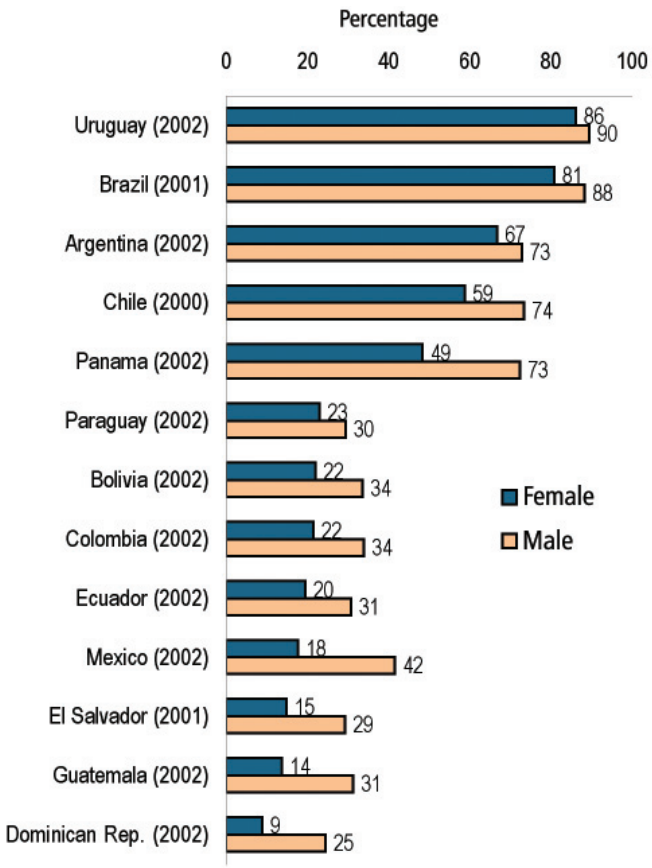
Note: The countries are shown in ascending order of average female:male income for those with 13 years or more years of schooling.
Source: ECLAC, based on special tabulations of household surveys in the respective countries. http://www.eclac.cl/mujer/. Accessed on 30 March 2009.

Retirement and Pension Income

Retirement and pensions, which are usually tied to formal work, are a stable source of income that contributes to the economic autonomy of older adults. The data show that, with certain exceptions, most older adults in the Region do not receive this kind of income, which is more serious for women because they are less likely to have insurance, have a higher prevalence of disabilities, and live longer. As shown in Figure 17, around 2002 more than 80% of men and women aged 65 and older were receiving retirement or pension income in Brazil and Uruguay. The percentages were also relatively high in Argentina and Chile, and in Panama the percentage was high for men. The country with the lowest percentages of women and men pensioners was the Dominican Republic, where only 9% of the former and 25% of the latter were receiving income of this kind.

Around 2006, 25.5% of the men and 15.4% of the women of working age[3] were affiliated with social security schemes in the 16 countries of Latin America for which information is available (*8*).

Figure 17. **Retirees and pensioners aged 65 and over (%), by sex, urban areas in 13 countries of the Americas, circa 2002**



Note: The countries are shown in descending order by percentage of women retirees and pensioners.
Source: ECLAC. Cuaderno No. 92. Estadísticas para la equidad de género: magnitudes y tendencias en América Latina. Santiago, 2007.

[3] Working-age population: population aged 15 and over, corresponding to the potentially active population. Source: ECLAC. Social Panorama of Latin America 2008.

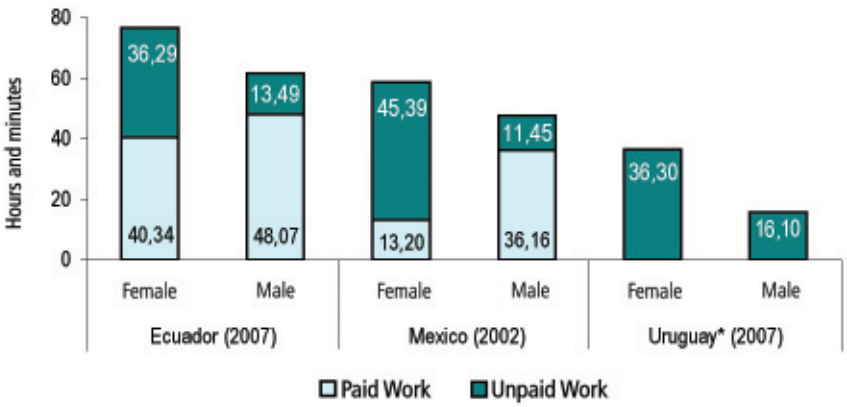
Unpaid Work

The failure to value women's work in the home arises from the belief that those tasks can be performed naturally and freely. In the area of health, the redistribution of responsibility for unpaid care in the home is taking on increasing importance because of the aging population and the prevalence of chronic diseases and disabilities associated with longevity.

> *If our sister or her husband's sister gets sick, we have to go out to the countryside to help—even more so if it's the mother-in-law.*
>
> Women from the community adjacent to the 1º de Mayo Health Center, El Alto, Bolivia
> Source: PAHO. Winning experience in the Best Practices Competition 2009. Bolivia: Gender-focused Primary Health Care ("Estrella" Health Services).

An analysis of paid versus unpaid work shows that women's working days are longer than those of men (Figure 18). For example, in Ecuador women work an average of 77 hours a week compared with 62 for men, and in Mexico women work 59 hours a week whereas men only put in 48 hours.

Figure18. **Time (in hours and minutes) spent by women and men per week on paid work and unpaid domestic work, three countries of Latin America with data available**

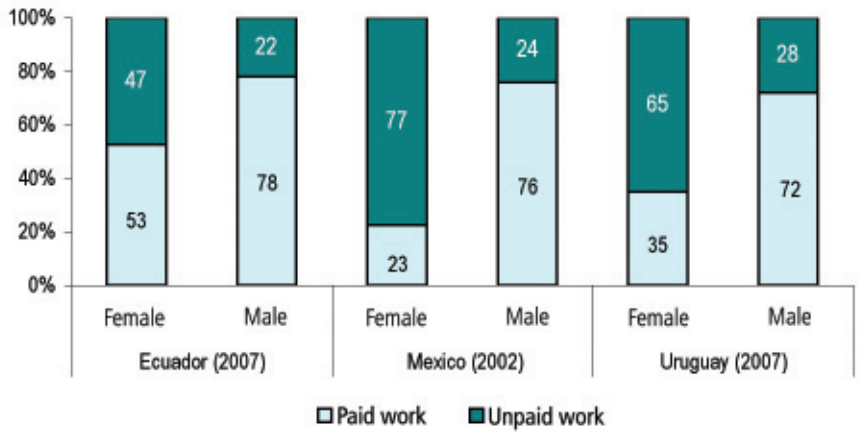


*No information available on time devoted to paid work in Uruguay.
Sources: (1) ECLAC. Millennium Development Goals 2006: a look to gender equality and empowerment of women in Latin America and the Caribbean. (2) INE, UNIFEM, et al. Uso del tiempo y trabajo no remunerado en el Uruguay. Módulo de la Encuesta continua de Hogares, Septiembre 2007 [Time use and unpaid work in Uruguay: Ongoing Household Survey Module, September 2007]. (3) CONAMU-INEC. El tiempo de ellas y de ellos. Indicadores de la Encuesta Nacional del Uso del Tiempo-2007. [The time of women and men: indicators from the National Time Use Survey 2007.]

> *Even when our hands and feet are hurting, if there is work to do at home, we can't go to bed.*
>
> Women from the community adjacent to the 16 de Julio Health Center, El Alto, Bolivia
> Source: PAHO. Winning experience in the Best Practices Competition 2009. Bolivia: Gender-focused Primary Health Care ("Estrella" Health Services).

Figure 19 shows the distribution of time spent by women and men on paid and unpaid work in Ecuador, Mexico, and Uruguay. Men devote between 22% and 28% of their time to unpaid work, whereas women spend between 47% and 77% of their time. Between 72% and 78% of men's working time is spent on paid work, compared to only 23% to 53% of women's time.

Figure 19. **Time devoted to paid and unpaid work (%), by sex, three countries of Latin America with data available**



Sources: (1) ECLAC. Millennium Development Goals 2006: a look to gender equality and empowerment of women in Latin America and the Caribbean, time use and unpaid work in Uruguay (graphic presentation of the results). (2) CONAMU-INEC. El tiempo de ellas y de ellos. Indicadores de la Encuesta Nacional del Uso del Tiempo-2007. [The time of women and men: indicators from the National Time Use Survey 2007.]

In order to design policies that will improve living conditions and the well-being of women and the population in general, it is essential to have reliable information on the magnitude of paid and unpaid work done by women and the contribution that it makes toward human and economic development in the countries.

POVERTY

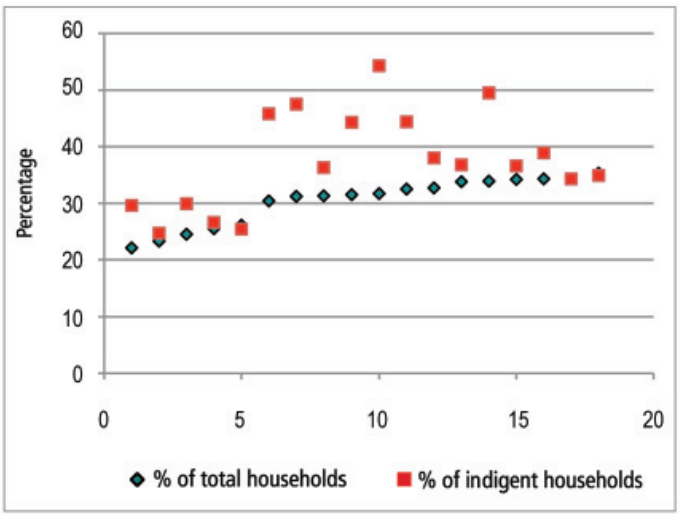
Reducing poverty is a crucial pillar of public policies aimed at achieving sustainable development with a focus on the well-being of the population, which includes improving the health of women and men in all population groups and at every stage of the life cycle. Poverty and extreme poverty have declined in Latin America from 48.3% and 22.5%, respectively, in 1990 to 34.1% and 12.6% in 2007 (*8*). However, this progress has not favored all population groups equally.

> In some countries the reduction of extreme poverty in indigenous and Afro-descendent populations has been less than for the rest of the population. For example, in Bolivia extreme poverty in the non-indigenous non-African descent rural population fell 17.4% between 1999 and 2007, whereas in indigenous and Afro-descendent populations the reduction was only 3.8%. In Ecuador urban extreme poverty in the non-indigenous non Afro-descendent population dropped 40% between 2002 and 2007, yet the decline for indigenous and Afro-descendent populations was only 3.2% (*8*).

Around 2006, between 22% and 35% of urban households in 18 countries of the Region were headed by women (Figure 20), and that proportion was much higher for indigent households at 25% to 54%. In six of the 18 countries, the percentage of indigent households headed by a woman exceeded 40%, and in one of them (Costa Rica) it was 54%.

In terms of the income contribution of women, data for 2005 indicate that in the urban areas of 18 countries of Latin America and the Caribbean between 5% (Costa Rica) and 15% (El Salvador) of two-parent households were able to rise above poverty thanks to the economic contribution of income earned by women. In the rural areas of these same countries the percentage of two-parent households that were able to emerge from poverty for this reason ranged between 3% in Costa Rica and 12% in Paraguay (*9*).

Figure 20. **Total households and indigent households headed by women (%), urban areas in 18 countries of the Americas, circa 2006**



Countries

1 Guatemala (2002)
2 Ecuador (2006)
3 Peru (2003)
4 Bolivia (2004)
5 Mexico (2006)
6 Panama (2006)
7 Chile (2006)
8 Brazil (2006)
9 Argentina (Greater B.A.) (2006)
10 Costa Rica (2006)
11 Venezuela (total country) (2006)
12 Colombia (2005)
13 Honduras (2006)
14 Dominican Republic (2006)
15 Nicaragua (2001)
16 Paraguay (Asuncion) (2005)
17 Uruguay (2005)
18 El Salvador (2004)

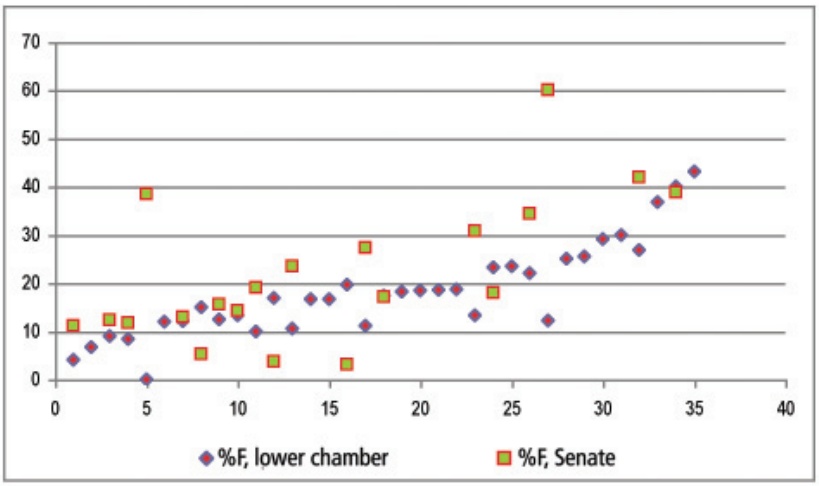
Note: The countries are shown in ascending order of percentage of total households headed by women.
Source: ECLAC. Social Panorama of Latin America 2007. Statistical Annex.

POLITICAL PARTICIPATION

Another manifestation of gender-based inequality is the low participation of women in decision-making. Figure 21 shows the percentage of women serving in the legislative branch in the countries of the Region. Even with the gains made in recent decades, the proportion continues to be very small. In 35 countries for which information was available, the percentage of women in the lower chamber ranged from 4% in Haiti to 43% in Cuba. Of 20 countries with information available on the participation of women in the upper chamber, or senate, this proportion ranged from 11.1% in Haiti to 38.9% in Argentina.

As a measure of affirmative action to expand opportunities for women and advance towards parity in parliamentary representation, the use of national laws requiring political party slates to include a percentage of women candidates can contribute to greater participation by women in popularly elected positions. However, in order to achieve sustainable results, this measure should be accompanied by other actions that promote progress toward gender equality in the reproductive area.

Figure 21. **Women in Parliament, 35 countries of the Americas, 2007 (%)**



Countries			
1 Haiti	10 Jamaica	19 St.Vincent and the Grenadines	28 Ecuador
2 Saint Kitts and Nevis	11 Barbados	20 Nicaragua	29 Suriname
3 Brazil	12 Bolivia	21 Venezuela	30 Peru
4 Colombia	13 Antigua and Barbuda	22 Dominica	31 Guyana
5 Belize	14 El Salvador	23 Grenada	32 Trinidad and Tobago
6 Guatemala	15 Panama	24 Mexico	33 Costa Rica
7 Uruguay	16 Dominican Republic	25 Honduras	34 Argentina
8 Chile	17 Saint Lucia	26 Canada	35 Cuba
9 Paraguay	18 United States of America	27 Bahamas	

Note: The countries are shown in ascending order of percentage of women serving in both chambers.
Source: http://www.ipu.org. Accessed on 18 February 2009.

With regard to the participation of women in health-related decision-making, 20% of all ministers of health were women in 2009 (*10*).

According to 2008 data from the Regional Observatory on Gender Equality (*11*), the participation of women on the national supreme court or highest court of justice was less than 10% in six countries of the Region; between 11% and 29% in 14 countries; between 31% and 46% in 12 countries; and only in Honduras did women occupy more than half the seats in the highest court of justice (53%).

III. HEALTH, DISEASE, AND MORTALITY

In order to understand the etiology of morbidity and mortality from a gender perspective, it is essential to go beyond biological differences and analyze the effect of social factors that differentially affect the health and mortality of women and men and different groups of women and men. Inequalities in the roles and power of men and women in different societies—variables affecting social stratum, age, and ethnic origin—are manifested not only in differential risks for the health and survival of both but also in asymmetries in the access to, and control over resources needed in order to promote and protect health.

The breakdown of health information by sex reveals conditions or problems that affect the morbidity of women or men exclusively. It also makes it possible to identify, of the conditions that are common to both sexes, those that have a differential impact on one sex or the other or on a subgroup within the sexes, depending on the geographical or social context. The identification and measurement of these social inequalities leads to reflection about the presence of unjust or avoidable disparities, not only in terms of risks and opportunities, but also regarding the responses provided for women and men by the health system.

The present chapter relies essentially on mortality information produced by the Pan American Health Organization (PAHO) on the basis of data provided by countries. Some morbidity data are also included as well, but access to this information is limited at the regional level. The limited availability of data should not take away from the importance of morbidity: it must be remembered that mortality is only the reflection of extreme deterioration of health and does not explain the striking variations in the health and quality of life of those who survive, among whom women predominate (*12*).

This analysis is not exhaustive, nor does it cover the most important health problems of the population. The emphasis here and in the rest of this publication is on the conditions and health problems that: (a) exclusively affect one of the sexes or a subgroup thereof; (b) manifest differently in the sexes; (c) involve different risks for each sex or subgroup thereof; (d) have different effects on the sexes, and (d) require different interventions for each sex.

LIFE EXPECTANCY

In all countries of the Americas, as in most of the world, life expectancy at birth (LEB) is higher for women than men. For 2005-2010, Canada had the highest life expectancy in the Region (80.7 years), while Canadian women (82.9 years) have a 4.6 year survival advantage over men (78.3). In Haiti, the country with the lowest LEB in the Region (60.9 years), women survive 3.7 years longer than men (62.8 and 59.1, respectively). The survival gap between the sexes is explained in part by genetic factors associated with greater mortality in males during the perinatal period and early childhood, when the differentiating effect of risks related to reproduction and the social gender roles would be minimal. Although the relative weight of the biological factor in accounting for the survival gap is still being debated, particularly in the case of adults, it is clear that throughout the life cycle, depending on the context, certain social factors have a differentiating effect on male and female survival and also affect the size of the gap. Among the most notable factors are the quality of maternal health care for women and conditions that precipitate accidents and violence for men. For example, in some countries, poverty and the undervaluation of women are frequently associated with high mortality rates during pregnancy, childbirth, and the puerperium. Maternal mortality significantly reduces the survival gap between the sexes and can even invalidate and reverse the biological advantage that women are presumed to enjoy (*13*). However, the size of the survival gap between men and women is not dictated exclusively by declining female mortality; it is also the effect of increased male mortality from causes related to accidents, violence, alcoholism, and smoking, which are reflected in sizable gaps in life expectancy at birth. Two examples are Brazil and Colombia, where the gaps are 7.1 and 7.4 years, respectively.

The above figures on LEB are national averages and as such they conceal significant differences within the countries for socioeconomic strata and ethnic groups. The gaps are considerably wider among women (Table 1).

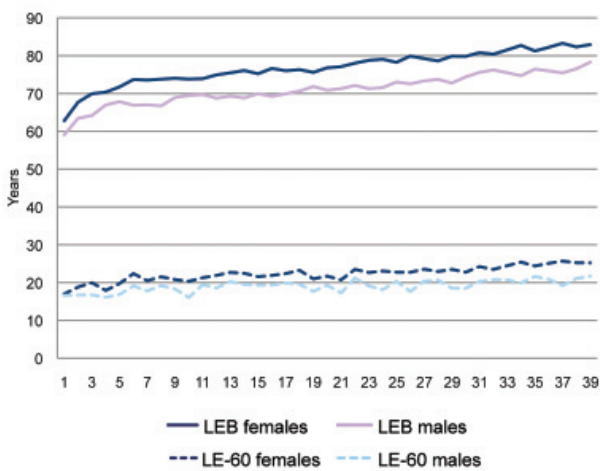
Table 1. **Life expectancy at birth for indigenous and non-indigenous populations, by sex, Panama, 2000 census**

Sex	Ethnic origin	
	Indigenous peoples	Non-indigenous peoples
Male	61.1	69.6
Female	63.6	75.1

Source: ECLAC, Indigenous and Afro-descendent Peoples of Latin America and the Caribbean: Socio-demographic Data for Policies and Programs. Santiago, Chile, 2006.

Another commonly used indicator of survival is life expectancy at age 60 (LE-60). Unlike LEB, which is influenced primarily by infant mortality, LE-60 shows the cumulative effects of health determinants such as poverty, education, and access to pensions over the course of adult life. Figure 22 illustrates the trend of both indicators for women and men in 39 countries of the Region for 2005-2010. As with LEB, life expectancy at age 60 is higher for women, ranging from a low of 17.0 years in Haiti to a high of 25.2 years in Canada. The figures for men are 16.6 and 21.7 years, respectively, in the same countries. The smallest difference between the sexes (0.4 years) is seen in Haiti, the country with the most adverse economic conditions.

Figure 22. **Life expectancy at birth (LEB) and at age 60 years (LE-60), by sex, 39 countries of the Americas, 2005-2010**



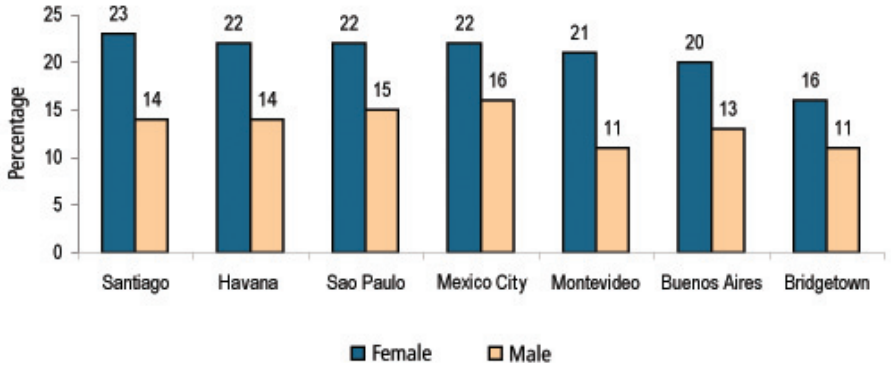
Countries

1 Haiti	21 Aruba
2 Bolivia	22 Ecuador
3 Guyana	23 Netherlands Antilles
4 Grenada	24 Argentina
5 Trinidad & Tobago	25 Panama
6 Honduras	26 French Guiana
7 Suriname	27 Belize
8 Guatemala	28 Mexico
9 Peru	29 Uruguay
10 Saint Vincent & the Grenadinas	30 Barbados
11 Paraguay	31 United States of America
12 El Salvador	32 Cuba
13 Dominican Republic	33 Chile
14 Brazil	34 Puerto Rico
15 Jamaica	35 Costa Rica
16 Colombia	35 Guadeloupe
17 Nicaragua	37 Virgin Islands (US)
18 Bahamas	38 Martinique
19 Saint Lucia	39 Canada
20 Venezuela	

Note: The countries are shown in ascending order of LEB for both sexes combined.
Source: United Nations. Division of Statistics. Statistics and Indicators on Women and Men. http://unstats.un.org/unsd/demographic/products/indwm/statistics.htm. Accessed on 3 May 2008.

It needs to be pointed out, however, that a higher LEB or LE-60 does not necessarily mean better health. Figure 23 shows that women aged 60 and over suffer more limitations than men of the same age. It has been widely documented that females, even though they live longer, experience greater morbidity and disability than males throughout the life cycle. This phenomenon is reported in all groups of adult women, although it is more pronounced for acute disorders and short-term disability in reproductive years and for chronic disorders and disabilities at more advanced ages. Men, on the other hand, experience less morbidity and disability but their health problems, when they occur, tend to be lethal (*14*).

Figure 23. **Population aged 60 years and over (%) limited in the performance of one or more activities of daily living,[a] by sex, selected cities in the Americas, 2000**



[a] Activities of daily living include bathing, eating without assistance, getting dressed, using the toilet, transferring from the bed to a chair, walking.
Source: PAHO/ Merck Institute on Aging and Health, Report on the State of Aging and Health in Latin America and the Caribbean, 2007.

LEADING CAUSES OF DEATH

The mortality profile in the Americas has changed significantly in recent decades. In most countries of the Region, chronic degenerative diseases and external causes such as accidents and homicides have been displacing communicable diseases as leading causes of morbidity and mortality. This section analyzes the five leading causes of death in the eight subregions of the Americas with an emphasis on the similarities and differences between the sexes for these causes. The subregions are: North America, Mexico, Central American Isthmus, Latin Caribbean, Non-Latin Caribbean, Andean Area, Brazil, and the Southern Cone.[4]

Table 2 summarizes proportional mortality for each of the five leading causes of death for each sex in the aforementioned subregions around 2002, as well as the ranking of these causes by relative importance for both the total population and each sex (*1*). These figures show first of all that, consistent with worldwide trends, ischemic heart disease and cerebrovascular disease are among the leading causes of death in the Region of the Americas, especially for women. Second, pneumonia and influenza continue to rank among the leading five causes of death in four of the eight subregions. Conditions originating from the perinatal period are a leading cause of death in three subregions. Although they represent a larger proportion of mortality among young girls, the difference between the two sexes is small. Third, the specific types of malignant neoplasms that are found among the five leading causes of death (lung in three subregions and prostate in one subregion) are important causes of death in men. Finally, there are three subregions in which assaults (homicides) are among the three leading causes of death in the male population.

[4] North America: Bermuda, Canada, and United States of America; Central American Isthmus: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama; Latin Caribbean: Cuba, Dominican Republic, French Guiana, Guadeloupe, Haiti, Martinique, and Puerto Rico; Non-Latin Caribbean: Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Netherlands Antilles, Turks and Caicos Islands, Virgin Islands (USA), Virgin Islands (UK), Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, and Trinidad and Tobago; Andean Area: Bolivia, Colombia, Ecuador, Peru, and Venezuela; Southern Cone: Argentina, Chile, Paraguay, and Uruguay.

a. **Cardiovascular diseases** (ischemic heart, cerebrovascular, and hypertensive disease and cardiac insufficiency) represent 32% of the total disease burden in the Region of the Americas (*15*), and in most of the subregions they rank among the leading causes of death for both men and women. Ischemic heart disease is the leading cause of death for men in six of the eight subregions, and for women in four. Cerebrovascular disease is the first or second most important cause of death for women in five subregions and for men in three. In addition, in four of the regions cardiac insufficiency[5] and hypertensive disease are reported among the leading causes of death in women but not men.

b. **Diabetes** is among the five main causes of death for women in all the subregions of the Americas except North America. Around 2002 it was the leading cause of female mortality in Mexico, the second most important cause in the Non-Latin Caribbean, and the third-ranking cause in Brazil. It was also a major cause of male mortality in North America, Mexico, and the Non-Latin Caribbean. Except for North America, proportional mortality from diabetes mellitus was higher among women than men.

c. **Malignant neoplasms of the lung, trachea, and bronchus** affect men disproportionately, mainly in association with higher rates of tobacco use. This group of neoplasms was the second cause of male mortality in North America and the fifth in the Latin Caribbean and the Southern Cone. Although these malignant neoplasms predominate in men, they have also become the third most important cause of female mortality in North America after ischemic heart and cerebrovascular diseases.

d. **Cirrhosis and other diseases of the liver** ranked as the third and fifth causes of death among men and women, respectively, in Mexico. These diseases, which are associated with alcohol abuse, affect men disproportionately. Even so, in the case of Mexico women are severely affected as well, although mortality is still much higher in men.

e. **HIV infection and AIDS** was the fourth most important cause of death among men in the Latin and Non-Latin Caribbean. Although the proportion of mortality from this cause is greater for men, for women in the Non-Latin Caribbean it was the fifth-ranking cause of death.

f. **Pneumonia and influenza** were the number one cause of death for both sexes in the Central American Isthmus and ranked third or fourth in the Latin Caribbean, the Andean Area, and the Southern Cone. **Intestinal infectious diseases** was the fourth most important cause of death in the Central American Isthmus. These diseases cause greater mortality in women than men.

g. **Conditions originating in the perinatal period** are among the leading five causes of death in the Central American Isthmus, the Andean Area, and Brazil. Although these causes affect both sexes similarly, their origin is related to maternal health problems and care received during pregnancy and childbirth, and they are more frequent in conditions of poverty and marginalization.

h. **Dementia and Alzheimer's disease** appear as the fourth most important cause of death among women in North America (5.4%), a reflection of the degree of aging in this subregion and the greater number of women aged 65 and over.

i. **Malignant neoplasm of the prostate** showed up as the fifth most important cause of male mortality (4.3%) in the Non-Latin Caribbean.

j. Although **complications of pregnancy, childbirth, and the puerperium** do not figure among the leading causes of death for the total population, it is important to point out that such complications are among the five leading causes of death for women aged 15 to 24 and 25 to 44 in 16 and 10 countries of the Region, respectively.

k. When the common causes of death for both sexes are examined, the largest difference between women and men is seen in **accidents and violence acts,** causes that are associated with stereotypical male roles and behavior. **Homicides** were the number one cause of male mortality in the Andean Area, where they accounted for 14% of male deaths, and they were the second most important cause of death for men in the Central American Isthmus (7%) and third cause in Brazil (8%). **Land transport accidents,** in turn, represented the fourth cause of male mortality in the Andean Area and Brazil, and the fifth cause in Mexico, where they accounted for almost 5% of male deaths. It is important to mention here that in the countries of the Americas for which information is available, between 14% and 52% of women have suffered from acts of physical violence inflicted by their partners. Although these acts jeopardize women's health, they seldom lead to a fatal outcome (see also Figure 72).

[5] Cardiac insufficiency is not a basic cause of death. When it is reported, it is indicative of a problem in the quality of the data.

Table 2. **Five leading causes of death and proportion of total deaths, by sex and subregion, Region of the Americas, circa 2002**

Cause of Death[1]	*Female*		*Male*	
North America	**%**	**Rank**	**%**	**Rank**
Ischemic heart disease	20.1	1	21.7	1
Cerebrovascular disease	8.3	2	5.4	3
Malignant neoplasm of the trachea, bronchus, and lung	5.5	3	7.8	2
Chronic diseases of the lower respiratory tract	5.1	5	5.1	4
Dementia and Alzheimer's disease	5.4	4	--	--
Diabetes mellitus	--	--	2.9	5
Mexico				
Diabetes mellitus	15.7	1	10.6	2
Ischemic heart disease	11.0	2	10.9	1
Cirrhosis of the liver and other chronic liver diseases	3.6	5	8.6	3
Cerebrovascular disease	7.0	3	5.0	4
Chronic diseases of the lower respiratory tract	4.4	4	--	--
Traffic accidents (terrestrial)	--	--	4.6	5
Central American Isthmus				
Pneumonia and influenza	9.3	1	8.1	1
Ischemic heart disease	7.3	2	6.4	3
Cerebrovascular disease	6.7	3	--	--
Intestinal infectious diseases	5.3	4	4.9	4
Conditions originating in the perinatal period	--	--	4.8	5
Assault (homicides)	--	--	7.1	2
Diabetes mellitus	5.1	5	--	--
Latin Caribbean				
Ischemic heart disease	11.4	1	11.2	1
Cerebrovascular disease	10.5	2	8.3	2
Pneumonia and influenza	5.4	3	5.3	3
HIV/AIDS	--	--	4.5	4
Diabetes mellitus	4.6	4	--	--
Hypertensive disease	4.3	5	--	--
Malignant neoplasm of the trachea, bronchus, and lung	--	--	3.6	5
Non-Latin Caribbean				
Ischemic heart disease	13.2	1	13.3	1
Cerebrovascular disease	11.7	3	9.1	2
Diabetes mellitus	12.5	2	8.1	3
HIV/AIDS	4.7	5	6.5	4
Hypertensive disease	6.2	4	--	--
Malignant neoplasm of the prostate	--	--	4.3	5
Andean Area				
Ischemic heart disease	10.7	1	9.8	2
Assault (homicides)	--	--	13.6	1
Cerebrovascular disease	8.6	2	5.5	3
Pneumonia and influenza	5.7	3	4.5	5
Conditions originating in the perinatal period	4.4	5	--	--
Diabetes mellitus	5.5	4	--	--
Traffic accidents (terrestrial)	--	--	4.8	4

Continued...

[1] The causes are listed in descending order by rank of the cause in the total population.
-- The condition is not among the five leading causes of death.
Source: PAHO. Health in the Americas 2007. Volume I.

Brazil				
Cerebrovascular disease	12.4	1	9.4	2
Ischemic heart disease	9.9	2	9.8	1
Assault (homicides)	--	--	7.8	3
Diabetes mellitus	6.1	3	--	--
Conditions originating in the perinatal period	4.4	5	--	--
Chronic diseases of the lower respiratory tract	--	--	4.3	5
Heart failure	4.7	4	--	--
Traffic accidents (terrestrial)	--	--	4.4	4
Southern Cone				
Cerebrovascular disease	10.0	2	8.1	2
Heart failure	10.1	1	7.6	3
Ischemic heart disease	7.1	3	8.8	1
Pneumonia and influenza	5.2	4	4.4	4
Diabetes mellitus	4.0	5	--	--
Malignant neoplasm of the trachea, bronchus, and lung	--	--	4.2	5

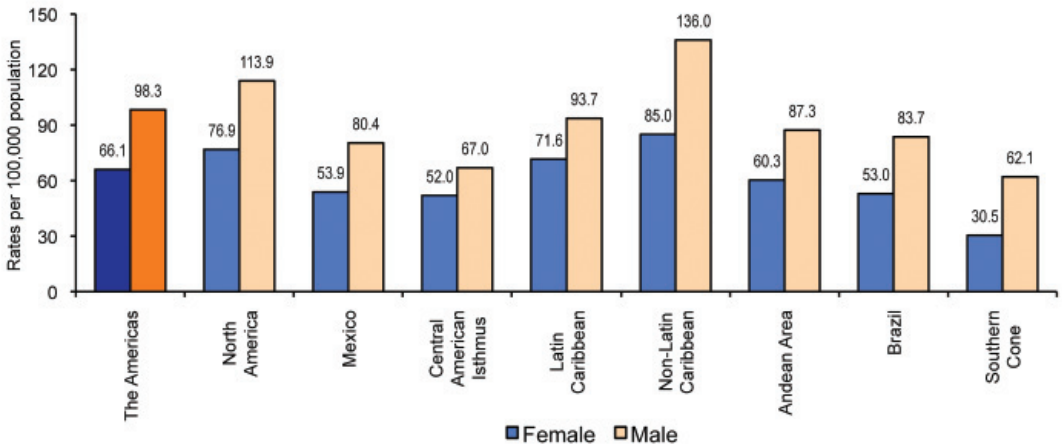
SEX DIFFERENCES IN MORTALITY FROM SELECTED CAUSES

Figures 24 to 42 were utilized to support the following analyses of sex inequalities for selected causes of death.

Cardiovascular Diseases

Figures 24 and 25 illustrate the sex differences in the magnitude of age-adjusted mortality from cerebrovascular and ischemic heart diseases in the eight subregions of the Americas. Age-adjusted mortality[6] from ischemic heart disease was higher for men than women in the eight subregions. In Figure 25 it can be seen that the difference between the sexes was especially marked in the Non-Latin Caribbean and North America, subregions where mortality from these causes was also highest in the total population. Risk factors include obesity, unbalanced diet, sedentary lifestyle, smoking, hypertension, and quality of health care being provided for these diseases, both by the health care services and through health promotion initiatives.

Figure 24. **Age-adjusted mortality rates for ischemic heart disease (per 100,000 population), by sex and subregion of the Americas, 2003-2005**

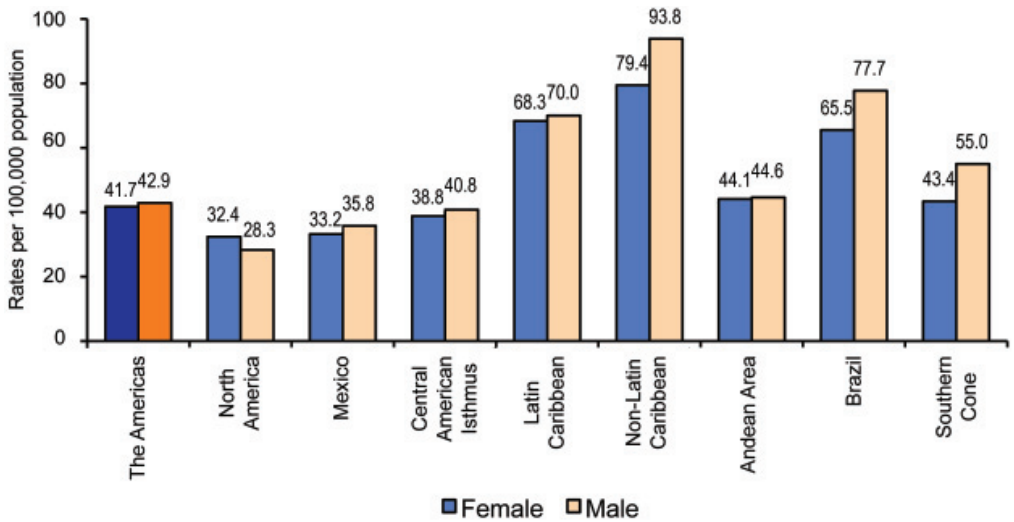


Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

[6] The age-adjusted mortality rate was calculated using the direct method and applying the world standard population distribution (2,400 infants under 1 year old, 9,600 children 1 to 4 years old; 19,000 from 5 to 14; 43,000 from 15 to 44; 19,000 aged 45 to 64; and 7,000 aged 65 and over). Source: WHO, World Health Statistics Annual 1996. Geneva, 1998 (*3*).

Figure 25 shows mortality from cerebrovascular disease by sex. These rates are lower than for ischemic heart disease, and the difference between the two sexes varies from one subregion to the next. Except in North America, where the rate for women is higher, either the difference between the sexes is minimal or the rate is higher for men, as it is in Brazil, the Non-Latin Caribbean, and the Southern Cone. The highest rates for both sexes are in the Non-Latin Caribbean, where they are triple the levels in North America, which has the lowest rates. The causes for these differences in mortality are not fully known, but they are related to the control of risk factors, the incidence of cerebrovascular events, access to services, and quality of care in the case of stroke and hypertension. It is important to point out that mortality from hypertension can be prevented at the primary health care level.

Figure 25. **Age-adjusted mortality rates for cerebrovascular disease (per 100,000 population), by sex and subregion of the Americas, 2003-2005**

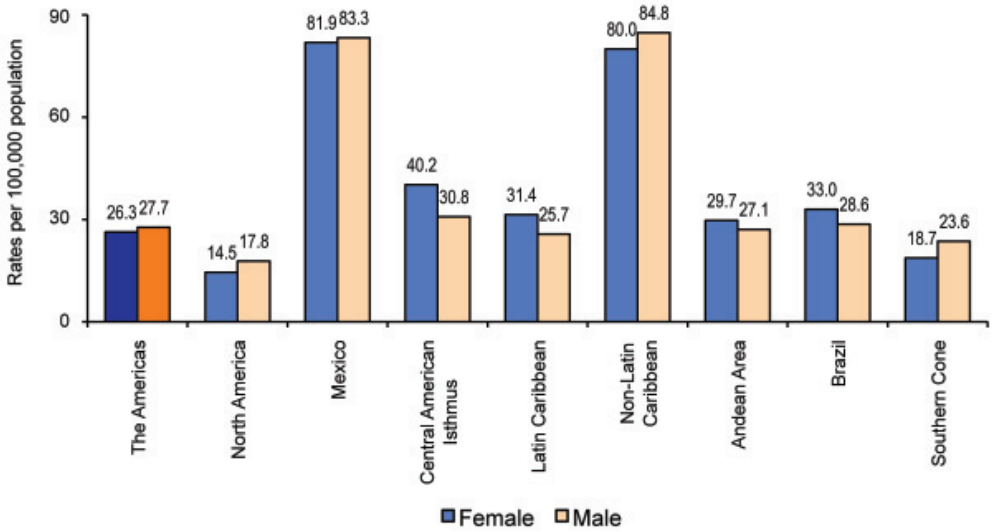


Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

Diabetes Mellitus

Figure 26 reveals major variations between the subregions in mortality from diabetes mellitus. The highest rates are in the Non-Latin Caribbean and Mexico: mortality from this disease in both these areas is at least 80 per 100,000 population. On the other hand, North America and the Southern Cone have the lowest adjusted mortality rates from diabetes (between 14.5 and 23.6 per 100,000 population, respectively). In four of the eight subregions—the Central American Isthmus, the Latin Caribbean, the Andean Area, and Brazil—the mortality rate per 100,000 is higher for women than for men; they are almost equal for the two sexes in Mexico; and they are higher for men in North America, the Non-Latin Caribbean, and the Southern Cone. As with most chronic diseases, the risk of adults becoming sick and dying from diabetes mellitus is associated with a sedentary lifestyle, overeating, or inappropriate nutrition. Complications from diabetes such as infected ulcers that lead to amputation, blindness and ultimately mortality from the disease can be prevented with adequate primary health care.

Figure 26. **Age-adjusted death rates for diabetes mellitus (per 100,000 population), by sex and subregion of the Americas, 2003-2005**



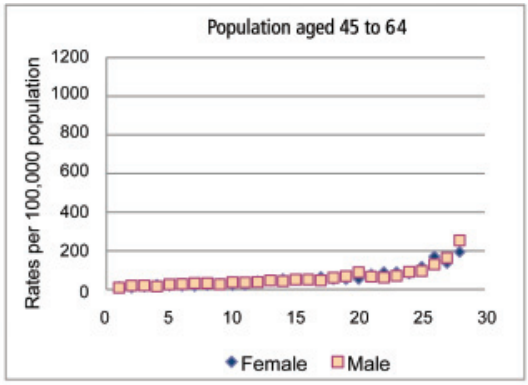
Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

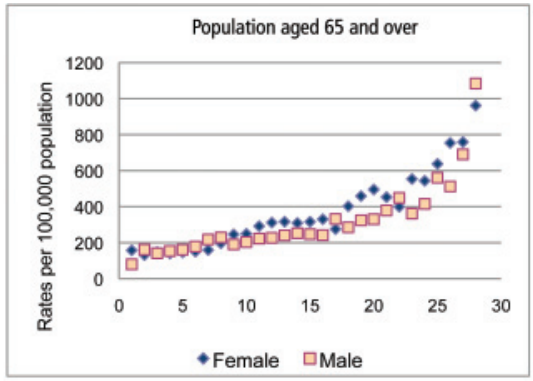
Data on mortality broken down by sex, age, and country reveal the impact of mortality from diabetes on the population, especially women, which increases with age and varies greatly from one country to the next. Figure 27 illustrates how mortality from diabetes mellitus rises sharply from one age group (45 to 64) to the next (age 65 and over). The rates in the first age group are considerably lower, and the difference between women and men is minimal. In the 65-and-over age group the highest mortality rates from diabetes per 100,000 population for both sexes combined are seen in Trinidad and Tobago (1,015), Mexico (729), Paraguay (641), Barbados (609), Guyana (485), and Nicaragua (464). Except in Trinidad and Tobago, the rates are higher for women. At the other end of the scale, the countries with the lowest rates per 100,000 population, in ascending order, are Cuba (121), Uruguay (143), Peru (145), Bolivia (146), the United States (152) and Canada (163), with no difference between men and women. Again, most mortality from diabetes in this age group can be prevented with adequate primary health care.

During the reporting period in question (circa 2004-2006), female mortality from diabetes in the group aged 45 to 64 exceeded the rate for males in 11 out of 28 countries of the Region, although the sex differences were usually small and the ratio was close to 1. However, in the 65-and-over population the differences between the sexes were more pronounced and the rates were higher for women in most of the countries. In 16 of the 28 countries under review, female mortality was at least 20% higher. In Cuba, the country with the lowest mortality from diabetes in that age group, mortality in women was almost double the rate for men (158 versus 80 per 100,000 population). The countries with the largest differences between the sexes (rates between 40% and 50% higher for women), after Cuba, were Paraguay, Nicaragua, Panama, Haiti, the Dominican Republic, El Salvador, and Guadeloupe, in that order.

Sex differences in mortality from diabetes are related to genetic factors, diet, excess weight and obesity, hypertension, access to services, and proper management of the disease. Its complications are serious and can include blindness, kidney damage, cardiovascular disease, and nervous system disease, and it can have particular during pregnancy and childbirth for both the woman and the fetus.

Figure 27. **Mortality from diabetes mellitus (per 100,000 population) in the populations aged 45 to 64 and 65 years and over, by sex, 28 countries of the Americas, circa 2004-2006**





Countries, population aged 45 to 64		Countries, population aged 65 and over	
1 Martinique (2003-2005)	15 Brazil (2003-2005)	1 Cuba (2004-2006)	15 Brazil (2003-2005)
2 Canada (2002-2004)	16 Ecuador (2003-2005)	2 Uruguay (2001,03,04)	16 El Salvador (2004-2006)
3 Uruguay (2001,03,04)	17 El Salvador (2004-2006)	3 Peru (2002-2004)	17 Suriname (2000,04,05)
4 Cuba (2004-2006)	18 Dominican Rep. (2002-2004)	4 Bolivia (2002,2003)	18 Dominican Rep. (2002-2004)
5 Chile (2003-2005)	19 Venezuela (2003-2005)	5 United States (2003-2005)	19 Haiti (2002-2004)
6 United States (2003-2005)	20 Puerto Rico (2003-2005)	6 Canada (2002-2004)	20 Panama (2002-2004)
7 Bolivia (2002,2003)	21 Guatemala (2002-2004)	7 Argentina (2004-2006)	21 Venezuela (2003-2005)
8 Peru (2002-2004)	22 Haiti (2002-2004)	8 Chile (2003-2005)	22 Puerto Rico (2003-2005)
9 Costa Rica (2004-2006)	23 Paraguay (2004-2006)	9 Martinique (2003-2005)	23 Nicaragua (2000-2002)
10 Argentina (2004-2006)	24 Suriname (2000,04,05)	10 Costa Rica (2004-2006)	24 Guyana (2003-2005)
11 Guadeloupe (2003-2005)	25 Nicaragua (2000-2002)	11 Ecuador (2003-2005)	25 Barbados (2000,2001)
12 Colombia (2003-2005)	26 Guyana (2003-2005)	12 Guadeloupe (2003-2005)	26 Paraguay (2004-2006)
13 Barbados (2000,2001)	27 Mexico (2004-2006)	13 Guatemala (2002-2004)	27 Mexico (2004-2006)
14 Panama (2002-2004)	28 Trinidad & Tobago (2000-2002)	14 Colombia (2003-2005)	28 Trinidad & Tobago (2000-2002)

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

Malignant Neoplasm of the Uterus

Even though simple, effective, and low-cost technologies have been available for the early detection and treatment of malignant neoplasm of the cervix for almost 50 years, this disease continues to be one of the leading causes of death for women in the Americas, where the mortality rate is among the highest in the world (*1*). As it can be seen in Table 3, malignant neoplasm of the uterus (including the cervix uteri, corpus uteri, and malignant tumor unspecified site) ranks among the first two causes of death for women aged 25 to 44 in 13 countries of the Region and among the first five causes of death for women aged 45 to 64 in 16 countries. During the period 2004–2006 mortality from this cause in the population aged 25 to 44 ranged from a low of 2 per 100,000 women in Canada to 29 per 100,000 in Bolivia; between 8 and 71 per 100,000 for the group aged 45 to 64 in the same countries, and between 28 and 164 per 100,000 for women over 65 years of age in Puerto Rico and Paraguay, respectively.

Figure 28 shows the magnitude of the differences in the rates for malignant neoplasm of the uterus and malignant neoplasm of the breast in 27 countries of the Region for two age groups: 45 to 64 and 65 years and over. The countries with highest mortality from malignant neoplasm of the uterus were, in descending order, Paraguay, Nicaragua, Trinidad and Tobago, Haiti, Bolivia, El Salvador, and the Dominican Republic.

Given the extent and avoidable nature of these circumstances, mortality from malignant neoplasm of the uterus is a critical manifestation of the profound socioeconomic inequalities that exist in the Region, as well as the low social value attached to a problem that exclusively affects women, especially poor women (*16*). It should be noted that the risk for this malignant neoplasm increases with smoking, the use of contraceptive hormones, and the presence of human papillomavirus, which is transmitted through sexual intercourse.

Malignant Neoplasm of the Breast

Table 3 shows that this type of tumor is among the five leading causes of death in women aged 25 to 44 in 16 countries, as well as in those aged 45 to 64 in 17 countries of the Region. Figure 28 shows that mortality from breast cancer tends to be greater than from malignant neoplasm of the uterus in women aged 45 to 64 in 15 of the 27 countries for which data were examined. The highest rates of mortality from malignant neoplasm of the breast were in countries of the Southern Cone (Argentina, Paraguay, and Uruguay), the Non-Latin Caribbean (Trinidad and Tobago), and North America (Canada and the United States). The lowest rates were in the Central American Isthmus (El Salvador and Guatemala).

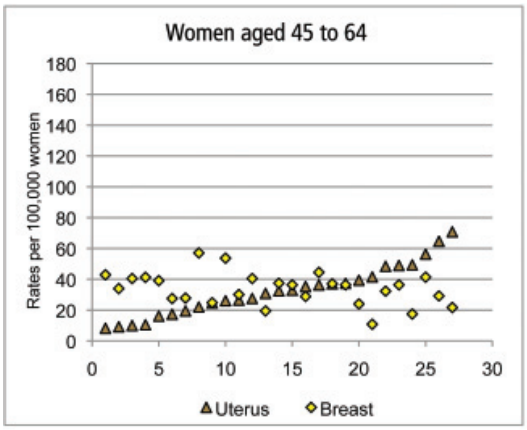
Table 3. **Malignant neoplasms (MN) of the uterus and the breast among the five leading causes of death in women aged 25 to 44 and 45 to 64, by country, circa 2004-2006**

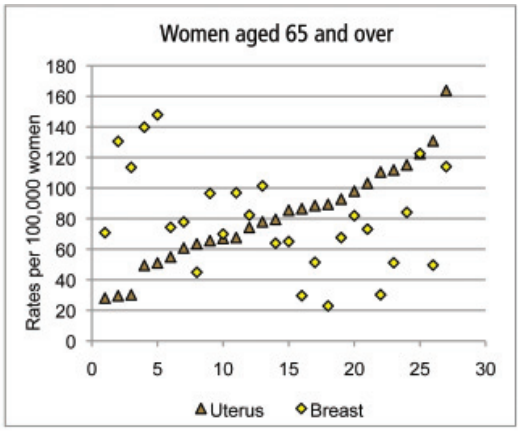
	First cause	Second cause	Third cause	Fourth cause	Fifth cause
			Women aged 25 to 44 years		
MN of the Uterus	Argentina Bolivia Chile Cuba Nicaragua Peru Venezuela	Colombia Costa Rica Ecuador Panama Paraguay Uruguay	El Salvador Mexico		Guatemala
MN of the Breast	Canada Guadeloupe Uruguay	Argentina Chile Cuba Puerto Rico Trinidad & Tobago	Costa Rica United States	Mexico Paraguay Venezuela	Brazil Panama Suriname
			Women aged 45 to 64 years		
MN of the Uterus	Peru		Bolivia Ecuador Paraguay	Argentina El Salvador Guadeloupe Guatemala Nicaragua Panama Venezuela	Colombia Cuba Guyana Suriname Uruguay
MN of the Breast	Argentina Guadeloupe	Canada Uruguay	Chile Costa Rica United States Puerto Rico	Brazil Colombia Cuba Dominican Republic Trinidad & Tobago	Mexico Panama Paraguay Venezuela

Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

Although the technology for preventing deaths from malignant neoplasm of the breast has not attained the efficacy of the strategies available for preventing malignant neoplasm of the uterus, early detection and treatment of breast tumors plays a decisive role in reducing case-fatality from that cause. For example, in the United States despite the higher frequency of malignant neoplasm of the breast in white women, mortality from this cause is higher in women of other ethnic or racial groups (*17*).

Figure 28. **Mortality from malignant neoplasms of the uterus and breast (per 100,000 women), in the age groups 45 to 64 and 65 and over, 27 countries of the Americas, circa 2004-2006**



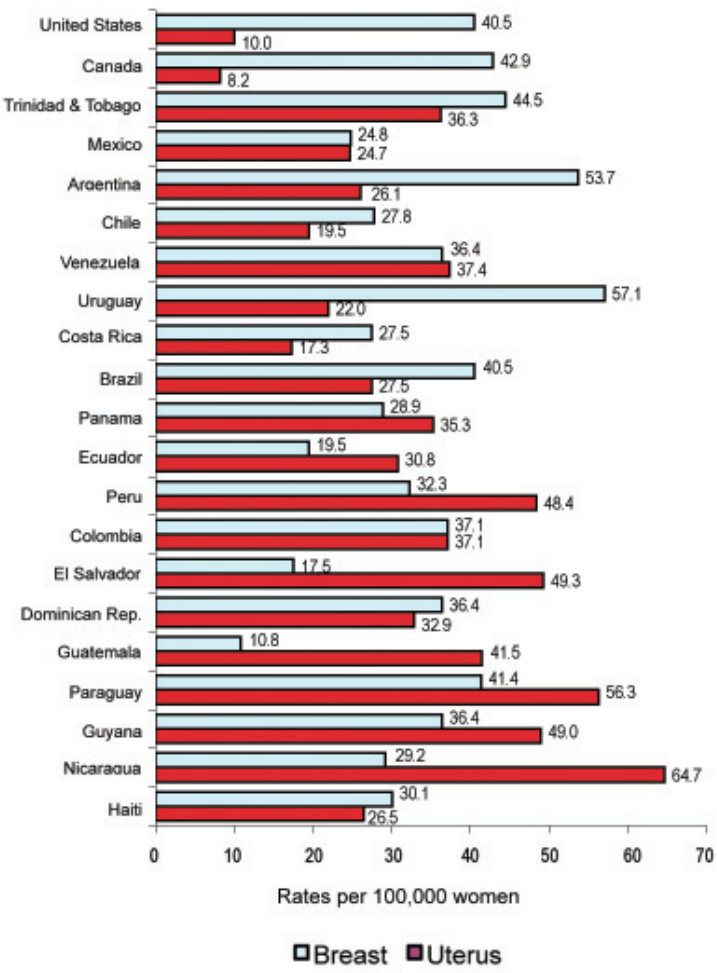


Countries, women aged 45 to 64		Countries, women aged 65 and over	
1 Canada (2002-2004)	15 Dominican Rep. (2002-2004)	1 Puerto Rico (2003-2005)	15 Guyana (2003-2005)
2 Puerto Rico (2003-2005)	16 Panama (2002-2004)	2 Canada (2002-2004)	16 Ecuador (2003-2005)
3 United States (2003-2005)	17 Trinidad & Tobago (2000-2002)	3 United States (2003-2005)	17 Peru (2002-2004)
4 Martinique (2003-2005)	18 Colombia (2003-2005)	4 Argentina (2004-2006)	18 Guatemala (2002-2004)
5 Guadeloupe (2003-2005)	19 Venezuela (2003-2005)	5 Uruguay (2001,03,04)	19 Panama (2002-2004)
6 Costa Rica (2004-2006)	20 Suriname (2000,04,05)	6 Brazil (2003-2005)	20 Venezuela (2003-2005)
7 Chile (2003-2005)	21 Guatemala (2002-2004)	7 Chile (2003-2005)	21 Dominican Rep. (2002-2004)
8 Uruguay (2001,03,04)	22 Peru (2002-2004)	8 Mexico (2004-2006)	22 El Salvador (2004-2006)
9 Mexico (2004-2006)	23 Guyana (2003-2005)	9 Martinique (2003-2005)	23 Bolivia (2002,2003)
10 Argentina (2004-2006)	24 El Salvador (2004-2006)	10 Guadeloupe (2003-2005)	24 Haiti (2002-2004)
11 Haiti (2002-2004)	25 Paraguay (2004-2006)	11 Costa Rica (2004-2006)	25 Trinidad & Tobago (2000-2002)
12 Brazil (2003-2005)	26 Nicaragua (2003-2005)	12 Suriname (2000,04,05)	26 Nicaragua (2003-2005)
13 Ecuador (2003-2005)	27 Bolivia (2002,2003)	13 Cuba (2004-2006)	27 Paraguay (2004-2006)
14 Cuba (2004-2006)		14 Colombia (2003-2005)	

Note: The countries are shown in ascending order of mortality from malignant neoplasm of the uterus.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

While mortality from malignant neoplasm of the uterus is higher in countries that have fewer resources, mortality from breast cancer does not correlate with a country's degree of development. In Figure 29 The countries are shown according to per capita gross national income, and it can be seen that in some of them high mortality rates from both types of malignant neoplasms coexist, especially in the Caribbean and in Paraguay.

Figure 29. **Mortality from malignant neoplasms of the uterus and breast (per 100,000 women) in the age groups 45 to 64 years, 21 countries of the Americas, circa 2004-2006**

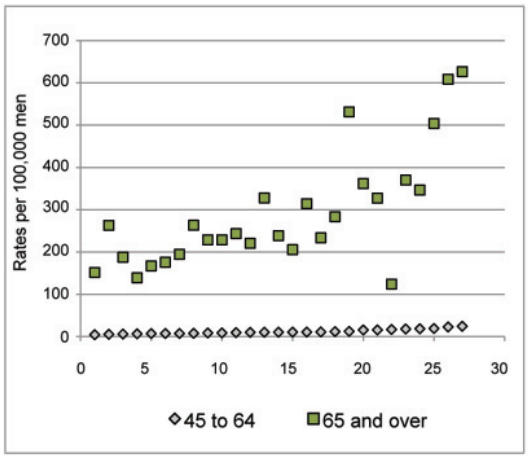


Note: The countries are shown in descending order of per capita gross national income.
Sources: (1) Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008. (2) Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

Malignant Neoplasm of the Prostate

Mortality from malignant neoplasm of the prostate primarily affects men aged 65 and over, with rates ranging from 124 per 100,000 in Bolivia to 627 per 100,000 in Trinidad and Tobago (Figure 30). In the group of 27 countries under review for the period 2004-2006, the highest rates for this type of malignant neoplasm (higher than 500 per 100,000 men) are in the Caribbean: Guadeloupe, Martinique, the Dominican Republic, and Trinidad and Tobago. In the group aged 45 to 64 the rates by country ranged from 4 to 24 per 100,000 men.

Figure 30. **Mortality from malignant neoplasm of the prostate (per 100,000 men) in age groups 45 to 64 and 65 and over, 27 countries of the Americas, circa 2004-2006**



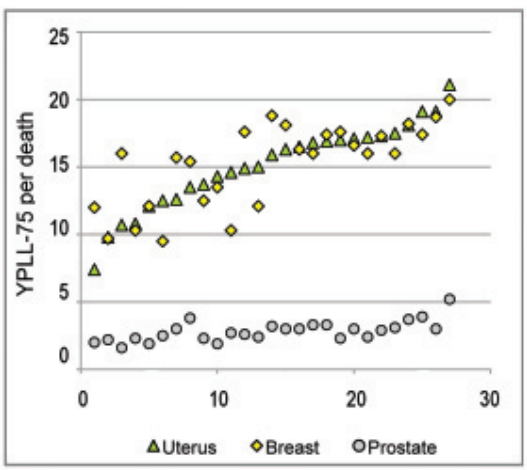
Countries

1 El Salvador (2004-2006)	15 Brazil (2003-2005)
2 Costa Rica (2004-2006)	16 Panama (2002-2004)
3 Ecuador (2003-2005)	17 Argentina (2004-2006)
4 Guatemala (2002-2004)	18 Venezuela (2003-2005)
5 Mexico (2004-2006)	19 Guadeloupe (2003-2005)
6 United States (2003-2005)	20 Cuba (2004-2006)
7 Canada (2002-2004)	21 Guyana (2003-2005)
8 Chile (2003-2005)	22 Bolivia (2002,2003)
9 Nicaragua (2003-2005)	23 Haiti (2002-2004)
10 Puerto Rico (2003-2005)	24 Uruguay (2001,03,04)
11 Colombia (2003-2005)	25 Martinique (2003-2005)
12 Peru (2002-2004)	26 Dominican Rep. (2002-2004)
13 Paraguay (2004-2006)	27 Trinidad & Tobago (2000-2002)
14 Suriname (2000,04,05)	

Note: The countries are shown in ascending order of rate for men aged 45-64.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

A look at the effects of mortality from the three types of malignant neoplasms described in the preceding paragraphs across the lifetime of women and men shows that mortality from malignant neoplasms of the breast and uterus begins relatively early in adult life, whereas mortality from malignant neoplasm of the prostate is concentrated in the more advanced ages. Thus, as Figure 31 shows, malignant neoplasms of the breast and uterus produce considerably more potential years of life lost (between 7 and 21 years) than mortality due to malignant neoplasm of the prostate (less than 5 years).

Figura 31. **Years of potential life lost prior to age 75 (YPLL-75) per death due to malignant neoplasms of the uterus, breast, and prostate, 27 countries of the Americas, circa 2004-2006**



Countries

1 Martinique (2003-2005)	15 Mexico (2004-2006)
2 Canada (2002-2004)	16 Suriname (2000,04,05)
3 Guadeloupe (2003-2005)	17 Brazil (2003-2005)
4 United States (2003-2005)	18 Guyana (2003-2005)
5 Puerto Rico (2003-2005)	19 El Salvador (2004-2006)
6 Uruguay (2001,03,04)	20 Colombia (2003-2005)
7 Trinidad & Tobago (2000-2002)	21 Panama (2002-2004)
8 Haiti (2002-2004)	22 Peru (2002-2004)
9 Chile (2003-2005)	23 Paraguay (2004-2006)
10 Costa Rica (2004-2006)	24 Guatemala (2002-2004)
11 Argentina (2004-2006)	25 Venezuela (2003-2005)
12 Ecuador (2003-2005)	26 Nicaragua (2003-2005)
13 Cuba (2004-2006)	27 Bolivia (2002,2003)
14 Dominican Rep. (2002-2004)	

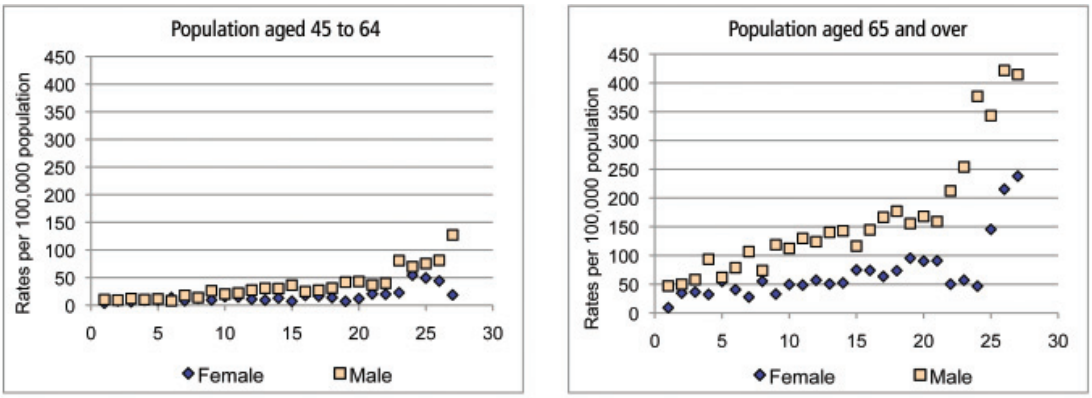
Note: The countries are shown in ascending order of YPPL-75 from malignant neoplasm of the uterus.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

Malignant Neoplasms of the Lung, Trachea, and Bronchus

As mentioned earlier, malignant neoplasms of the lung, trachea, and bronchus affect men more than women and are one of the leading causes of mortality. Mortality rates for men and women in the groups aged 45 to 64 and 65 and over (Figure 32) show that mortality from these neoplasms is highest in the population aged 65 and over and that it is greatest in men, particularly those aged 65 years and over. Nevertheless, mortality from these neoplasms is very significant for women in Canada, Cuba, and the United States, where it has outstripped mortality from malignant neoplasm of the breast.

The gap between the sexes in mortality from this cause is associated with higher tobacco use in males, a behavior that was traditionally encouraged in men but condemned in women. This gap has been narrowing in response to social shifts that have changed the definitions of femininity and facilitated women's economic access to consumer goods.

Figure 32. **Mortality from malignant neoplasms of the lung, trachea, and bronchus (per 100,000 population) in age groups 45 to 64 and 65 and over, by sex, 27 countries of the Region, circa 2004-2006**



Countries, population aged 45 to 64	
1 Guyana (2003-2005)	15 Trinidad & Tobago (2000-2002)
2 Ecuador (2003-2005)	16 Dominican Rep. (2002-2004)
3 Costa Rica (2004-2006)	17 Colombia (2003-2005)
4 Guatemala (2002-2004)	18 Chile (2003-2005)
5 El Salvador (2004-2006)	19 Paraguay (2004-2006)
6 Haiti (2002-2004)	20 Guadeloupe (2003-2005)
7 Mexico (2004-2006)	21 Venezuela (2003-2005)
8 Nicaragua (2003-2005)	22 Brazil (2003-2005)
9 Puerto Rico (2003-2005)	23 Argentina (2004-2006)
10 Peru (2002-2004)	24 Canada (2002-2004)
11 Bolivia (2002,2003)	25 United States (2003-2005)
12 Panama (2002-2004)	26 Cuba (2004-2006)
13 Suriname (2000,04,05)	27 Uruguay (2001,03,04)
14 Martinique (2003-2005)	

Countries, population aged 65 and over	
1 Guyana (2003-2005)	15 Peru (2002-2004)
2 Haiti (2002-2004)	16 Panama (2002-2004)
3 Guatemala (2002-2004)	17 Brazil (2003-2005)
4 Martinique (2003-2005)	18 Chile (2003-2005)
5 El Salvador (2004-2006)	19 Venezuela (2003-2005)
6 Ecuador (2003-2005)	20 Colombia (2003-2005)
7 Guadeloupe (2003-2005)	21 Dominican Rep. (2002-2004)
8 Nicaragua (2003-2005)	22 Paraguay (2004-2006)
9 Trinidad & Tobago (2000-2	23 Argentina (2004-2006)
10 Costa Rica (2004-2006)	24 Uruguay (2001,03,04)
11 Mexico (2004-2006)	25 Cuba (2004-2006)
12 Puerto Rico (2003-2005)	26 Canada (2002-2004)
13 Suriname (2000,04,05)	27 United States (2003-2005)
14 Bolivia (2002,2003)	

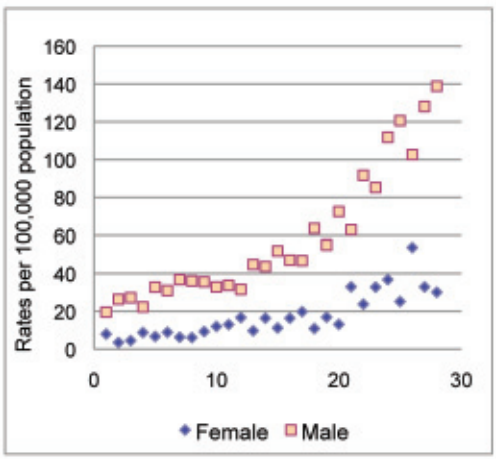
Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

Cirrhosis and Other Chronic Diseases of the Liver

This type of chronic disease affects men disproportionately. Even in the case of Mexico, where cirrhosis is the fifth-ranking cause of death for women (Table 2), estimated mortality rates[7] for the population reveal a wide gap between the sexes: 46 deaths per 100,000 for men and 14 per 100,000 for women (18). An important risk factor associated with this pathology is alcohol abuse, which along with smoking has been traditionally tolerated in men and stigmatized in women. Liver infections also contribute to other chronic diseases of the liver.

Mortality rates for cirrhosis and other chronic diseases of the liver in the population aged 45 to 64 (Figure 33) show that males carry the greatest burden of mortality from this cause, with variations in the size of the gap between the sexes in 28 countries. In fact, mortality in women reached half the rate for men in only three countries; in another 18 countries female mortality was 30% or less than the rates for men. The five countries with the highest male mortality rates (between 100 and 139 per 100,000 men) were, in descending order, Mexico, Nicaragua, Guyana, Guatemala, and Bolivia. For women, the highest rates ranged between 30 and 54 per 100,000 and occurred, in descending order, in Bolivia, Guatemala, the Dominican Republic, Peru, Nicaragua, and Mexico.

Figure 33. **Mortality from cirrhosis and other chronic diseases of the liver (per 100,000 population) in the population aged 45 to 64, by sex, 28 countries of the Americas, circa 2004-2006**



Countries	
1 Canada (2002-2004)	15 Guadeloupe (2003-2005)
2 Barbados (2000,2001)	16 Costa Rica (2004-2006)
3 Martinique (2003-2005)	17 El Salvador (2004-2006)
4 Colombia (2003-2005)	18 Puerto Rico (2003-2005)
5 Argentina (2004-2006)	19 Ecuador (2003-2005)
6 Cuba (2004-2006)	20 Brazil (2003-2005)
7 Uruguay (2001,03,04)	21 Dominican Rep. (2002-2004)
8 Paraguay (2004-2006)	22 Chile (2003-2005)
9 Trinidad & Tobago (2000-2002)	23 Peru (2002-2004)
10 Panama (2002-2004)	24 Guatemala (2002-2004)
11 United States (2003-2005)	25 Guyana (2003-2005)
12 Haiti (2002-2004)	26 Bolivia (2002,2003)
13 Venezuela (2003-2005)	27 Nicaragua (2000-2002)
14 Suriname (2000,04,05)	28 Mexico (2004-2006)

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

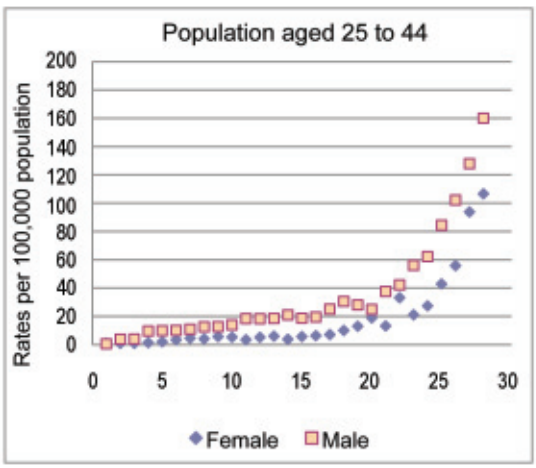
[7] Estimated mortality rates are obtained from registered mortality corrected for underreporting and redistribution of deaths due to causes assigned to the category Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, not elsewhere classified (ICD-10: R00-R99). Source: http/www.paho.org/English/SHA/glossary.htm.

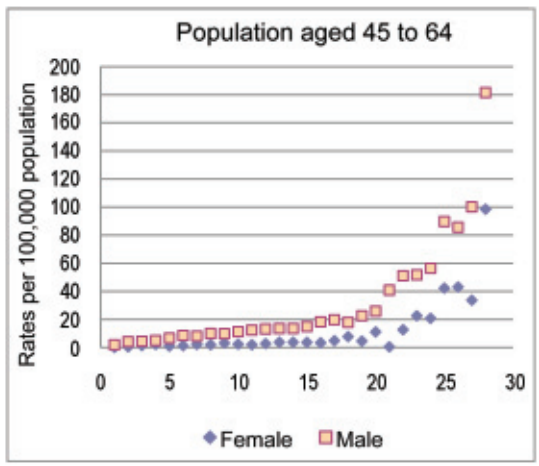
HIV Infection

HIV/AIDS disease is the fourth-ranking cause of death for males in the Latin and Non-Latin Caribbean (Table 2). Although mortality has been and continues to be higher in males than in females throughout the Region, the annual proportion of new infections is higher among women in several countries, especially in the group aged 15 to 24 (see also the chapter on Reproductive Health in this publication).

Figure 34 shows mortality due to HIV disease for women and men in the groups aged 25 to 44 and 45 to 64 in 28 countries of the Region around 2004-2006. In terms of sex differences in mortality, in the population aged 25 to 44 the highest rates for women and men were seen in Haiti, with 107 and 160 per 100,000 population respectively, while the lowest were in Bolivia, with 0.6 and 1.1, respectively. In the population aged 45 to 64, the corresponding rates for women and men were 98 and 181 per 100,000 population in Haiti at the highest end, and 0.1, and 2.0 in Cuba at the lowest. For both sexes, the figures indicate that four countries of the Caribbean (Haiti, Guyana, Suriname, and Trinidad and Tobago) had the highest mortality, ranging from 64 to 130 per 100,000 population in both age groups. Bolivia, Canada, Cuba, and Nicaragua were at the opposite end of the scale, with rates of less than 3 per 100,000 population.

Figura 34. **Mortality from HIV disease (per 100,000 population) in the populations aged 25 to 44 and 45 to 64, by sex, 28 countries of the Americas, circa 2004-2006**





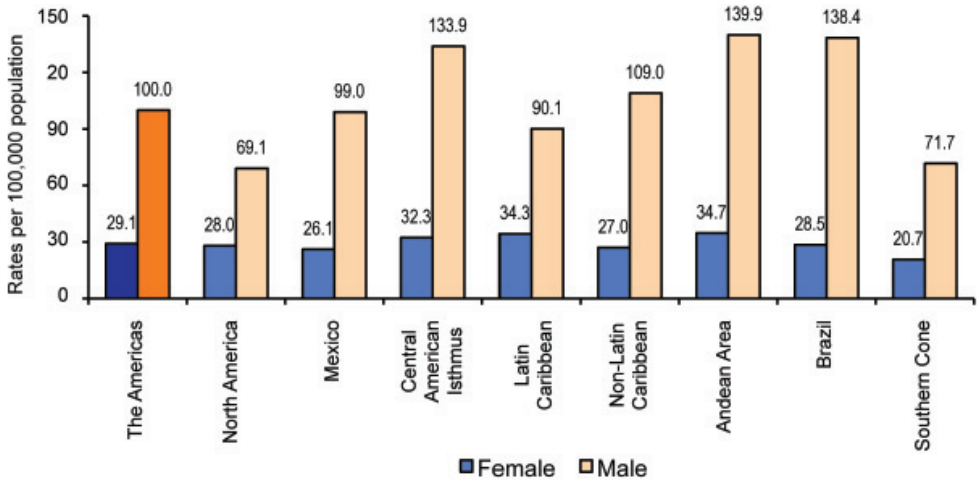
Countries, population aged 25 to 44		Countries, population aged 45 to 64	
1 Bolivia (2002,2003)	15 Uruguay (2001,03,04)	1 Cuba (2004-2006)	15 Guatemala (2002-2004)
2 Cuba (2004-2006)	16 Colombia (2003-2005)	2 Canada (2002-2004)	16 Colombia (2003-2005)
3 Canada (2002-2004)	17 Guatemala (2002-2004)	3 Nicaragua (2000-2002)	17 Guadeloupe (2003-2005)
4 Chile (2003-2005)	18 Peru (2002-2004)	4 Bolivia (2002,2003)	18 Brazil (2003-2005)
5 Costa Rica (2004-2006)	19 Brazil (2003-2005)	5 Chile (2003-2005)	19 Peru (2002-2004)
6 Nicaragua (2000-2002)	20 El Salvador (2004-2006)	6 Ecuador (2003-2005)	20 El Salvador (2004-2006)
7 United States (2003-2005)	21 Puerto Rico (2003-2005)	7 Argentina (2004-2006)	21 Puerto Rico (2003-2005)
8 Martinique (2003-2005)	22 Dominican Rep. (2002-2004)	8 Costa Rica (2004-2006)	22 Panama (2002-2004)
9 Paraguay (2004-2006)	23 Panama (2002-2004)	9 Paraguay (2004-2006)	23 Dominican Rep. (2002-2004)
10 Argentina (2004-2006)	24 Barbados (2000,2001)	10 Uruguay (2001,03,04)	24 Barbados (2000,2001)
11 Ecuador (2003-2005)	25 Suriname (2000,04,05)	11 Mexico (2004-2006)	25 Suriname (2000,04,05)
12 Venezuela (2003-2005)	26 Trinidad & Tobago (2000-2002)	12 Venezuela (2003-2005)	26 Guyana (2003-2005)
13 Guadeloupe (2003-2005)	27 Guyana (2003-2005)	13 Martinique (2003-2005)	27 Trinidad & Tobago (2000-2002)
14 Mexico (2004-2006)	28 Haiti (2002-2004)	14 United States (2003-2005)	28 Haiti (2002-2004)

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

External Causes

The most significant difference between males and females in the causes of mortality that affect both sexes is seen in external causes,[8] most of which stem from cultural roles and expectations associated with masculinity and are particularly prevalent in the young population. Figure 35 shows that age-adjusted mortality from external causes was three times higher for males in the Region as a whole (2003-2005). It was almost five times higher for males in Brazil and four times higher in the Central American Isthmus, the Andean Area, the Non-Latin Caribbean, and Mexico. In North America and the Latin Caribbean the male:female mortality ratio was 2.5.

Figure 35. **Age-adjusted mortality rates for external causes (per 100,000 population), by sex and by subregion, Region of the Americas, 2003-2005**



Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

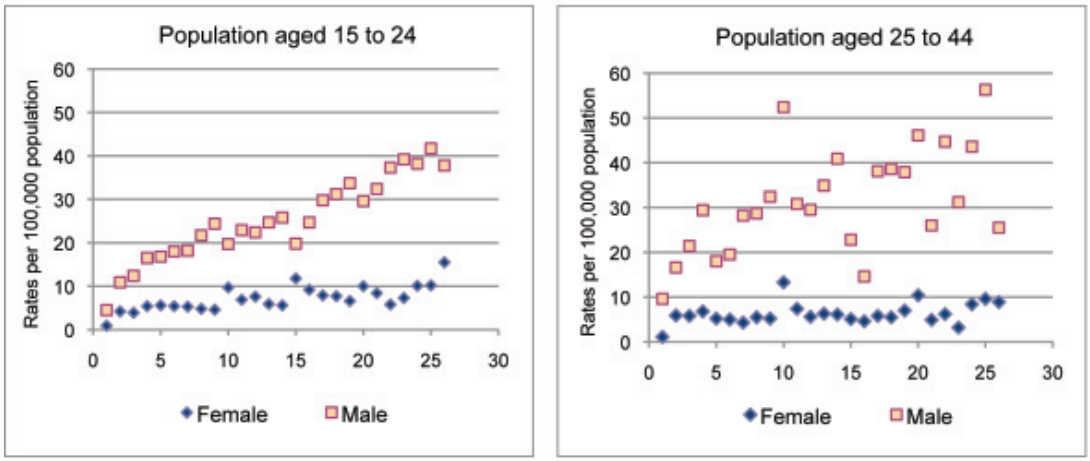
Transport Accidents

Land transport accidents represented the fourth most important cause of male mortality in the Andean Area and Brazil and the fifth-ranking cause in Mexico (Table 2). Figure 36 shows that in the group aged 15 to 24, and even more so in the population aged 25 to 44, mortality from transport accidents tends to be lower in women than men. The male:female ratio in the group aged 25 to 44 is significantly higher than in the group aged 15 to 24 in all the countries analyzed.

Male mortality from transport accidents is higher in the group aged 25 to 44 compared with mortality from this cause in the population aged 15 to 24 in 22 of the 26 countries or territories analyzed, whereas the rate for women is lower in 14 of the same 26 countries or territories. The only four countries or territories in which male mortality from transport accidents declined with age are Canada, United States, Martinique, and Puerto Rico.

[8] This category includes causes classified in Chapter XX of ICD-10 (codes V01-Y89).

Figure 36. **Mortality from transport accidents (per 100,000 population) in the groups aged 15 to 24 and 25 to 44, by sex, 26 countries of the Americas, circa 2004-2006**

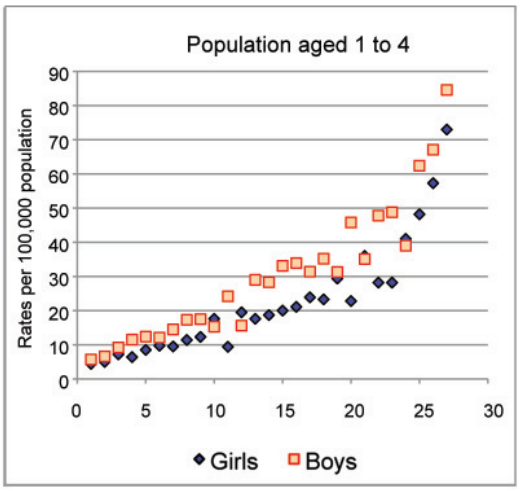


Countries		
1 Guatemala (2002-2004)	10 El Salvador (2004-2006)	19 Mexico (2004-2006)
2 Haiti (2002-2004)	11 Colombia (2003-2005)	20 Venezuela (2003-2005)
3 Peru (2002-2004)	12 Paraguay (2004-2006)	21 Puerto Rico (2003-2005)
4 Trinidad & Tobago (2000-2002)	13 Ecuador (2003-2005)	22 Guadeloupe (2003-2005)
5 Uruguay (2001,03,04)	14 Nicaragua (2000-2002)	23 Martinique (2003-2005)
6 Argentina (2004-2006)	15 Cuba (2004-2006)	24 Dominican Rep. (2002-2004)
7 Chile (2003-2005)	16 Canada (2002-2004)	25 Brazil (2003-2005)
8 Costa Rica (2004-2006)	17 Guyana (2003-2005)	26 United States (2003-2005)
9 Suriname (2000,04,05)	18 Panama (2002-2004)	

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

The predominance of males in mortality from transport accidents, as well as the increase in this predominance with age, is rooted in cultural values that facilitate greater mobility for males outside the home, particularly adults; in sex-related differential access to economic resources that facilitate this mobility; and in cultural values that foster (or tolerate) risk-prone behaviors and aggressiveness associated with masculinity. Greater male mortality from accidents can be observed starting in infancy, as shown in information for children 1 to 4 years old (Figure 37). This phenomenon may be indicative of differential socialization of girls and boys which translates into different risks that primarily affect males. This reasoning seems logical: if, on the other hand, there were a genetic element that accounted for the excess accidents in males, then there would be reason to ponder the high levels of female mortality in this age group that have appeared in some of the countries.

Figure 37. **Mortality from accidents in boys and girls aged 1 to 4 years (per 100,000 population), 27 countries of the Americas, circa 2004-2006**



Countries

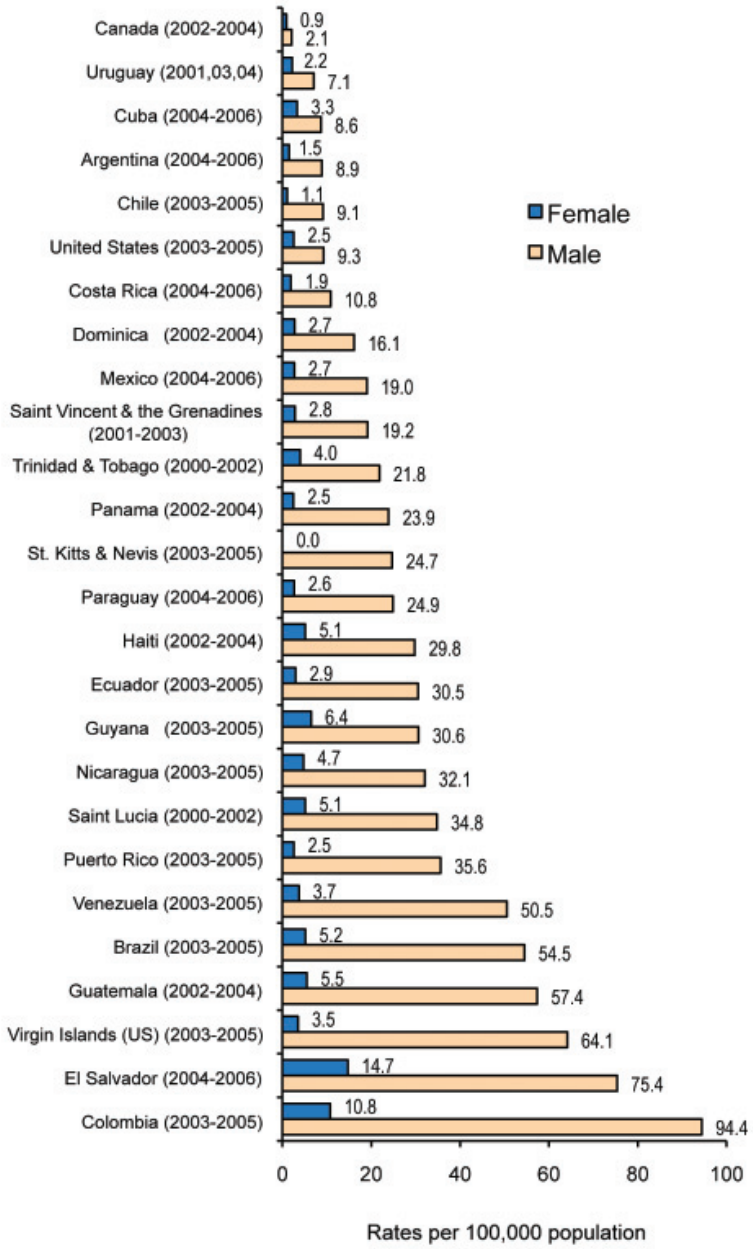
1 Puerto Rico (2003-2005)
2 Canada (2002-2004)
3 Guatemala (2002-2004)
4 Costa Rica (2004-2006)
5 United States (2003-2005)
6 Uruguay (2001,03,04)
7 Chile (2003-2005)
8 Cuba (2004-2006)
9 Argentina (2004-2006)
10 Trinidad & Tobago (2000-2002)
11 Martinique (2003-2005)
12 Guyana (2003-2005)
13 Panama (2002-2004)
14 Ecuador (2003-2005)
15 Brazil (2003-2005)
16 Haiti (2002-2004)
17 Suriname (2000,04,05)
18 Paraguay (2004-2006)
19 Dominican Rep. (2002-2004)
20 Nicaragua (2000-2002)
21 Belize (1999-2001)
22 El Salvador (2004-2006)
23 Mexico (2004-2006)
24 Colombia (2003-2005)
25 Venezuela (2003-2005)
26 Bolivia (2002,2003)
27 Peru (2002-2004)

Notes: (1) The countries included had at least 10 deaths from these causes in children 1 to 4 years old.
(2) The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

Homicide

Of all the external causes of mortality, homicides exhibit the most pronounced differences between the sexes. Figure 38 shows that for the period around 2003-2005 mortality due to homicide in females of all ages ranged from less than 1 per 100,000 in Canada and Saint Kitts to a high of 14.7 in El Salvador, whereas for males the range went from 2.1 in Canada and 94.4 in Colombia.

Figure 38. **Age-adjusted mortality rates due to homicide (per 100,000 population), by sex, 26 countries of the Americas, circa 2003-2005**

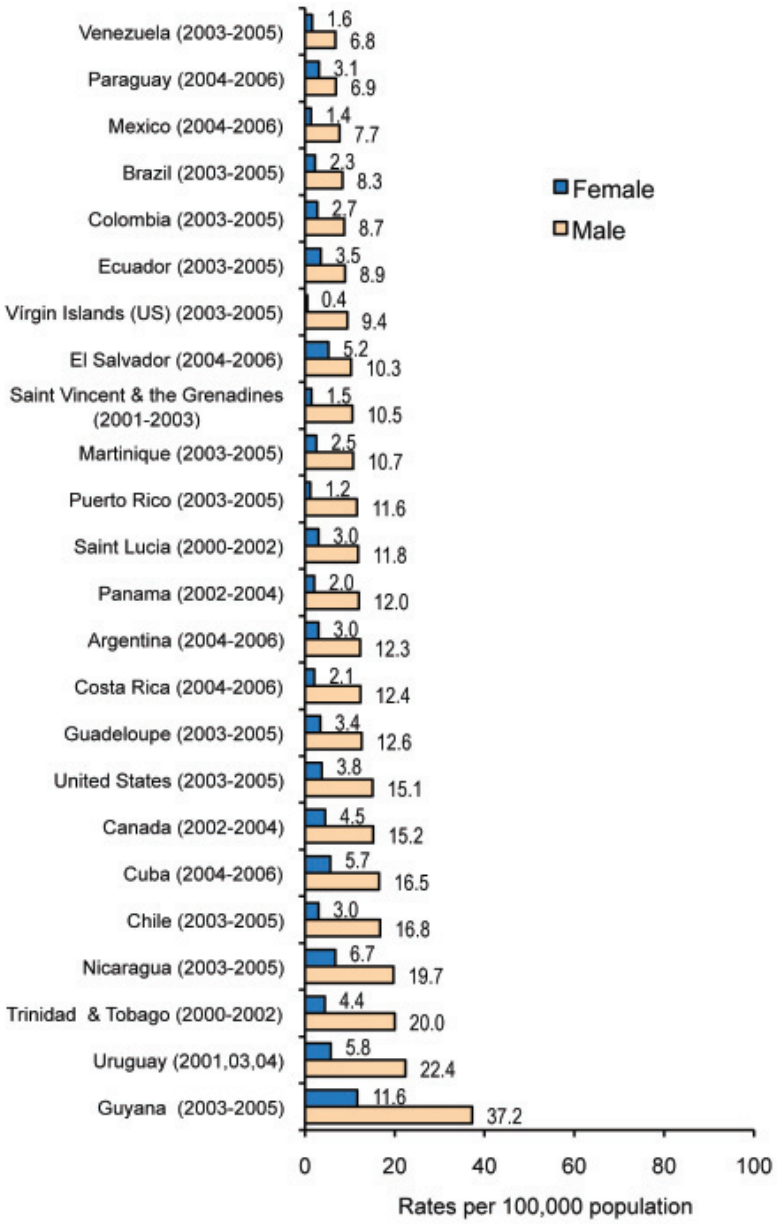


Note: The countries are shown in ascending order of the homicide rate for males.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

Suicide

Suicide is an extreme negative indicator of mental health, and, as in the case of other violent acts, disproportionately affects the survival of men. As seen in Figure 39, in all the countries of the Region the number of suicides tends to be substantially higher for men than women, reaching a factor of 23 times higher for men in the Virgin Islands (USA) and 10 times higher in Puerto Rico.

Figure 39. **Age-adjusted mortality rates due to suicide and self-inflicted harm (per 100,000 population), by sex, 24 countries of the Americas, circa 2003-2005**

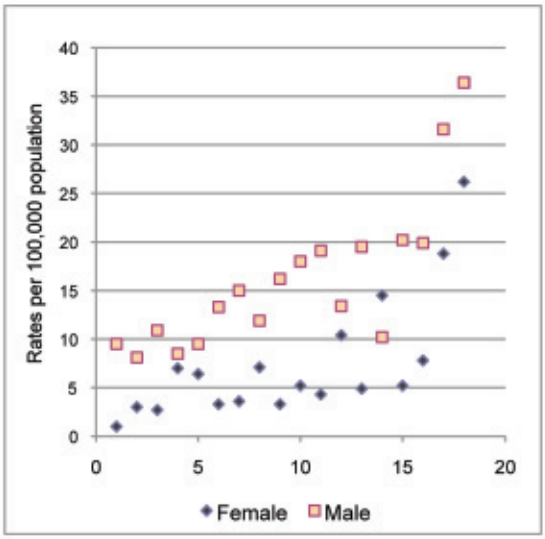


Note: The countries are shown in ascending order of the rate for males.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

This type of self-inflicted violence takes on special importance during adolescence, a stage of life in which it becomes the first or second cause of death in both sexes. According to data collected by PAHO, during the period around 2004-2006 suicide was the leading cause of death for females in the group aged 15 to 24 in Ecuador, Guyana, and Nicaragua, and for males in the same age group in Argentina, Chile, and Uruguay. It was the second most important cause of death for females aged 15 to 24 in nine additional countries and the second cause for males in the same age group in five countries (*19*).

Figure 40 shows that suicide rates in young people vary from country to country. Around 2004-2006 the countries with the highest suicide rates in the population aged 15 to 24 were Guyana, with 31 per 100,000 population, and Nicaragua, with 25 per 100,000 population. The countries with the lowest rates were Puerto Rico and Brazil, each at around 5 per 100,000 population. Mortality from suicide in the group aged 15 to 24 was higher for males in all the countries except El Salvador, where the rate was 15 per 100,000 for females and 10 per 100,000 for males. The male:female ratios for suicide were almost equal in Ecuador and Paraguay. In Colombia, Cuba, Guyana, and Nicaragua the male:female ratio was lower than 2, and in the 11 remaining countries the rate for males was more than double—in seven of them, more than four times higher.

Figure 40. **Mortality due to suicide (per 100,000 population) in the group aged 15 to 24, by sex, 18 countries of the Americas, circa 2004-2006**

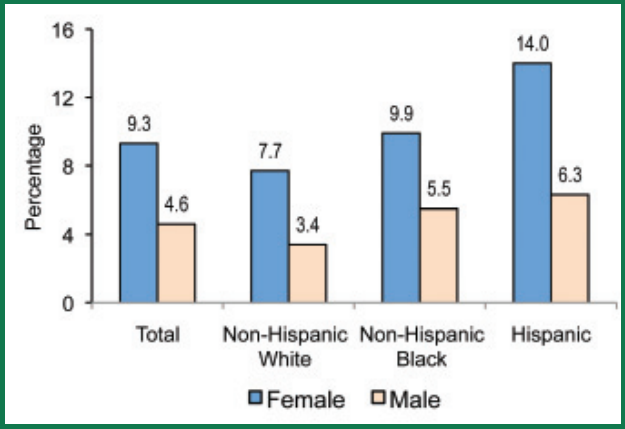


Countries
1 Puerto Rico (2003-2005)
2 Brazil (2003-2005)
3 Mexico (2004-2006)
4 Paraguay (2004-2006)
5 Cuba (2004-2006)
6 Costa Rica (2004-2006)
7 Panama (2002-2004)
8 Colombia (2003-2005)
9 United States (2003-2005)
10 Canada (2002-2004)
11 Chile (2003-2005)
12 Ecuador (2003-2005)
13 Argentina (2004-2006)
14 El Salvador (2004-2006)
15 Uruguay (2001,03,04)
16 Trinidad & Tobago (2000-2002)
17 Nicaragua (2000-2002)
18 Guyana (2003-2005)

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

Given the cultural and legal issues that affect the medical certification of suicide as a cause of death, the available statistics probably do not reflect the real magnitude of this problem. Although mortality from suicide tends to be higher for men, attempted suicide tends to be more frequent for women. Figure 41 shows that cultural and ethnic factors can contribute to this complicated and multifaceted situation.

Figure 41. **Students from 9th to 12th grade who attempted suicide (%), by sex, race, and Hispanic origin, United States, 2007**



Note: Data are for the 12 months prior to the survey.
Source: U.S. National Center for Health Statistics. Health, United States, 2008. Available at http://www.cdc.gov/nchs/hus.htm

In addition to homicides and suicides, eight countries of the Region reported high mortality from injury of undetermined intent[9] in the population aged 25 to 44, with a high in women of 11.5 per 100,000 population in Guatemala. This country also had the highest rate for men: 85.3 per 100,000 population. The lowest rate for men was 16.7 per 100,000 population in Haiti (Table 4). In several countries (for example, Peru, the Dominican Republic, and Suriname), mortality rates for injury of undetermined intent were much higher than those for homicide or suicide.

Table 4. **Mortality due to injury of undetermined intent (per 100,000 population) in the group aged 25 to 44, by sex, eight countries of the Region of the Americas, circa 2003-2005**

Country	Female	Male
Haiti (2002-2004)	5.8	16.7
Guyana (2003-2005)	3.7	18.2
Peru (2002-2004)	5.9	25.6
French Guiana (2003-2005)	2.5	48.0
Dominican Republic (2002-2004)	8.0	55.0
Venezuela (2003-2005)	4.7	56.5
Suriname (2000,04,05)	9.8	61.2
Guatemala (2002-2004)	11.5	85.3

Note: The countries are shown in ascending order of the rate for males.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

[9] When it is not possible to determine whether a death was caused by an accident, homicide, or suicide, it is classified as an injury of undetermined intent.

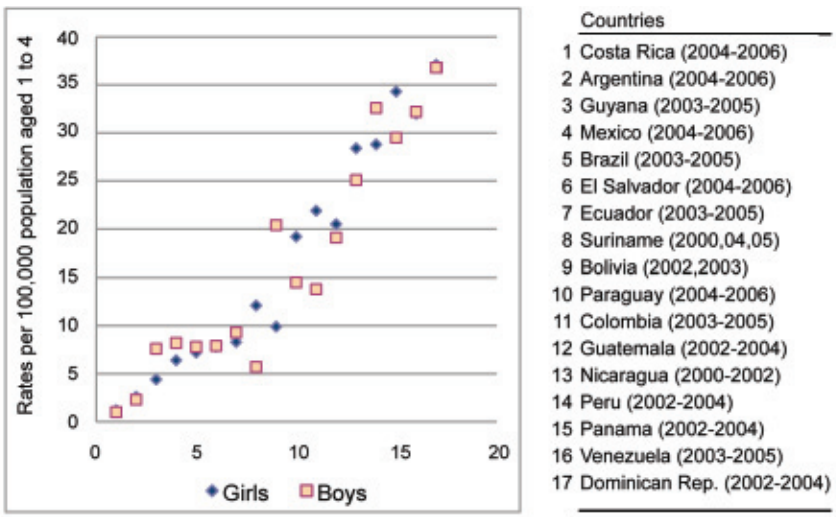
NUTRITIONAL PROBLEMS

Even though poverty has declined in the Region of the Americas, nutritional impairments—an indicator that is closely related to lack of economic resources—continue to be a significant health problem that causes disability in many excluded and marginalized population groups. Socially constructed roles and gender standards interact with biological differences between women and men to affect their nutritional status. Although malnutrition affects both sexes, women, for biological reasons and because of their social role, experience greater risk of nutritional deficiencies. In addition, for reasons related to their reproductive role such as menstruation, pregnancy and lactation, their nutrient requirements are greater during the reproductive age. The biological need of women is turned into a deficiency in certain groups not only as an effect of poverty in their environment, which keeps from them acquiring appropriate food, but also due to the absence of interventions that recognize their role and respond to their needs.

The nutritional problems of women generate a vicious cycle of malnutrition. The nutritional status of newborn boys and girls is related to the nutritional status of the mother during pregnancy and lactation. Deficient nutrition in newborns is manifested in subsequent stages of their life cycle, limiting the development of their skills and their productivity and, in the case of women, increasing the risks associated with their reproductive and maternal functions. Moreover, anthropological research has shown that in some social groups the effects of poverty and marginalization are exacerbated by inequity in the allocation of food resources within the home, since special importance is given to the male child starting early in life and also to the male "provider."

Although inequality is not usually recognized in the nutritional status of boys and girls, the information on mortality from nutritional deficiencies and anemia during childhood presented in Figure 42 provides elements that could indicate that inequality does in fact exist between the sexes. In any case, the best known form of nutritional deficiency in women of childbearing age is iron-deficiency anemia, which will be analyzed in the section on Reproductive Health.

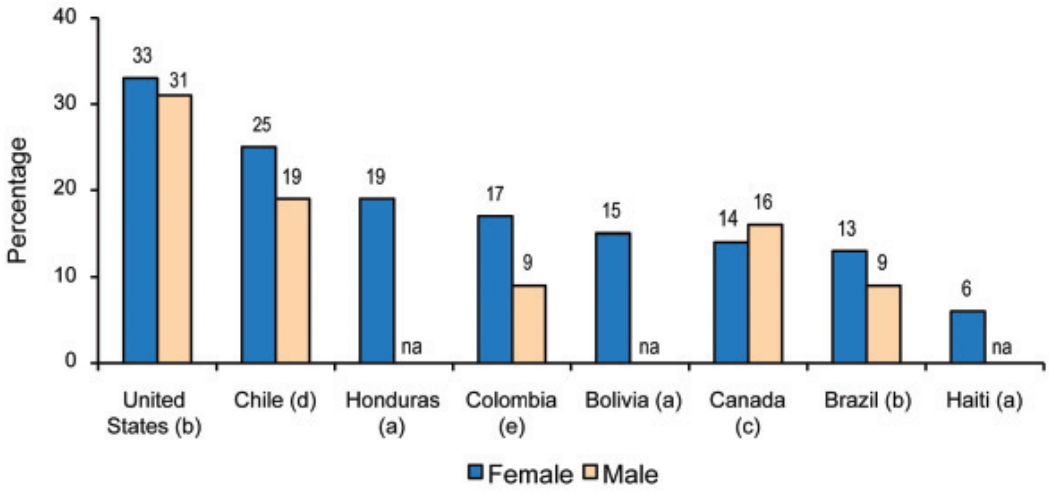
Figure 42. **Mortality due to nutritional deficiencies and anemia in children 1 to 4 years old (per 100,000 population), by sex, in 17 countries of the Americas, circa 2004-2006**



Notes: (1) The countries listed had a minimum of 3 deaths due to this cause in children 1 to 4 years old in each sex. Haiti, which has a rate of 277 per 100,000 population in males and 348 per 100,000 in females, is not included.
(2) Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

In addition to inequities in nutrition, a problem of growing importance in the Region is obesity, which includes risks of acquiring chronic diseases and tends to be more serious for women, as suggested by the figures available for some of the countries. Figure 43 shows that in 8 countries with data available, obesity in women ranges from a high of 33% in the United States to 6% in Haiti, with rates between 25% and 13% in other countries (Chile, Honduras, Colombia, Bolivia, Canada, and Brazil). In four of the five countries that have data disaggregated by sex, the proportion of obesity is greater in women. Only in Canada were males predominant.

Figure 43. **Prevalence of obesity (%), by sex, 8 countries of the Americas with data available, 2002-2006**



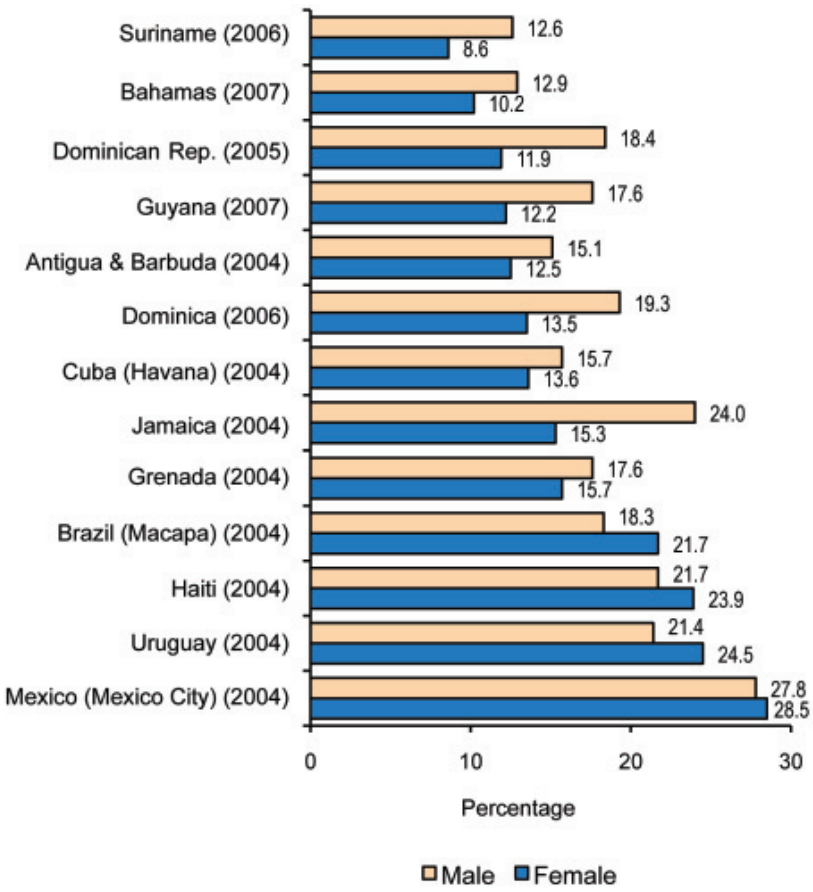
Notes: 1) Age ranges: (a) 20 years and over; (b) 17 years and over; (c) 15- 49 years; (d) 18 -64 years; (e) 18 years and over. 2) The countries are shown in descending order of the rate for women. na: data not available.
Source: PAHO. Basic Indicators: Gender, Health, and Development in the Americas, 2007. Washington, D.C., 2007.

Another nutritional problem is eating disorders such as anorexia and bulimia, which particularly affect females of privileged social strata, especially during adolescence. These food deprivation disorders are associated in many cases with cultural stereotypes of feminine beauty in which a high value is placed on being thin.

TOBACCO AND ALCOHOL CONSUMPTION

Tobacco use is a risk behavior particularly associated with cardiovascular problems and malignant neoplasm of the lung. Traditionally, this habit has been more frequent among men than women. Although this trend continues, the gap between the sexes is narrowing as a consequence of social and economic shifts that have changed cultural expectations regarding femininity, promoted modern images, and given women easier access to their own economic resources. Moreover, cigarette smoking has been encouraged through advertising campaigns that specifically target women. These changes have led to a rise in smoking rates among women, particularly young women, and a resulting increase in mortality from malignant neoplasm of the lung in the female population, especially in more developed countries (Figure 32). Information from 13 countries of Latin America and the Caribbean (2000-2007), presented in Figure 44, indicates that for adolescents in the 13-to-15 year age group the percentage of tobacco use for girls exceeded that of boys in four countries or cities: Brazil (Macapá), Haiti, Uruguay, and Mexico (Mexico City).

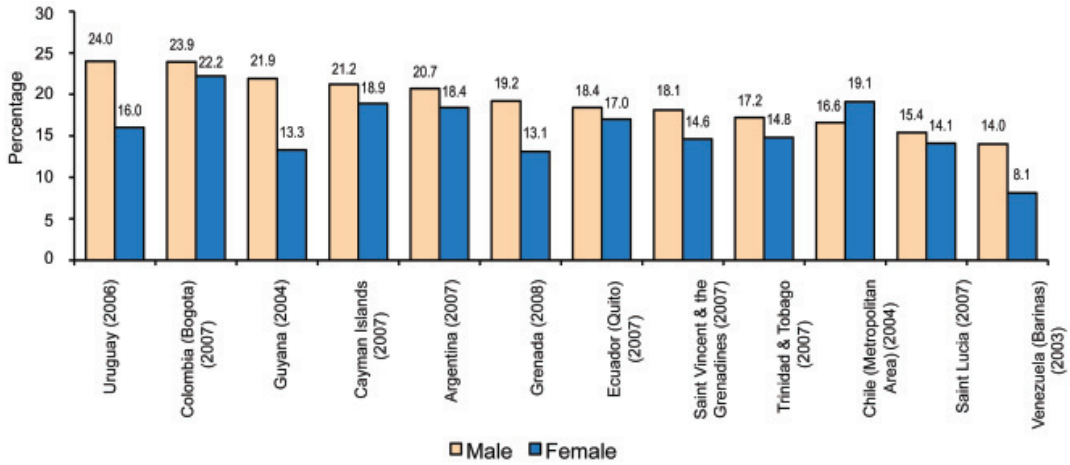
Figure 44. **Prevalence of tobacco use [1] in adolescents aged 13 to 15 (%), by sex, 13 countries or cities of the Americas, circa 2000-2007**



[1] Use of any amount of a tobacco product during the 30 days before the survey.
Note: The countries are shown in ascending order of tobacco use by females.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., 2007. http://www.paho.org/Spanish/sha/coredata/tabulator/newtabulator.htm. Accessed on 8 May 2009.

Similarly, for alcohol consumption the gaps between males and females have narrowed as well, especially among young people. In a recent survey of students 13 to 15 years old it was found that 14% to 24% of the boys and 8% to 19% of the girls were dealing with health challenges, difficulties in school, problems with family or friends, or had gotten into fights, because of alcohol consumption (Figure 45). The differences in percentages between men and women were not significant, and in Chile (Metropolitan Area) the percentage was higher for women than for men. Alcohol consumption is a problem that should be integrated into initiatives aimed at promoting a healthy lifestyle in order to avoid not only the health consequences but also the added social and financial burden for the family and the state.

Figure 45. **Students aged 13 to 15 (%) who have had problems [1] stemming from alcohol consumption at least once in their lives, by sex, 12 countries or cities of the Americas, circa 2007**



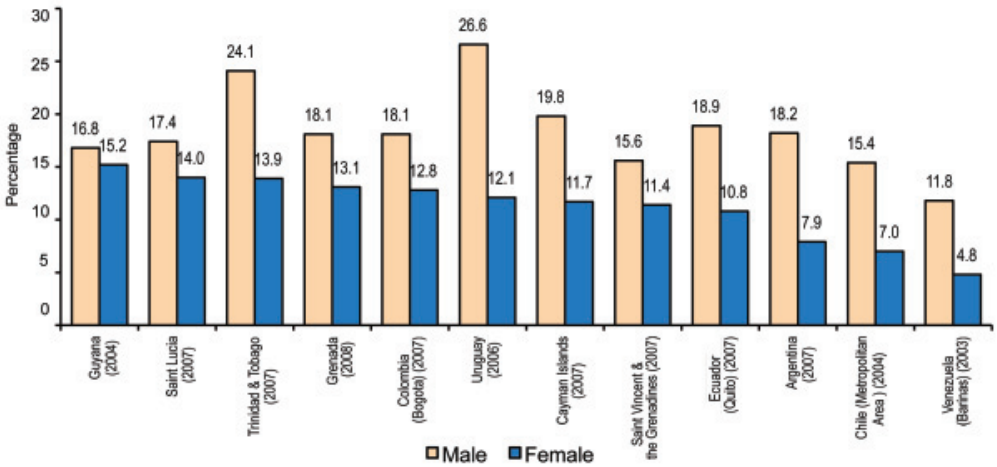
[1] Hang-over, felt sick, got into trouble with family or friends, missed school, or got into fights.
Note: The countries and cities are listed in descending order of the percentage for males.
Source: WHO. Global School-based Student Health Survey. http://www.who.int/chp/gshs/factsheets/en/index.html. Accessed on 26 June 2009.

OTHER HEALTH PROBLEMS

Lack of Physical Activity

Although it is recognized that acquiring the habit of physical activity at an early age helps to maintain a healthy life well into advanced years, this practice is not a daily routine for adolescents. Figure 46 shows that in all the countries or cities for which information is available the percentage of adolescents who engage in physical activity is low for both sexes, and lower for women. The differences in physical activity by sex are significant in Argentina, Chile (Metropolitan Area), Uruguay, and Venezuela (Barillas), where the percentage for men is more than double the rate for women. On the other hand, in Trinidad and Tobago, Cayman Islands, and Ecuador the percentage of men and women who engage in physical activity is about the same.

Figure 46. **Students who engaged in at least 60 minutes of physical activity a day in the 7 days prior to the survey (%), by sex, 12 countries or cities of the Americas, circa 2007**



Note: The countries are shown in descending order of the percentage for females.
Source: WHO Global School-based Student Health Survey.http://www.who.int/chp/gshs/factsheets/en/index.html. Accessed on 26 June 2009.

Occupational Health

It is widely known that work—formal, informal, and unpaid—plays a fundamental role in economic and social well-being, power, and prestige. It is also an important social determinant that affects the health of people. Moreover, gender-based inequalities in the workplace have an impact on health (*20*). Additionally, as women attempt to balance the time they spend on productive and reproductive work, caregiving in the home, and service to the community, their work days are longer and their heavy schedule undermines maintenance of their health.

Work places and working conditions can be risks that jeopardize the health of women and men differently. For example, construction work and mining expose men to accidents and cause proportionately higher mortality for them. Work on banana plantations and in floriculture can expose both women and men to toxic chemicals that can contribute to the incidence of malignant neoplasms, generate reproductive problems, and even cause death. At the same time, exposure to smoke from using firewood as fuel in the home can cause respiratory diseases, especially in women for whom home is the workplace.

Even though more is known about the problems associated with the work of men, recently several work-related risks have been identified in which women predominate. For example, in assembly plants in Latin America it has been confirmed that women are exposed to harmful chemicals, ergonomic risks, noise, and stress (*20, 21*). In addition, women are exposed to sexual harassment in the workplace more often than men, and work-related fatigue is also more common among women (*20*).

Health Problems Associated with Longevity

Because the population distribution in the Americas is aging, it is crucial to document sex differences in the health of older adults in order to design initiatives that meet the specific needs of this population group. The diseases that afflict women and men in their advanced years are different, and therefore the health sector's response should be different as well.

Studies on the health and well-being of the older adult population conducted in Latin America, and the Caribbean as well as the United States and Canada have shown that hypertension, diabetes mellitus, and disability, among others, are problems that affect older adults in particular (*1*). Women aged 60 and over tend to have a greater degree of disability than men of the same age group. As mentioned previously (Figure 23), surveys conducted in seven cities of the Americas have revealed that between 16% and 23% of women aged 60 and over were impaired in their ability to bathe, eat, get dressed, use the toilet, transfer from the bed to the chair, or walk. The percentage of men affected by these limitations ranged between 11% and 14%. Women, on the other hand, have more problems with osteoporosis and arthritis. For example, in the United States in 2004 the rate of hospitalization for hip fracture per 100,000 population was double for women compared with men or 1,113 and 558 per 100,000, respectively (*22*).

IV. REPRODUCTIVE HEALTH AND ACCESS TO SERVICES

The definition of reproductive health adopted at the International Conference on Population and Development (Cairo, 1994) implies that people should be able to have a satisfying and safe sex life; the freedom to decide if, when, and how often to reproduce; and access to the information, means, and services that will ensure women a safe experience with pregnancy and childbirth.

The greatest qualitative difference between the health of women and that of men has to do with sexual and reproductive activity. Women assume the biological consequences of pregnancy, childbirth, and lactation, as well as the responsibility of child care that society assigns to them. Women carry the greater burden of contraception and are more vulnerable to sexually transmitted infections. As a result, problems related to sexual and reproductive health represent approximately 20% of the total disease burden borne by women, compared with 15% borne by men (*1*). The unequal power relationships between the sexes predominant in American societies serve to limit women's control over their own sexuality and their capacity to be protected against unwanted sexual relations and pregnancies as well as sexually transmitted infections, the effects of which are devastating.

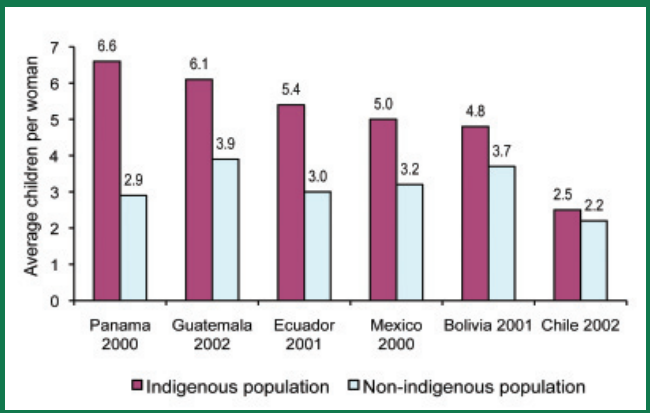
FERTILITY

Women's increasing entry into the labor market and their greater access to formal education in recent decades have strengthened their autonomy and influenced the nature of relationships between genders and the ability of individuals to make decisions about their lives. One of the results of these changes is women's growing control over their own reproduction, which, added to access to better contraceptive technology, has contributed to a decline in the average number of children born to women in Latin America and the Caribbean from nearly 6 in 1955-1959 (*23*) to 2.3 in 2008 (*3*)—a reduction of approximately 60% in 48 years.

However, the reduction in fertility has not been the same in all the countries. There are persistent socioeconomic disadvantages that predominate in certain groups of the population and constitute a barrier to decisions that women might otherwise take regarding their reproduction. For example, in 2008, while the number of children per woman was 2 or lower in Canada, Chile, Cuba, the United States, Martinique, Puerto Rico, and most of the Non-Latin Caribbean islands, this number was 4.1 in Guatemala and more than 3 in Bolivia, French Guiana, Haiti, and Honduras (*3*). Ethnic populations are even more affected by high fertility rates. Figure 47 shows that in all the countries studied except Chile indigenous women have more children than non-indigenous women. In Panama, for example, in 2000 the average number of children of indigenous women was double the number for non-indigenous women.

In addition to the positive effect of planned pregnancy on the health of women and their children, the exercise of women's sexual and reproductive rights contributes to the achievement of gender equality, which has been established as Goal 3 of the Millennium Development Goals.

Figure 47. **Total fertility rate, indigenous and non-indigenous population, six countries of the Americas, 2000 census round**



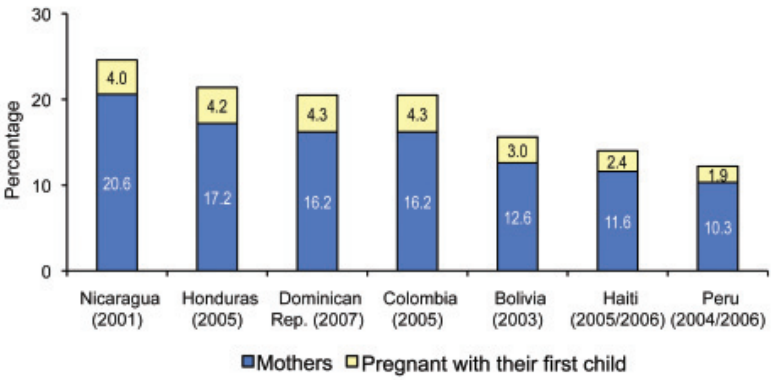
Note: The countries are shown in descending order of the TFR in the indigenous population.
Source: ECLAC. Indigenous and Afro-descendent Peoples of Latin America and the Caribbean: Socio-demographic Data for Policies and Programs. Santiago, Chile: 2006.

PREGNANCY AND MATERNITY IN ADOLESCENCE

Teen pregnancy and maternity can have a serious impact on the future of young mothers and their children, not only because of the challenges to their physical health but also because of the constraints that early maternity imposes on educational, social, and employment opportunities. The adolescent population, especially at low socioeconomic levels, has its own unique obstacles in terms of access to and use of resources for sexual and reproductive health. This explains, at least in part, why the specific fertility rate for adolescents remains high in the Region of the Americas.

According to the Demographic and Health Surveys conducted in some of the countries of Latin America and the Caribbean in recent years, the percentage of young women aged 15 to 19 who were already mothers or pregnant with their first child when the survey was conducted ranged from 12.2% in Peru to 24.6%—one in four—in Nicaragua (Figure 48).

Figure 48. **Adolescent women aged 15 to 49 who are mothers or pregnant with their first child (%), seven countries of the Americas, most recent year with data available**



Source: MEASURE DHS STATcompiler. ORC Macro, 2008. http://www.measuredhs.com. Accessed on 2 September 2008.

As seen in Table 5, there are differences by level of schooling and area of residence. Among adolescents with a higher educational level the proportion of mothers or first-time pregnant women is lower. It is also lower for adolescents living in urban areas compared to those in rural areas.

Table 5. **Adolescent women who are mothers or pregnant with their first child (%), by educational level and area of residence, seven countries of the Americas, most recent year with data available**

Country	No education	Primary education	Secondary and higher education	Urban Area	Rural Area	Total
Nicaragua (2001)	46.3	32.4	16.3	21.3	30.2	24.7
Honduras (2005)	46.3	31.5	10.5	17.7	26.0	21.5
Dominican Rep. (2007)	51.3	32.0	14.7	18.3	26.0	20.6
Colombia (2005)	52.3	42.3	16.3	18.5	26.9	20.5
Bolivia (2003)	47.2	25.2	9.8	12.9	21.9	15.7
Haiti (2005/06)	30.0	16.6	8.7	11.0	16.7	14.0
Peru (2004/06)	nd	33.2	9.0	8.4	21.1	12.2

Note: The countries are shown in descending order of the total.
Source MEASURE DHS STATcompiler. : ORC Macro, 2008. http://www.measuredhs.com. Accessed on 2 September 2008.

These percentages have not varied greatly in recent years. In four countries for which information is available—namely, Bolivia, Colombia, Haiti, and the Dominican Republic—the period between 1995 and 2005 saw sizeable changes in the percentage of adolescents without schooling who were already mothers or pregnant with their first child. In Bolivia the percentage rose from 37.5 to 47.2, and in the Dominican Republic the figure fell from 58.3 to 51.5 (*24*).

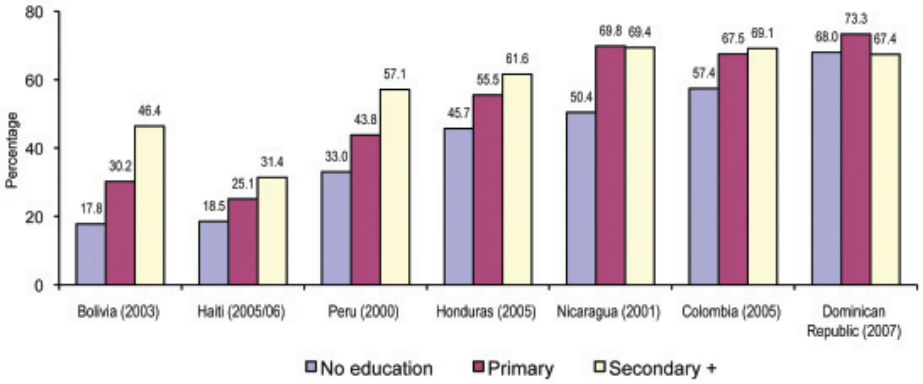
> *You often see girls raising children. They don't get married. This is nothing new. It has always been this way.*
>
> Teenage girls, Garifuna community, Guatemala.

CONTRACEPTIVE USE

Data for Latin America and the Caribbean for around 2005 indicate that the percentage of women aged 15 to 49 living in a union who were using some form of contraception averaged 68%, although some 10 countries and territories had figures below 50%. In Bolivia and Haiti the proportion of contraceptive use was lower than 30%, and in Anguilla, Guyana, Honduras, Cayman Islands, Panama, Suriname, Trinidad and Tobago, and Venezuela the proportion was between 30% and 49% (*3*).

These differences between countries are also reproduced within each country. As seen in Figure 49, analysis by educational status of women living in a union shows that the use of modern contraceptive methods increases in tandem with level of education. The exception was the Dominican Republic, where the percentage of contraceptive use among women with higher-level education (secondary and +) is slightly lower than that of women without education. In Bolivia the estimated percentage for women with higher-level education is 2.7 times greater than for those without education.

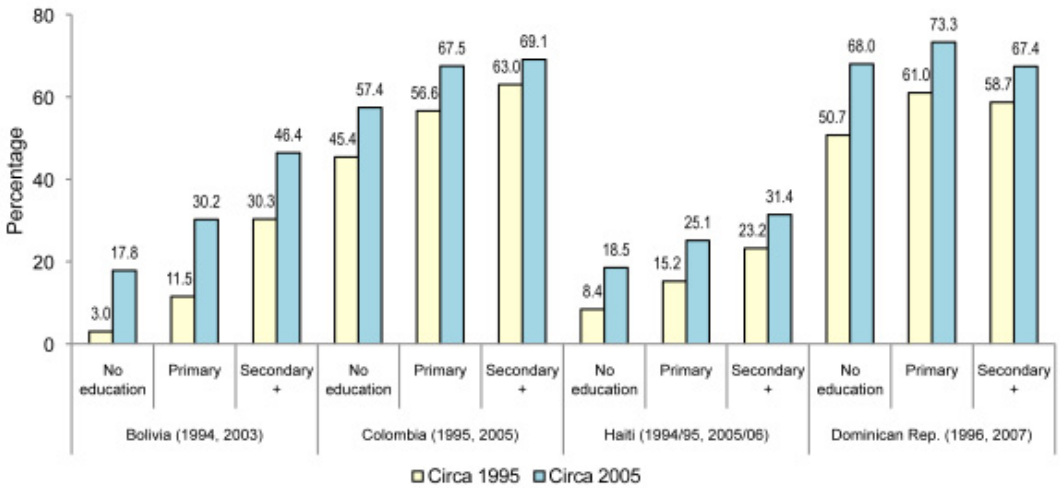
Figure 49. **Currently married women aged 15 to 49 who use modern contraceptive methods (%), by level of education, seven countries of the Americas, circa 2005**



Source: MEASURE DHS STATcompiler. Macro International, Inc., 2008. http://www.measuredhs.com. Accessed 27 November 2008.

A comparison of women aged 15 to 49 living in a union who used modern contraceptive methods in or around 1995 versus the same group in 2005 (Figure 50) shows an increase in levels of education in the four countries considered—Bolivia, Colombia, Haiti, and the Dominican Republic. Bolivia had the largest increases in the ten-year period: the use of modern planning methods by women without education was six times greater in the most recent period; for those with primary schooling it almost tripled; and for those with higher-level education it went up 50%.

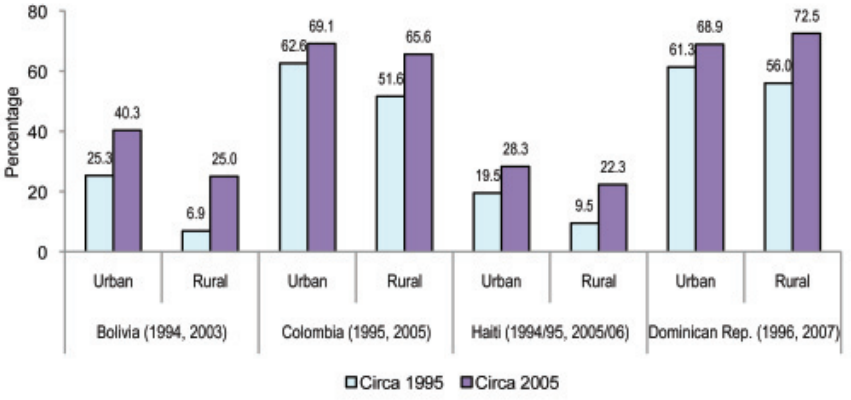
Figure 50. **Currently married women aged 15 to 49 who use modern contraceptive methods (%), by level of education, four countries of the Americas, circa 1995 and 2005**



Source: MEASURE DHS STATcompiler. Macro International, Inc., 2008. http://www.measuredhs.com. Accessed on 27 November 2008.

Considering area of residence, over the period 1995-2005 the increase in use of modern family planning methods was greater in rural areas than in cities (Figure 51). In Bolivia, despite significant increases in both areas of residence, there is still a pronounced disparity between the two with much lower contraceptive use in the rural areas. However, in the Dominican Republic the use of modern contraceptives in 2007 was higher in the rural area (72.5%) compared with cities (68.9%).

Figure 51. **Currently married women aged 15 to 49 who use modern contraceptive methods (%), by area of residence, four countries of the Americas, circa 1995 and 2005**



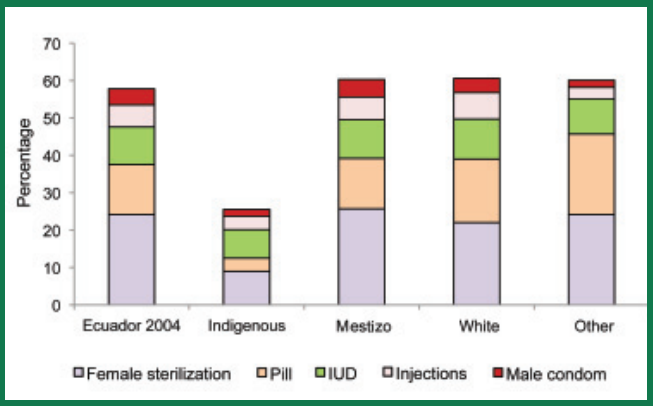
Source: MEASURE DHS STATcompiler. Macro International, Inc., 2008. http://www.measuredhs.com. Accessed on 27 November 2008.

Here in the countryside they don't think it's nice for women to take stuff to keep from having children. We're supposed to have the children.

Women from the community adjacent to Hospital Achacahi, Bolivia.
Source: PAHO. Winning experience in the Best Practices Competition 2009. Bolivia: Gender-focused Primary Health Care ("Estrella" Health Services).

Differences in contraceptive use are also seen between groups of different ethnic origin (Figure 52). Although there is little information disaggregated for this variable, data from Ecuador show that in 2004 fewer than 26% of indigenous women living in a union used contraceptive methods, even though at the national level the proportion was 55%. The contraceptive method used most often by Ecuadorian women living in a union in all the ethnic groups was female sterilization; among indigenous women, the second method most preferred method was the intrauterine diaphragm, and in the other groups, the pill.

Figure 52. **Currently married women aged 15 to 49 who use modern contraceptive methods (%), by ethnic origin, Ecuador, 2004**

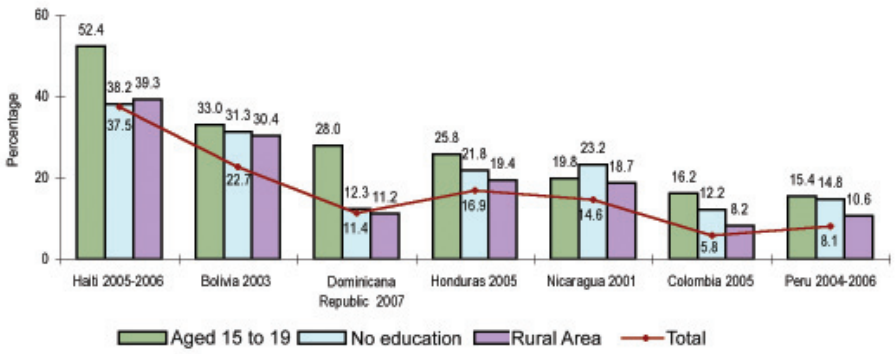


Source: CEPAR. Demographic and Maternal and Child Health Survey, ENDEMAIN 2004. Final Report. Quito, October 2005.

Unmet Need for Family Planning

The unmet need for family planning is an indicator that provides useful information for facilitating improved access to services that offer women the option of preventing unwanted pregnancies. In the seven countries analyzed (Figure 53), the unmet need for family planning was greatest among women in the adolescent age range, compared with women without education and those living in rural areas. The exception was Nicaragua, where women without education faced a greater unmet need than adolescents. In Haiti 52% of adolescents living in a union declared that their need for family planning services was unmet. It should be emphasized that one of the factors associated with the reduction of teen pregnancy is access to reproductive health resources—e.g., information, methods, and quality family planning services—and, of course, the actual use of these resources.

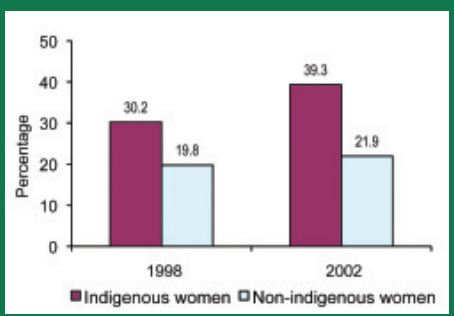
Figure 53. **Currently married women aged 15 to 49 with unmet need for family planning (%), by selected characteristics, seven countries of the Americas, circa 2005**



Note: The countries are shown in descending order of percentage in women aged 15 to 19.
Source: MEASURE DHS STATcompiler. Macro International Inc, 2009. http://www.measuredhs.com. Accessed on 7 May 2009.

In Guatemala the unmet need for family planning increased between 1998 and 2002 for both indigenous and non-indigenous women, but to a greater extent for the former (Figure 54): in 1998 the gap was 10 percentage points, and by 2002 it had widened to 17 points. This situation has implications for family planning programs that are not meeting the rising demand.

Figura 54. Currently married indigenous and non-idigenous women aged 15 to 49 with unmet need for family planning (%), Guatemala, 1998 and 2002



Source: ECLAC. Indigenous and Afro-descendent Peoples of Latin America and the Caribbean: Socio-demographic Data for Policies and Programs. Santiago, Chile: 2006.

MATERNAL HEALTH

> *Women's health is health for all. But it seems as if, in exchange for bringing another life into the world, she loses her own.*
>
> Aymara women, Bolivia (*25*)

High-Risk Births

The right to decide on the number of children, when to have them, and the spacing of births has been firmly established as a basic right of couples, and particularly women. It has been demonstrated that a large number of pregnancies and pregnancies that are closely spaced or occur very early or very late in a woman's reproductive life are avoidable risks to the health and survival of both the mother and the child. These risks are further magnified by adverse socioeconomic circumstances that limit access to a healthy diet and adequate gynecological and obstetric services.

With regard to ages, in 38 countries and territories of the Region the percentage of teens aged 15 to 19 who gave birth in 2007 ranged between 1% in Canada to 11% in Guatemala, Nicaragua, and the Dominican Republic. At the other end, in the group aged 35 to 49 the highest figures were for Haiti, with 7%, followed by Guatemala, with 6% (*18*). The information available indicates that in four of the seven countries analyzed (Colombia, Haiti, Honduras, and Peru) 20% of the births occurred at intervals of less than 24 months, while in Nicaragua the proportion was 26%, and in two countries (Bolivia and the Dominican Republic) it was 28%. As for women who have more than three births, the differences between the countries ranged from 18% in Colombia to 38% in Haiti (Table 6).

Table 6. **Births (%) of order greater than 3 and births within 24 months of last delivery, seven countries of the Americas, 2000–2005, most recent year with data available**

Country	Births order > 3 (%)	Births within 24 months of last delivery (%)
Bolivia (2003)	37	28
Colombia (2005)	18	20
Haiti (2005)	38	20
Honduras (2005)	30	20
Nicaragua (2001)	29	26
Peru (2000)	27	20
Dominican Republic (2002)	20	28

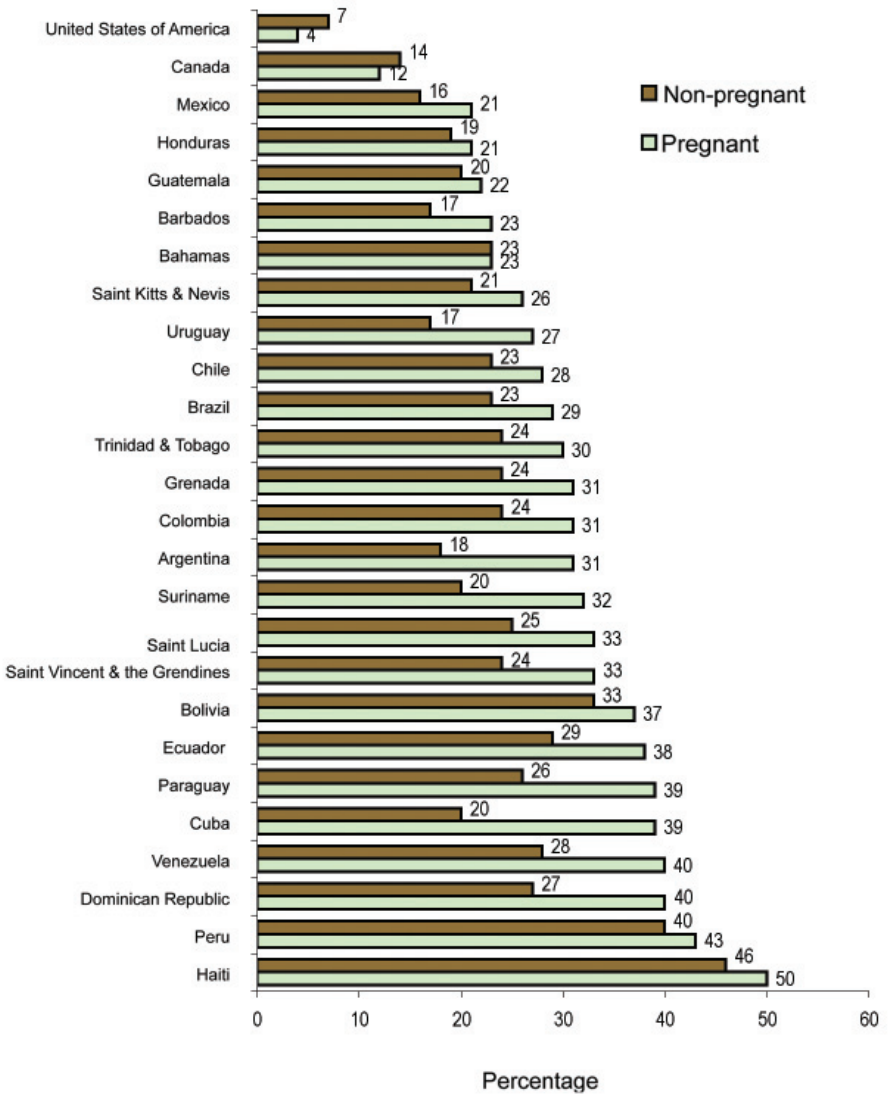
Source: PAHO. Basic Indicators: Gender, Health, and Development in the Americas, 2007. Washington, D.C., 2007.

Anemia in Pregnant Women

As pointed out in the section on nutritional problems, in most cases of anemia, iron deficiency is the most common form of nutritional deficiency. It is recognized that the iron requirements of women increase with menstruation and become even greater during pregnancy and lactation. In Latin America and the Caribbean more than one-fourth of all women suffer from iron-deficiency anemia. Figure 55, which illustrates the prevalence of anemia in pregnant and non-pregnant women aged 15 to 49, shows that the prevalence of this disorder is higher among pregnant women in almost all the countries of the Region except the United

States and Canada. The prevalence of anemia in pregnant women in the Region as a whole (2002-2007) ranged from a low of 4% in the United States to a high of 50% in Haiti. Among non-pregnant women the proportion was 7% in the United States and 46% in Haiti. The prevalence of anemia in pregnant women was at least 30% in 15 of the 26 countries for which information was available. In three countries the prevalence of anemia among non-pregnant women of childbearing age was also 30% or higher (*18*).

Figure 55. **Prevalence of anemia in pregnant and non-pregnant women aged 15 to 49 (%) in 26 countries of the Americas, 2002-2007, most recent year with data available**



Note: The countries are shown in ascending order of percentage in pregnant women.
Source: PAHO. Basic Indicators: Gender, Health, and Development in the Americas, 2007. Washington, D.C., 2007.

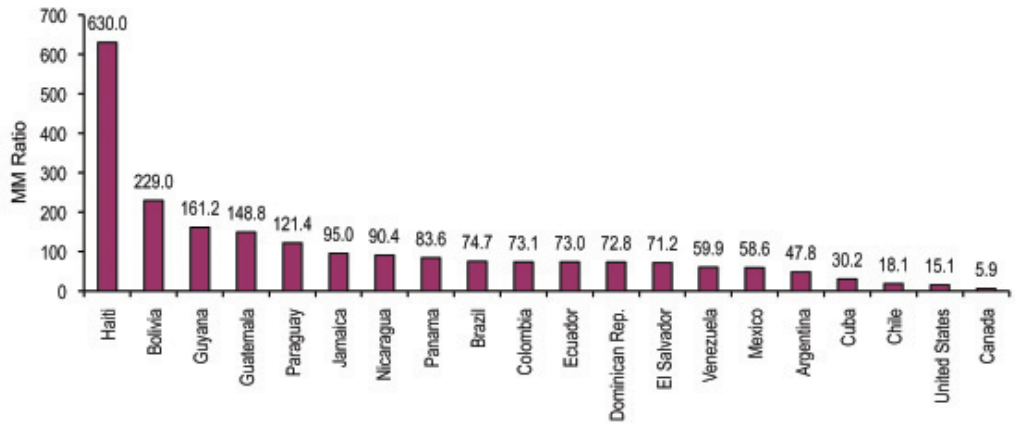
Maternal Mortality

Maternal mortality has been called the clearest test of social inequity and strongest expression of disadvantage because it threatens the basic rights of wide-ranging groups of women in the Region (*26*).

Maternal death is unjust because it is essentially preventable. For several decades the knowledge and technology have been available to prevent these deaths, which occur mainly in poor and marginalized women. According to information provided by the Ministries of Health in the countries of the Region, in 2003 there were 11,652 deaths due to maternal causes (*1*)—in other words, every day 32 women died from causes related to maternity.

Maternal mortality shows wide gaps between the countries of the Americas. In 2007, for example, seven Non-Latin Caribbean islands did not report any maternal deaths at all, and three more islands, along with Belize, Costa Rica, and Uruguay, reported between 1 and 14 maternal deaths that year. Of the countries for which information is available on the maternal mortality ratio[10] for 2003-2007, the figure ranged from 5.9 per 100,000 live births in Canada to 630 per 100,000 in Haiti (Figure 56). In other words, the probability of dying from maternal causes in Haiti was 107 times greater than in Canada, and the probability of dying from these causes in Bolivia was 39 times greater than in Canada (*3*).

Figure 56. **Maternal mortality ratio (per 100,000 live births), 20 countries of the Americas, 2003–2007, most recent year with data available**

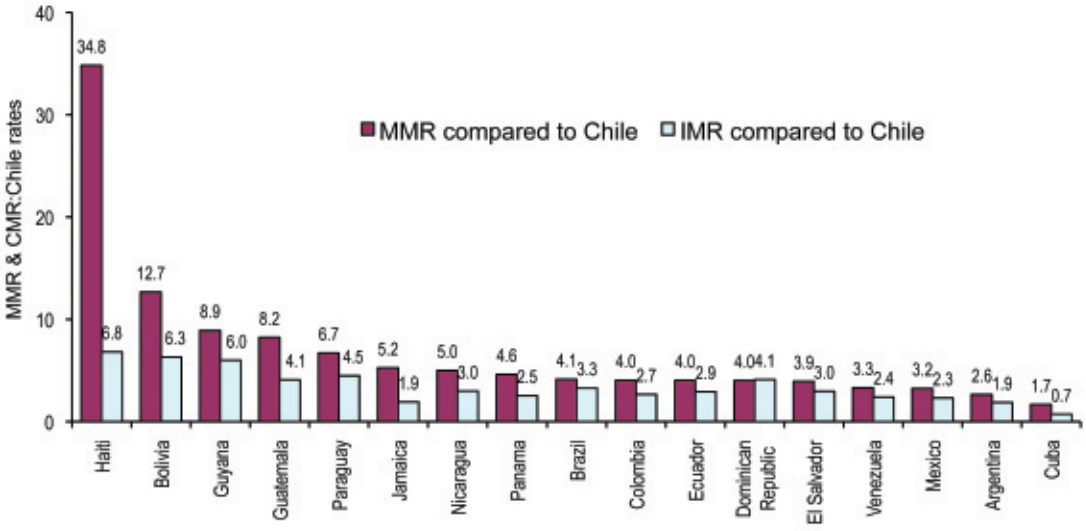


Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

The maternal mortality ratio and the infant mortality rate are indicators of the health status of the population. Reducing them is a priority that has been enshrined in a number of international commitments. The gaps for maternal mortality in Latin America and the Caribbean are significantly larger than those for infant mortality.[11] For example, in a comparison of Haiti and Chile (Figure 57), the infant mortality rate in Haiti was seven times higher than it is in Chile, whereas the maternal mortality ratio was 35 times greater in the former than in the latter. Since Chile has the lowest maternal mortality ratio and infant mortality rate in Latin America (18.1 and 7, respectively, around 2006), that country was selected as the basis for determining the reducible gap for both indicators in the rest of the countries.

[10] In some countries, because of the small number of events, the maternal mortality ratio did not meet standards for reliability and accuracy; in those cases the number of events is shown.
[11] The size of the respective gaps was calculated by dividing the maternal mortality ratios and the infant mortality rates of each country by the respective figures for Chile.

Figure 57. **Reducible gaps in maternal and infant mortality in selected countries of Latin America and the Caribbean: ratio of each of the two rates relative to the rates in Chile, maternal mortality ratio circa 2006, and infant mortality rate circa 2008**

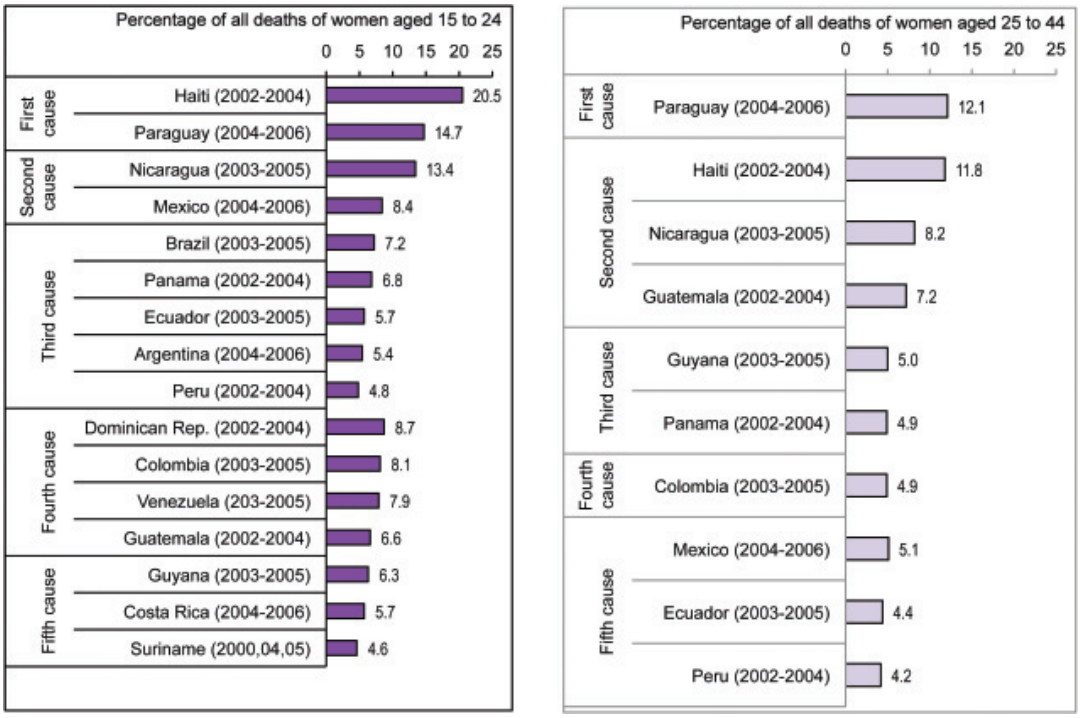


Note: The countries are shown in descending order of reducible gap in the maternal mortality ratio.
Sources: (1) PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008. (2) PAHO. Project of Information and Analysis of the Health. Regional Core Health Data Initiative; Technical Information System in Health. Washington DC, 2007.

Similar inequalities are reproduced within the countries. For example, in Guatemala in the year 2000 the maternal mortality ratio for indigenous women was three times that for non-indigenous women (27). In terms of infant mortality, around that same year the indigenous to non-indigenous ratio in 10 selected countries ranged from 1.1 in Chile to 3.3 in Panama (*28*).

Maternal causes continue to rank among the leading causes of death in many countries of the Region. Figure 58 shows that in the group aged 15 to 24 in around 2004-2006 maternal causes figured among the five leading causes of death in 16 countries: it was the number one cause in two countries, the second cause in another two, the third cause in five countries, the fourth cause in four countries, and the fifth cause in three countries. In Haiti 20.5% of the deaths in women aged 15 to 24 were due to complications of pregnancy, childbirth, and the puerperium, whereas in the countries where it appears in fifth place fewer than 6% of the young women in the same age group died from these maternal causes. Moreover, complications of pregnancy, childbirth, and the puerperium were often among the five leading causes of death in women aged 25 to 44, mainly in the countries where they were also among the five leading causes of death in women aged 15 to 24.

Figure 58. **Ranking of maternal causes of death, women aged 15 to 24 and 25 to 44, by country, most recent data available**



Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C.

The risk of dying from maternal causes is higher for girls aged 10 to 14 than for any other age group. Table 7 shows that in the four countries for which information is available the maternal mortality ratio for girls aged 10 to 14 ranges from 42 per 100,000 live births in Chile to 190 in Argentina. In the group aged 15 to 19 the maternal mortality ratio ranges from 20 per 100,000 live births in Chile to 38 in Brazil. In other words, the risk of dying from maternal causes for girls aged 10 to 14 is about twice that for girls aged 15 to 19 in Brazil and Chile, 3.5 times that in Mexico, and 8 times that in Argentina.

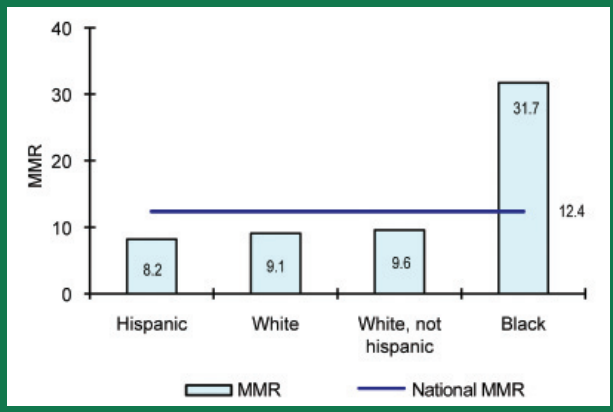
Table 7. **Maternal mortality ratio per 100,000 live births in mothers aged 10 to 14 and 15 to 19, four countries of the Americas, circa 2003**

Country	Mothers 10-14 years of age	Mother 15-19 years of age
Argentina	190	23
Mexico	131	37
Brazil	65	38
Chile	42	20

Note: The countries are shown in descending order of maternal mortality ratio in mothers aged 10 to 14.
Source: PAHO. Health in the Americas 2007. Volume I: Regional.

It is important to look at the differences within the countries. Maternal mortality is also higher for indigenous and Afro-descendent women, although few countries include the variable of ethnic origin in their vital statistics. In the United States the maternal mortality ratio for black women was 2.5 times that for women in general in 2005, and four times that for Hispanic or Latin women (Figure 59).

Figure 59. **Maternal mortality ratio (per 100,000 live births), by race, United States, 2005**

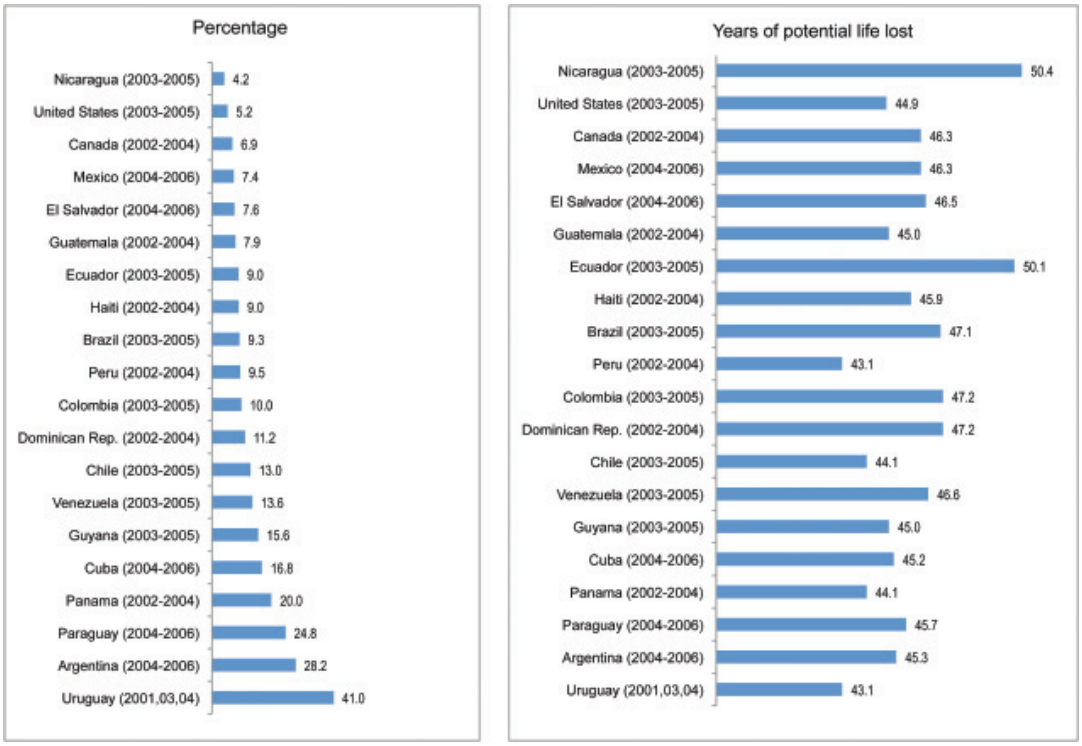


Source: U.S. National Center for Health Statistics. Health, United States, 2007. Available at: http://www.cdc.gov/nchs/hus.htm.

Maternal Mortality from Unsafe Abortion

The complications of abortion continue to be a serious public health problem in the Americas, especially when the procedure is performed under unsafe conditions. Even so, in most of the countries of the Americas abortion is still illegal. It is estimated that in Latin America more than 4 million abortions are performed every year, about half of them in the larger countries: Argentina, Brazil, and Mexico (*1*). Figure 60 shows that the contribution of abortion to maternal mortality ranges from 4.2% in Nicaragua to 41% in Uruguay. In the latter country, however, there were only 14 maternal deaths reported in 2007, and 6 of these were associated with abortion; the high percentage of deaths from abortion is due to the low total number of maternal deaths, which distorts the proportion of mortality from this cause. The figure also shows the number of years of potential life lost prior to age 75 for each death from abortion, ranging from 43.1 years in Uruguay and Peru to 50.4 in Nicaragua.

Figure 60. **Maternal deaths from abortion (%) and years of potential life lost prior to age 75 for each death from abortion, 20 countries of the Americas, circa 2005**

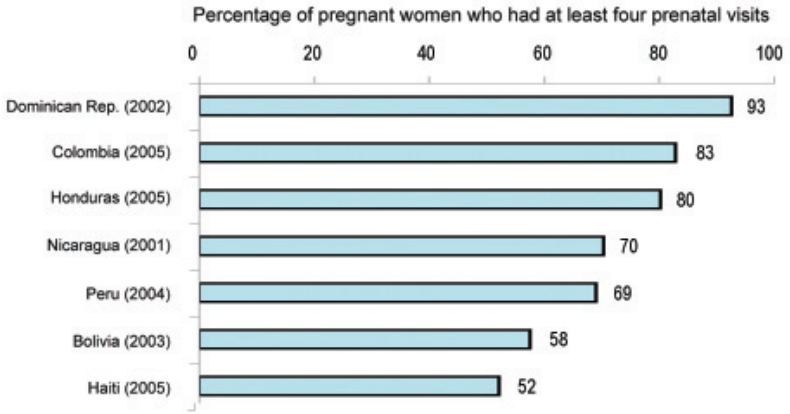


Note: The countries are shown in ascending order of percentage of maternal deaths from abortion.
Source: PAHO. Health Information and Analysis Project, data on mortality and population. Washington, D.C., July 2008.

CARE IN PREGNANCY AND CHILDBIRTH

Prenatal care is fundamental in order to detect problems in pregnancy and prevent complications of childbirth. It is recommended that pregnant women have between four and five appropriately scheduled prenatal consultations in order to support good health for both the mother and the child (*1*). The data available from demographic and maternal and child health surveys indicate that in several countries the proportion of pregnant women who have at least four prenatal check-up visits is high. However, there are striking differences in access to these services: in the seven countries for which information was available, the proportion of women who had at least four prenatal visits ranges from 52% in Haiti to 93% in the Dominican Republic (Figure 61).

Figure 61. **Pregnant women who had at least four prenatal visits (%), seven countries of the Americas, 2001-2005, most recent year with data available**

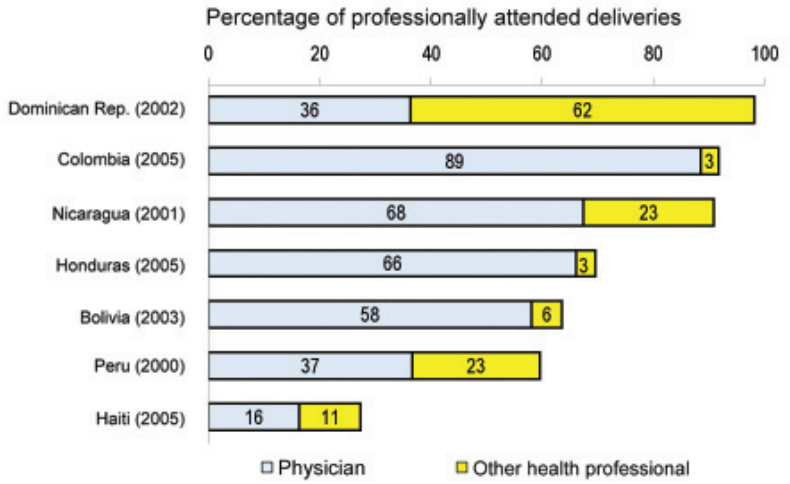


Sources: (1) Peru: Instituto Nacional de Estadística e Informática (INEI), USAID, Measure DHS/ORC, Macro International, Inc., 2006; Encuesta ENDES Continua 2004. Lima. (2) Other countries: MEASURE DHS STATcompiler. Macro International Inc, 2008. http://www.measuredhs.com. Accessed on 23 May 2008.

Like prenatal care, professional delivery care is recommended internationally in order to ensure the health of mothers and their children. Births attended by trained personnel[12] reached a high of 87.8% in the Region around 2006. However, an analysis by country shows that this percentage ranged from lows of 26% in Haiti and 31.4% in Guatemala to 100% in nine Non-Latin Caribbean islands (*3*).

Figure 62 shows that in four of the seven countries where demographic and maternal and child health surveys have been conducted (2000 and 2005), care provided by physicians surpassed care offered by other health professionals except in the Dominican Republic, where 36% of delivery care was provided by physicians and 62% by other health professionals.

Figure 62. **Births attended by professionals (%) in seven countries of the Americas, 2001-2005, most recent year with data available**

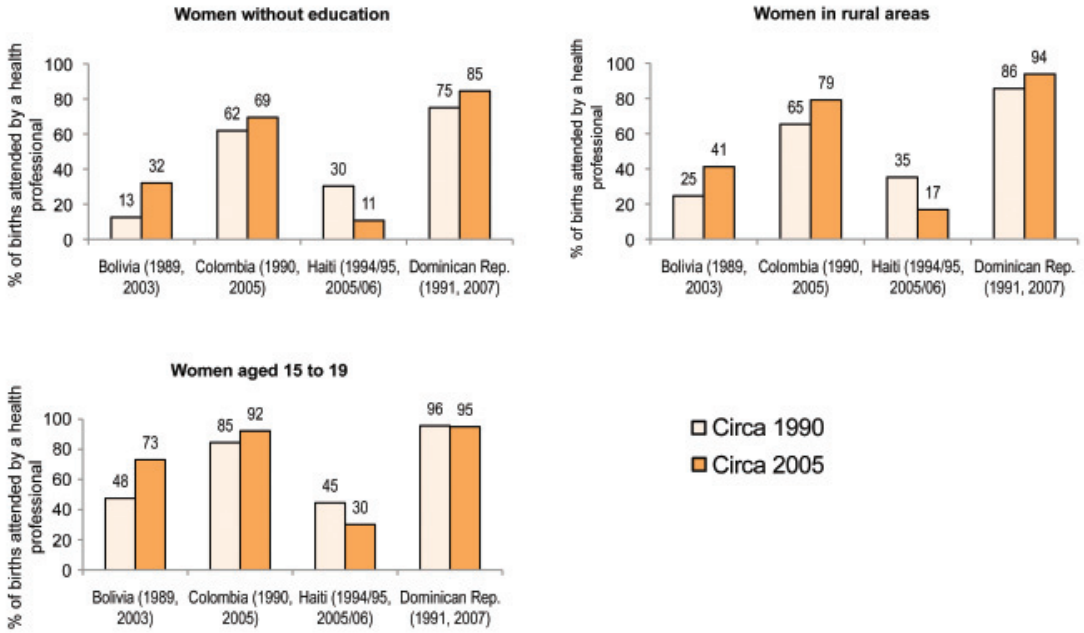


Source: MEASURE DHS STATcompiler. Macro International Inc, 2008. http://www.measuredhs.com. Accessed on 23 May 2008.

[12] Trained personnel include obstetricians, physicians trained in delivery care, accoucheurs, graduate midwives, and graduate nurses trained in delivery care. It does not include trained or untrained traditional birth attendants.

In three of the four countries shown in Figure 63, the percentage of professionally attended births increased in both time periods studied in almost all the categories analyzed: mothers without education, mothers living in rural areas, and teenage mothers. The exception was Haiti, where care declined in all the categories indicated.

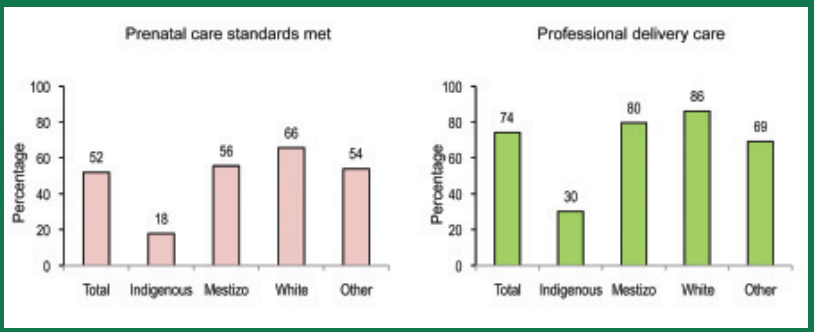
Figure 63. **Births attended by physicians or other health professionals (%) in women without education, women in rural areas, and adolescents aged 15 to 19, four countries of the Americas, circa 1990 and 2005**



Source: MEASURE DHS STATcompiler. Macro International Inc., 2008. www.measuredhs.com. Accessed on 5 December 2008.

In Ecuador indigenous women are at a considerable disadvantage in terms of meeting standards for both prenatal monitoring and professional delivery care. In 2004 the ratio of white women meeting prenatal monitoring standards relative to their indigenous counterparts was almost 4:1, and the ratio for professional delivery care was 3:1 (Figure 64).

Figure 64. **Prenatal care and professional delivery care (%), by ethnic origin, Ecuador, 2004**



Notes: (1) The prenatal monitoring standards are: first visit during the first trimester and five or more total visits. (2) The data on delivery care are for live births from July 1999 until June 2004.

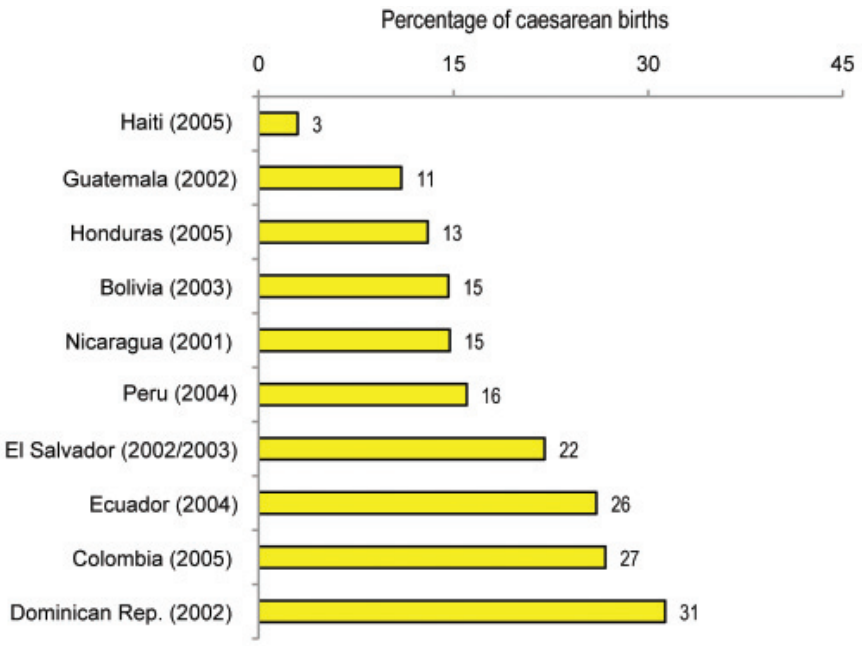
Source: CEPAR. Demographic and Maternal and Child Health Survey, ENDEMAIN 2004. Final Report. Quito, October 2005.

Caesarean Births

The incidence of caesarean section is an indicator of the quality of perinatal maternal care. WHO has pointed out that 15% to 20% of deliveries should be performed by caesarean section because of complications or other risk situations (*1*).

In five of 10 countries for which information was available for around 2004 (Figure 65) the proportion of caesarean deliveries was precisely between 15% and 20%. However, in three countries the proportion was more than 25%, reaching a high of 31% in the Dominican Republic. In Haiti, caesarean births represented only 3% of the total, suggesting a lack of access to this type of care, resulting in a negative impact for maternal and child health.

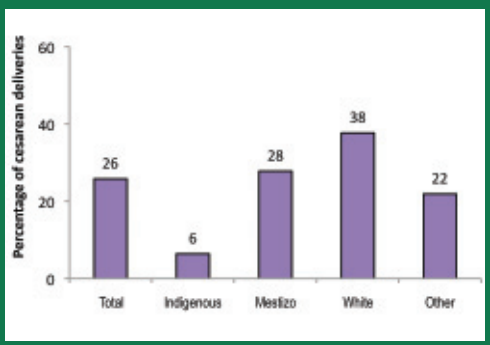
Figure 65. **Caesarean births (%), 10 countries of the Americas, 2001-2005, most recent year with data available**



Sources: (1) Bolivia, Colombia, Haiti, Honduras, Nicaragua, and the Dominican Republic: MEASURE DHS STATcompiler. Macro International Inc, 2008. http://www.measuredhs.com. Accessed 23 May 2008. (2) El Salvador and Guatemala: DRH/CDC. Reproductive, Maternal, and Child Health in Central America. Trends and Challenges Facing Women and Children. El Salvador, Guatemala, Honduras, Nicaragua. 2005. (3) Peru: Instituto Nacional de Estadística e Informática (INEI), USAID, Measure DHS/ORC Macro 2006. Encuesta Demográfica y de Salud Familiar ENDES Continua 2004 [Household Demographic and Health Survey 2004] Lima.

The data for Ecuador reveal that, even though the percentage of caesarean births for the entire country was much higher than the level recommended by WHO, in the case of indigenous women, it was only 6% of total deliveries, compared with 38% among white women (Figure 66).

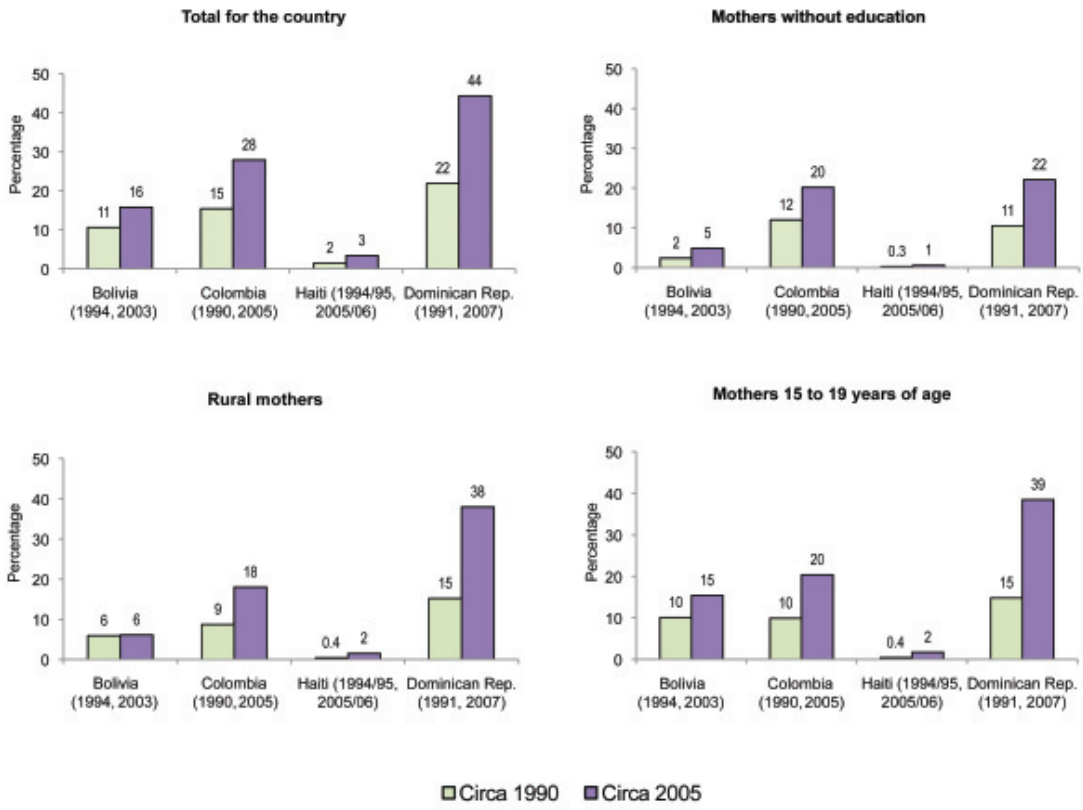
Figure 66. **Caesarean deliveries (%) by ethnic origin, Ecuador, 2004**



Source: CEPAR. Demographic and Maternal and Child Health Survey 2004, ENDEMAIN 2004. Final Report. Quito, October 2005.

The percentage of caesarean births in the four countries analyzed (Figure 67) show an increase between 1990 and 2005 in all the selected categories: mothers without education, mothers living in rural areas, and teenage mothers. However, the nature of these increases had special characteristics. In Haiti, for example, the increases were very small even though the initial values had also been very low. In the Dominican Republic, on the other hand, the percentages in 2007 were more than double the levels for 1991 in all the categories considered. The proportion of caesarean births for teenage mothers in that country was 39% in 2007.

Figure 67. **Caesarean births (%) for the country as a whole, mothers without education, mothers living in the rural area, and mothers aged 15 to 19, four countries of the Americas, circa 1990 and 2005**



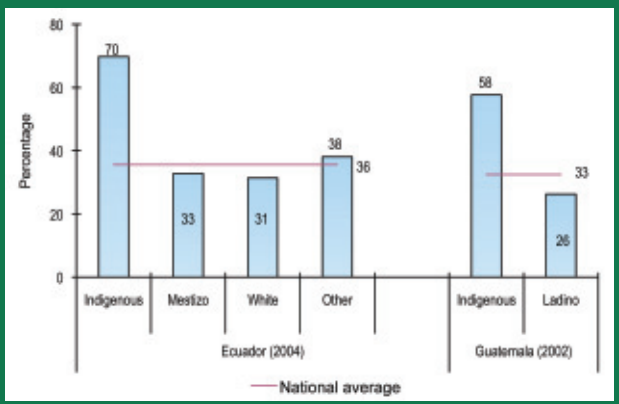
Source: MEASURE DHS STATcompiler, Macro International Inc., 2008. www.measuredhs.com. Accessed on 5 December 2008.

PAP SMEAR

The Pap smear is an integral component of reproductive health rights and services. It is easy to administer and permits the detection of malignant neoplasm of the uterus in its early stages when it can be treated effectively and at low cost.

In two countries for which information is available (Ecuador and Guatemala) it is troubling to see the high percentages of women, especially indigenous women, who have never had a Pap smear (Figure 68).

Figure 68. Women who have never had a Pap smear (%), by ethnic origin, Ecuador and Guatemala, circa 2004



Note: The data for Ecuador correspond to sexually experienced women aged 15 to 49; the Guatemala figures are for women aged 30 to 49.

Sources: (1) Source: CEPAR. Demographic and Maternal and Child Health Survey, ENDEMAIN 2004. Final Report. Quito, October 2005. (2) Guatemala: MSPAS/INE/UVG/CDC/USAID/ASDI/APRESAL/European Union/UNDP/UNICEF/UNFPA/Project POLICY II/CARE. Encuesta Nacional de Salud Materno-Infantil 2002 [National Maternal and Child Health Survey 2002]. Guatemala, October 2003.

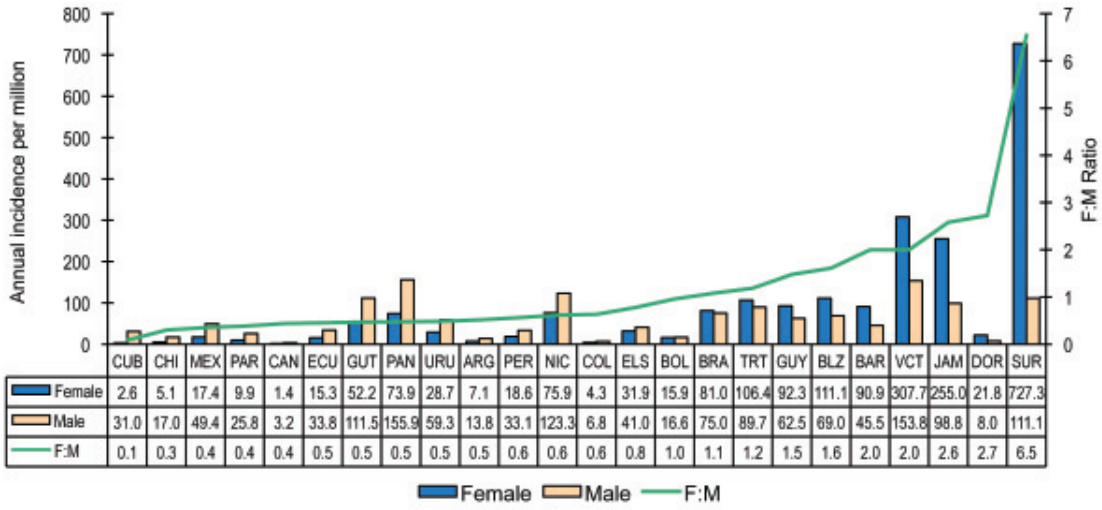
SEXUALLY TRANSMITTED INFECTIONS (STIs)

Although STIs are common to both sexes, women exhibit greater biological vulnerability because the area of exposure during sexual intercourse is broad and fragile. Moreover, infected women often tend to exhibit fewer symptoms of some of these infections, with the result that they fail to get timely treatment. In terms of the sexual behavior of women and men, roles, expectations, and social positions influence the patterns of risk and vulnerability in both cases. Socially constructed gender roles and expectations of men can contribute to unprotected sexual aggressiveness with multiple partners, while expectations of women turn them into passive receptors.

HIV and AIDS

In general, most new cases of AIDS affect men. However, in recent years, HIV infection rates have been increasing rapidly among women, with higher proportions being reported in women in some countries of the Non-Latin Caribbean, the Latin Caribbean, and the Central American Isthmus, especially in the population aged 15 to 24 (Figure 69).

Figure 69. **Annual reported cases of AIDS in the population aged 15 to 24 (per 1,000,000 population), 24 countries of the Americas, 2005**

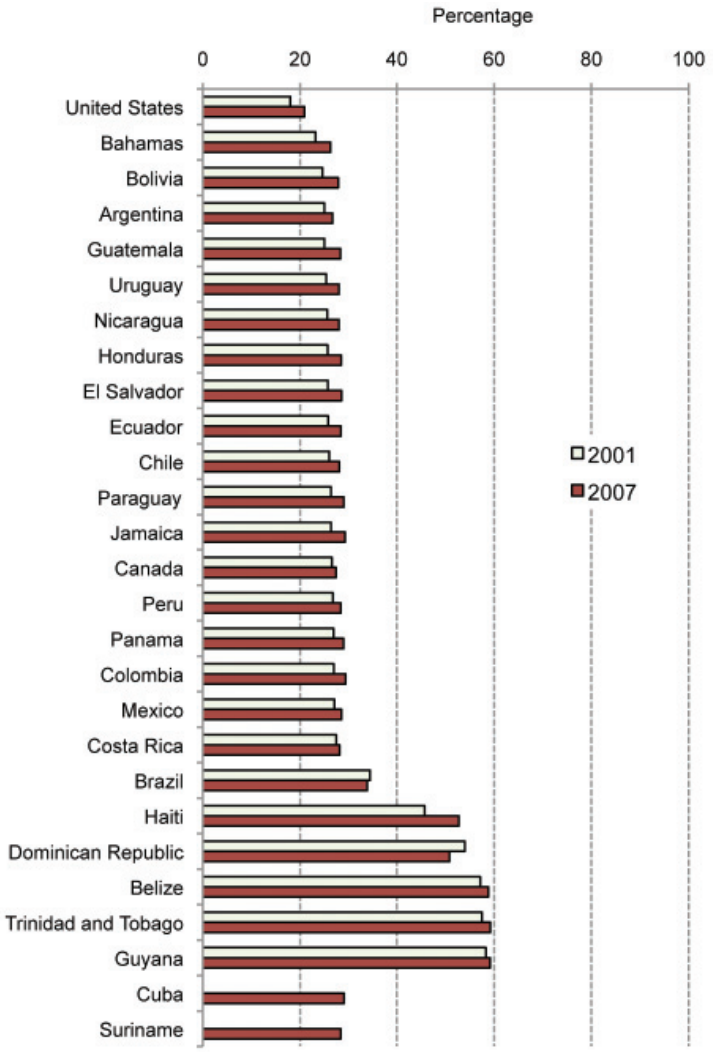


	CUB	CHI	MEX	PAR	CAN	ECU	GUT	PAN	URU	ARG	PER	NIC	COL	ELS	BOL	BRA	TRT	GUY	BLZ	BAR	VCT	JAM	DOR	SUR
Female	2.6	5.1	17.4	9.9	1.4	15.3	52.2	73.9	28.7	7.1	18.6	75.9	4.3	31.9	15.9	81.0	106.4	92.3	111.1	90.9	307.7	255.0	21.8	727.3
Male	31.0	17.0	49.4	25.8	3.2	33.8	111.5	155.9	59.3	13.8	33.1	123.3	6.8	41.0	16.6	75.0	89.7	62.5	69.0	45.5	153.8	98.8	8.0	111.1
F:M	0.1	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.8	1.0	1.1	1.2	1.5	1.6	2.0	2.0	2.6	2.7	6.5

Notes: The countries are shown in ascending order of the male:female ratio.
Country abbreviations: ARG, Argentina; BAR, Barbados; BLZ, Belize; BOL, Bolivia; BRA, Brazil; CAN, Canada; CHI, Chile; COL, Colombia; CUB, Cuba; DOR, the Dominican Republic; ECU, Ecuador; ELS, El Salvador; GUT, Guatemala; GUY, Guyana; JAM, Jamaica; MEX, Mexico; NIC, Nicaragua; PAN, Panama; PAR, Paraguay; PER, Peru; VCT, Saint Vincent and the Grenadines; SUR, Suriname; TRT, Trinidad and Tobago; URU, Uruguay.
Source: PAHO. Basic Indicators: Gender, Health, and Development in the Americas, 2007. Washington, D.C., 2007.

An analysis of all cases of HIV in 2001 and 2007 reveals that the proportion of infected women is growing in the Region. Only in the Dominican Republic has there been a reduction in the proportion of women in the population 15 years of age and older infected with HIV (Figure 70). In Belize, Guyana, and Trinidad and Tobago, for every 100 people aged 15 years old and over living with HIV, almost 60 are women.

Figure 70. **Women 15 years of age and older with HIV as a percentage of the total population aged 15 and older with HIV, 27 countries of the Americas, 2001 and 2007**



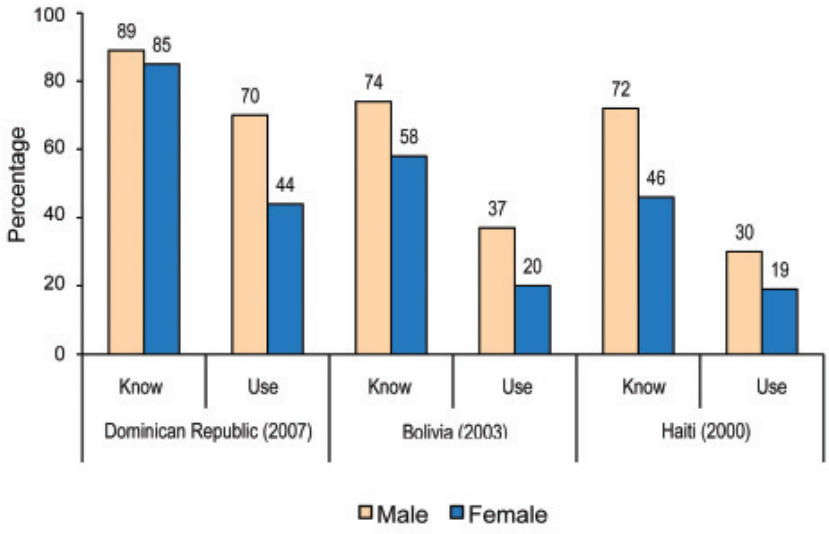
Note: The countries are shown in ascending order of percentage for 2001.
Source: UNAIDS. 2008 Report on the Global AIDS Epidemic. July 2008. http:/www.unaids.org/en/HiV_data.

The detection rate of HIV infection in pregnant women and newborns has increased in recent years. In some areas of the Dominican Republic, one in 12 women receiving prenatal monitoring was found to be infected with HIV. The percentages for other countries for which information was available were 7.1% in Guyana, 3.6% in the Bahamas, 2.5% in Belize, 1.5% in Jamaica, and 1.4% in Honduras (*1*).

Condom Use

Condoms are used as a family planning device and also provide protection against sexually transmitted infections (STIs), including HIV. Condom use is not widespread, even though it is known to be a means of preventing STIs. For example, in the Dominican Republic 85% of the women and 89% of the men aged 15 to 24 reported that they were aware of condom use as a means of preventing HIV, but in that same age group only 44% of the women and 70% of men had used a condom in their most recent at-risk sexual exposure. Similar behavior patterns are seen In Bolivia and Haiti (Figure 71).

Figure 71. **Young people aged 15 to 24 who are aware of the condom as a means of protection against STIs and young people who used a condom in their most recent at-risk sexual exposure (%), by sex, three countries of the Americas, 2000-2007, most recent year with data available**



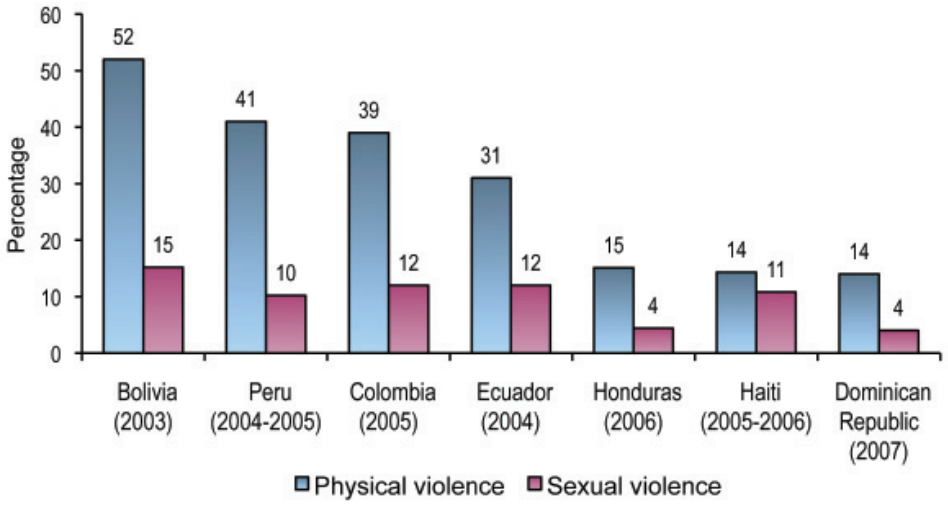
Sources: HIV/AIDS Survey Indicators Database. http:/www.measuredhs.com/hivdata/. Accessed on 5 May 2009.

V. VIOLENCE AGAINST WOMEN

Violence against women is an invasion of human rights that has devastating effects on the physical and mental health of the survivors. For more than one decade this form of aggression has been recognized as a public health problem. Within the family, the magnitude and impact of intimate partner violence, which mainly affects women, is one of the health problems faced by all population groups in the Americas. Physical violence against women is accompanied by psychological violence and often sexual violence as well. Its impact on reproductive health can be serious and includes the risk of acquiring HIV and other STIs. Sometimes violence is carried to the ultimate extreme—i.e., murder.

In the countries for which information is available, it has been possible to confirm a high prevalence of physical and sexual violence against women inflicted by their husbands or partners. Figure 72 shows the percentage of women who had been in a union at some time and reported that they had been victims of physical abuse. The proportion ranged between 14% in the Dominican Republic and Haiti to 52% in Bolivia, while the proportion of sexual violence was between 4% in the Dominican Republic and Honduras and 15% in Bolivia.

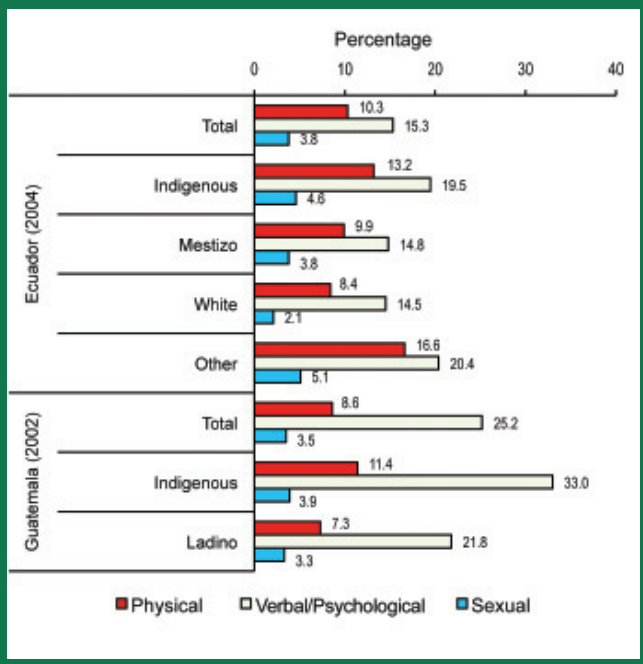
Figure 72. **Women aged 15 to 49, ever married, who report that they have been victims of intimate partner violence (%), seven countries of the Americas, circa 2005**



Source: Measure DHS, Demographic and Health Surveys, ORC Macro, except for Ecuador: CEPAR. ENDEMAIN.

Although violence against women is a problem found in all population groups, indigenous, Afro-descendent, displaced, and migrant women are more exposed. For example, in Ecuador the rate of physical violence against women in the indigenous population was 28% higher than for the country as a whole. In Guatemala physical violence was 56% more prevalent among indigenous women than among Ladino women (Figure 73).

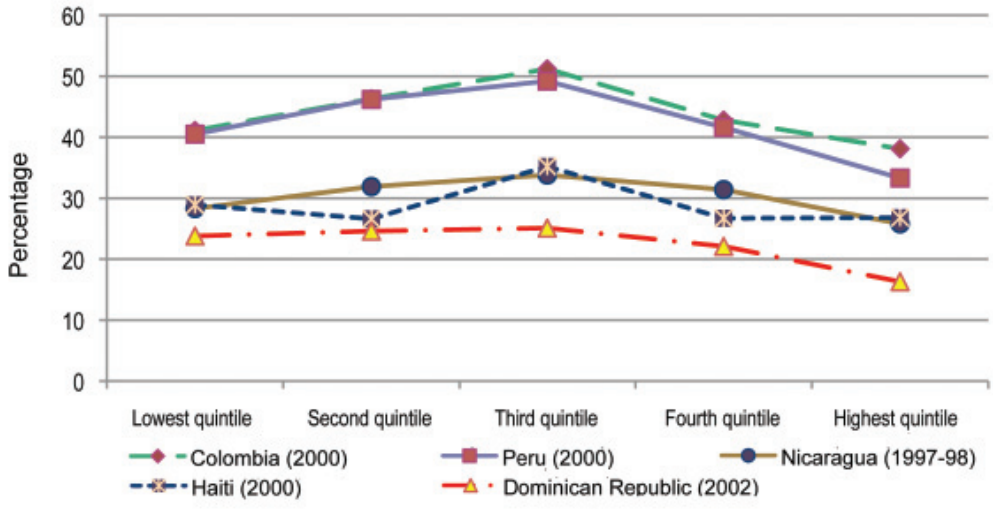
Figure 73. **Women aged 15 to 49 who experienced intimate partner violence in the last 12 months (%), by type of violence and ethnic origin, Ecuador 2004 and Guatemala 2002**



Sources: 1) Ecuador: Source: CEPAR. Demographic and Maternal and Child Health Survey, ENDEMAIN 2004. Final Report. Quito, October 2005. (2) Guatemala: MSPAS/INE/UVG/CDC/USAID/ASDI/APRESAL/EU /UNDP/UNICEF/UNFPA/Project POLICY II/CARE. Encuesta Nacional de Salud Materno Infantil 2002 [National Maternal and Child Health Survey 2002], Guatemala, October 2003.

It has also been confirmed that household income level is unrelated to violence against women. As it can be seen in Figure 74, the highest prevalence occurs in the average income quintile.

Figure 74. **Women who ever experienced intimate partner violence (%), by household income quintile, five countries of the Americas, circa 2000**



Note: The data for Peru correspond to physical violence; in the other countries they correspond to physical or sexual violence or both.
Source: Kishor, Sunni and Kiersten Johnson. Profiling Domestic Violence - A Multi-Country Study. Calverton, Maryland: ORC Macro. June 2004.

Despite the existence of legislation, prevention and care programs, regional and national networks, campaigns, and other interinstitutional initiatives to combat violence, a sizeable percentage of the women who are faced with the problem do not ask for help, thus jeopardizing their physical, psychological, and reproductive well-being. According to data available from demographic and health surveys for six countries, of the women who had experienced intimate partner violence at some time, between 44% in Haiti (2005-2006) and 62% in Colombia (2005) did not request any type of assistance. In the six countries, between 18% and 26% of them sought help within their own families (*18*).

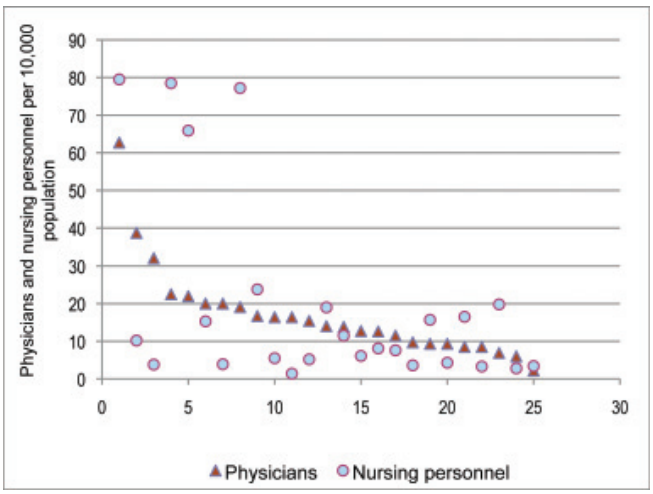
Eradicating violence against women continues to be a challenge for societies throughout the world. It is a complex, multidimensional problem. The efforts made so far and the resources allocated in national budgets are not sufficient to enable the United Nations Member States to meet the international commitments they have made to prevent, punish, and eradicate violence against women.

VI. HEALTH HUMAN RESOURCES

In general, more women participate in health care than men, although the decision-making positions tend to be dominated by the latter. Census and survey data from 13 countries of the Region show that between 65% and 70% of all health care personnel are women (*1*), but they are mainly nurses and nursing assistants who have less power and income and are lower in the hierarchy.

In 15 of the 25 countries of the Americas for which information is available, there are more physicians than nursing personnel (Figure 75).

Figure 75. **Number of physicians and nursing personnel per 10,000 population, 25 countries of the Americas, circa 2005**



Countries

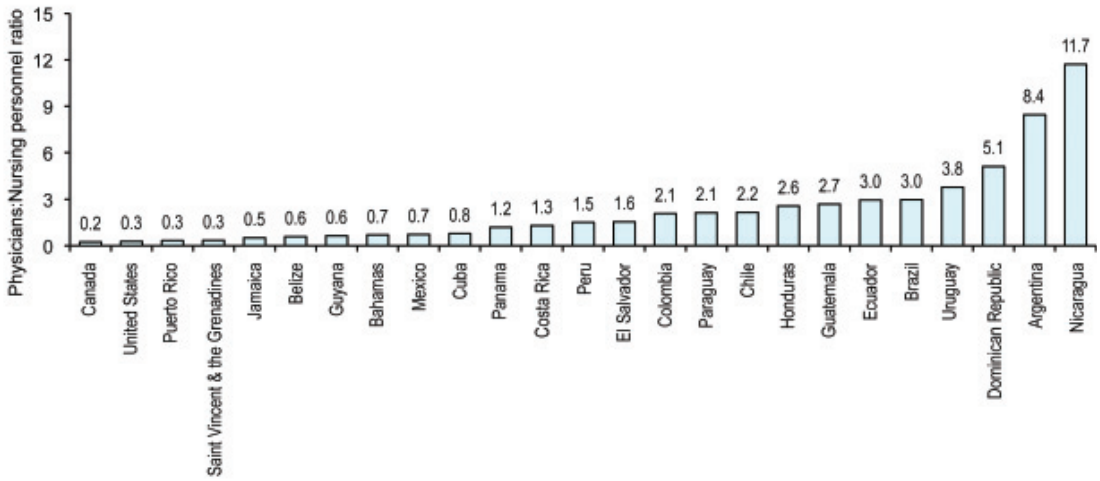
1 Cuba	14 Panama
2 Uruguay	15 Colombia
3 Argentina	16 El Salvador
4 United States	17 Peru
5 Puerto Rico	18 Guatemala
6 Costa Rica	19 Belize
7 Dominican Republic	20 Chile
8 Canada	21 Jamaica
9 Bahamas	22 Honduras
10 Brazil	23 Saint Vincent & the Grenadines
11 Nicaragua	24 Paraguay
12 Ecuador	25 Guyana
13 Mexico	

Note: The countries are shown in descending order of the number of physicians per 10,000 population.
Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

The ratio of physicians to nursing personnel in the 15 countries with the largest numbers of physicians (Figure 76) was 12:1 in Nicaragua, 8:1 in Argentina, and 5:1 in the Dominican Republic. This abundance of physicians and scarcity of nursing personnel leads to a number of problems in the organization and delivery of health services, especially when primary health care is fundamental to achieving health for the entire population and universal access.

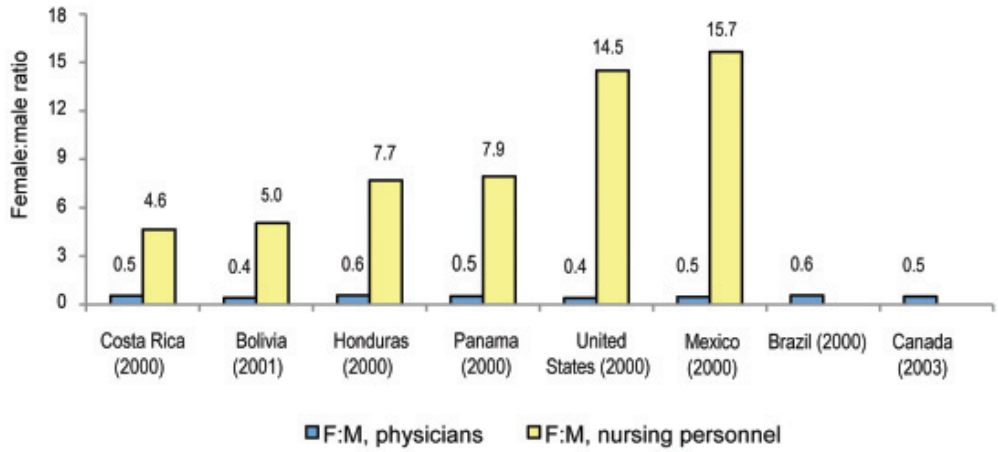
At the same time, women are coming to represent an increasingly larger proportion of all physicians. In the eight countries for which information was available for around 2000 there were between 39 and 56 female physicians for every 100 male physicians. Meanwhile, nursing personnel continue to be largely females. In the six countries for which information was available, the number of female nurses was 5 to 16 times greater than the number of male nurses (Figure 77).

Figure 76. **Ratio of physicians to nursing personnel, 25 countries of the Americas, circa 2005**



Note: The countries are shown in ascending order by ratio of physicians to nursing personnel.
Source: PAHO. Health Situation in the Americas: Basic Indicators 2008. Washington, DC. 2008.

Figure 77. **Female:Male ratio of physicians and nursing personnel, eight countries of the Americas, circa 2000**



Note: The countries are shown in ascending order by the female:male ratio of nursing personnel.
Source: WHO. World Health Atlas, www.who.int/globalatlas/dataQuery. Accessed on 16 February 2009.

Given the roles assigned to each sex, responsibility for the provision of health care services for other members of the household and the community has traditionally fallen to women. Despite the sustained contribution of women to the improvement of health, this contribution continues to be invisible, undervalued, and unsupported, since caregiving is considered intrinsic to the nature of women and an extension of unpaid domestic work. This issue requires special attention, given the growing demand for in-home health care to deal with the aging population, the rising prevalence of chronic diseases, and the shift of caregiving from the formal health sector to homes and communities. This latter trend is a response to policies designed to save public health sector monies and is based on the assumption that there are women outside the labor market who would take on this caregiving in the home, even though women are joining the work force at a rapidly increasing pace. For all these reasons it is fundamental to measure and assess the contribution made to health systems by unpaid health services performed mainly by women.

VII. CONCLUSIONS

The main points that emerge from the present document relate to the availability of data, the systematic differences between women and men in health-related areas, the social determinants that drive these differences, and the need to gain more knowledge about key issues through specific research.

With regard to the availability of data:

- In some cases, up-to-date national data on health-related topics, disaggregated by sex, were unavailable for the preparation of this document. For example, the most recent mortality data were for 2006.

- Statistical data on the state of health of specific groups of the population—for example, those living below the poverty line, indigenous and Afro-descendent populations, older adults, and others—were scarce. This information gap makes it impossible to perform the analyses that would show clear inequalities in health and their determinants—situations that are unjust and avoidable. The absence of this information also limits the possibility of defining adequate responses.

- Within the framework of international commitments, it is essential to continue striving to improve national health information systems in collaboration with the Member States and international cooperation agencies. Strategies are needed to improve the recording of health data disaggregated by sex, ethnic origin, and other variables, as well as analyses from a gender and ethnic perspectives, and the presentation and use of the results.

- The availability of up-to-date, reliable health data broken down by sex, ethnic origin, age and other variables will facilitate the establishment of systems to monitor progress toward gender equality in health.

On inequalities in state of health and socioeconomic determinants:

- The socioeconomic indicators presented in this report show that progress has been made in reducing inequalities between women and men in education and, to a lesser extent, in participation in the labor market. However, these achievements have not been matched across the board: inequalities persist in access to economic resources and political participation.

- National averages should be regarded with caution because situations continue to exist within the countries that are more disadvantageous for poor, indigenous, Afro-descendent, rural, and adolescent women.

- Some of the most significant inequalities between and within countries could be redressed in part through programs that respond to the specific needs of women and men at different stages of the life cycle. These areas include:

    - Maternal mortality. In some countries the maternal mortality ratio continues to be quite high. The indicators relating to access to reproductive health resources that would help to reduce such deaths show disadvantages for certain groups, such as indigenous, adolescent, and Afro-descendent women.

    - Violence against women. Recognized as a violation of human rights and a public health problem, violence against women still affects a high percentage of women in the Region.

- Mortality from malignant neoplasm of the uterus. This cause of death is avoidable with early detection. There are major inequalities between countries. Figures on access to the Pap test show that indigenous women have the least access to this resource.

- Risk-prone and violent behaviors that undermine the health of men. Mortality from homicide, accidents and suicide is considerably higher for men than women. The mortality rates from "injury of undetermined intent" indicate that mortality registration need to be improved.

With regard to the need for research on key issues:

- The older adult population is increasing rapidly, which means that it is important for data on the leading causes of morbidity in this age group to be made available on a regular basis. This information would make it possible to project the health services demand for this population and define care options that would not fall primarily on the shoulders of women.

- The absence of information on the unpaid contributions made by women and men to the health care system confirms the need for a line of research that generates evidence for advocacy in decision-making.

- Except for diseases that are required to be reported and pertinent data collected through specific surveys, there is an information gap on causes of morbidity in different population groups.

- Differential data for men and women are also lacking with regard to the quality of services and care provided, as well as out-of-pocket expenditures on health care. In addition, information is needed on human resources available in the countries, broken down by profession and workplace, to meet health care needs.

- In order to better interpret gender-related inequalities in health, it is fundamental to promote research on the interrelationships between the social determinants of health and their differential effects on the risk of disease and death for men and women of different age groups.

One final point: in addition to the need for information on inequalities in health, any serious effort to develop policies and programs aimed at reducing gender inequities in health must include the empowerment of women, a comprehensive approach to addressing the determining social factors with specific strategies based on context, an intersectoral perspective, and the participation of civil society in decision-making processes and monitoring by citizens.

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STATISTICAL ANNEX

I. Demographic Context

II. Socioeconomic Context

III. Health, Disease, and Mortality

IV. Reproductive Health and Access to Services

V. Violence against Women

VI. Health Human Resources

I. Demographic Context

Table 1. **Growth of total fertility rate (children per woman), 1960-1965 to 2005-2010**

Subregion	1960-65	1965-70	1970-75	1975-80	1980-85	1985-90	1990-95	1995-2000	2000-05	2005-10
Latin America & the Caribbean	5.97	5.54	5.04	4.48	3.92	3.41	3.03	2.73	2.52	2.37
North America	3.35	2.55	2.01	1.78	1.81	1.89	1.99	1.95	1.99	2.00

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp
Accessed on 29 August 2008.

Table 2. Growth of the population of the Americas, by age group, 1960-2010

Subregion	Year	Population (thousands) by age group			
		0-4 years	5-14 years	15-64 years	65 and over
Latin America and the Caribbean	1960	37,265	56,312	118,521	8,069
	1970	45,632	76,603	153,671	11,637
	1980	52,345	91,685	204,158	16,192
	1990	55,732	104,991	262,023	21,525
	2000	56,286	110,078	326,715	29,970
	2010	55.608	110,630	386,599	40,859
North America	1960	23,097	40,340	122,265	18,447
	1970	19,678	46,456	143,410	22,387
	1980	18,577	38,932	169,853	28,184
	1990	21,697	39,775	188,029	34,419
	2000	21,690	45,663	209,373	38,946
	2010	23,209	45,567	234,856	44,943

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp
Accessed on 29 August 2008.

Table 3. **Distribution of the population of Latin America and the Caribbean by age group and sex, 1960 (in thousands)**

5-year age groups	Male	Female
0-4 years	18,864	18,402
5-9 years	15,695	15,376
10-14 years	12,770	12,471
15-19 years	10,519	10,347
20-24 years	9,088	9,021
25-29 years	7,832	7,919
30-34 years	7,046	7,144
35-39 years	5,994	6,068
40-44 years	4,994	5,055
45-49 years	4,449	4,522
50-54 years	3,730	3,806
55-59 years	3,034	3,109
60-64 years	2,344	2,499
65-69 years	1,651	1,821
70-74 years	1,086	1,256
75-79 years	616	747
80-84 years	269	351
85 and over	108	163
Total	110,089	110,077

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp. Accessed on 14 February 2009.

Table 4. **Distribution of the population of Latin America and the Caribbean by age group and sex, 2010 (in thousands)**

5-year age groups	Male	Female
0-4 years	28,377	27,231
5-9 years	28,316	27,244
10-14 years	28,002	27,069
15-19 years	27,302	26,697
20-24 years	25,866	25,983
25-29 years	24,665	25,059
30-34 years	22,526	23,359
35-39 years	20,510	21,411
40-44 years	18,420	19,437
45-49 years	16,621	17,635
50-54 years	13,896	14,912
55-59 years	11,463	12,438
60-64 years	8,742	9,655
65-69 years	6,510	7,448
70-74 years	4,799	5,812
75-79 years	3,267	4,313
80-84 years	2,018	2,928
85 and over	1,396	2,367
Total	292,696	300,998

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp. Accessed on 14 February 2009.

Table 5. **Distribution of the population of North America by age group and sex, 1960 (in thousands)**

5-year age groups	Male	Female
0-4 years	11,796	11,301
5-9 years	10,873	10,428
10-14 years	9,725	9,315
15-19 years	7,682	7,499
20-24 years	6,337	6,403
25-29 years	6,318	6,274
30-34 years	6,829	6,851
35-39 years	7,014	7,111
40-44 years	6,511	6,604
45-49 years	6,072	6,191
50-54 years	5,425	5,577
55-59 years	4,563	4,856
60-64 years	3,850	4,298
65-69 years	3,225	3,716
70-74 years	2,351	2,834
75-79 years	1,525	1,946
80-84 years	757	1,055
85 and over	395	642
Total	101,248	102,901

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp. Accessed on 14 February 2009.

Table 6. **Distribution of the population of North America by age group and sex, 2010 (in thousands)**

5-year age groups	Male	Female
0-4 years	11,894	11,315
5-9 years	11,636	11,073
10-14 years	11,711	11,146
15-19 years	12,690	12,065
20-24 years	12,730	12,169
25-29 years	12,313	11,925
30-34 years	11,687	11,438
35-39 years	11,532	11,411
40-44 years	11,796	11,837
45-49 years	12,705	12,905
50-54 years	12,293	12,743
55-59 years	10,754	11,333
60-64 years	8,885	9,644
65-69 years	6,431	7,286
70-74 years	4,654	5,591
75-79 years	3,496	4,604
80-84 years	2,512	3,822
85 and over	2,043	4,504
Total	171,762	176,811

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp. Accessed on 14 February 2009.

Table 7. **Growth of the female population aged 15-49, 1960-2010 (in thousands)**

Subregion	1960	1970	1980	1990	2000	2010
Latin America and the Caribbean	50,076	65,153	87,106	112,506	139,706	159,581
North America	46,933	55,057	65,848	75,043	80,688	83,750

Source: United Nations. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp.
Accessed on 22 November 2008.

Table 8. **Growth of the population aged 65 and over, 1960-2010**

Subregion	Year	65 years and over (millions)	% of total population	
			65 +	80 +
Latin America and the Caribbean	1960	8.1	3.7	0.4
	1970	11.6	4.0	0.5
	1980	16.2	4.4	0.6
	1990	21.5	4.8	0.8
	2000	30.0	5.7	1.0
	2010	40.9	6.9	1.5
North America	1960	18.4	9.0	1.4
	1970	22.4	9.7	1.8
	1980	28.2	11.0	2.3
	1990	34.4	12.1	2.6
	2000	38.9	12.3	3.2
	2010	44.9	12.9	3.7

Source: United Nations. Popolation Division. World Population Prospects: The 2006 Revision. http://esa.un.org/unpp.
Accessed on 5 February 2009

II. Socioeconomic Context

Table 9. **Literacy rate of the population aged 15 to 24 (%), 25 countries, 2007**

Country	Total	Male	Female	F:M
Cuba	100.0	100.0	100.0	1.00
Trinidad and Tobago	99.5	99.5	99.5	1.00
Aruba	99.3	99.2	99.4	1.00
Argentina	99.1	98.9	99.3	1.00
Chile	99.1	98.9	99.2	1.00
Uruguay	98.7	98.3	99.1	1.01
Bolivia	98.5	99.0	97.9	0.99
Netherlands Antilles	98.2	98.2	98.3	1.00
Mexico	98.1	98.2	97.9	1.00
Costa Rica	98.0	97.6	98.5	1.01
Colombia	97.9	97.6	98.3	1.01
Peru	97.9	98.5	97.2	0.99
Brazil	97.8	97.0	98.5	1.02
Venezuela (a)	97.2	96.3	98.1	1.02
Ecuador	96.5	96.2	96.7	1.01
Paraguay	96.4	96.2	96.6	1.00
Panama	96.3	96.5	96.1	1.00
Dominican Republic	96.0	95.0	97.0	1.02
Suriname	95.2	95.7	94.6	0.99
El Salvador	95.2	94.6	95.8	1.01
Jamaica	94.3	90.9	97.9	1.08
Honduras	90.3	87.9	92.8	1.06
Nicaragua	88.7	85.4	91.9	1.08
Guatemala	85.5	88.1	82.9	0.94
Haiti	81.7	76.3	87.2	1.14

(a) Data: 2001.
Note: Countries are shown in descending order of percentage of both sexes combined.
Source: http://www.uis.unesco.org. Accessed on 29 September 2008.

Table 10. **Average income of women and men and female:male ratio of average income, urban areas of 18 countries, circa 2007**

Country	Average income Female	Average income Male	Female income: Male income
Peru (2003)	1.8	3.4	0.5
Paraguay (2007)	2.0	3.0	0.7
Honduras (2007)	2.3	2.9	0.8
Nicaragua (2005)	2.3	3.3	0.7
Guatemala (2006)	2.3	4.2	0.5
Bolivia (2007)	2.5	4.2	0.6
Colombia (2005)	2.7	3.8	0.7
El Salvador (2004)	3.0	3.8	0.8
Ecuador (2007)	3.0	4.8	0.6
Mexico (2006)	3.0	4.9	0.6
Uruguay (2007)	3.1	4.6	0.7
Dominican Rep. (2007)	3.3	5.5	0.6
Venezuela (national) (2007)	3.5	4.4	0.8
Brazil (2007)	3.5	5.3	0.7
Argentina (Greater B.A.) (2006)	4.5	7.0	0.6
Costa Rica (2007)	4.6	6.6	0.7
Panama (2007)	4.8	6.7	0.7
Chile (2006)	5.1	7.5	0.7

Notes: (1) Average income expressed in multiples of the per capita poverty line in the respective country. (2) Data for employed economically active population. (3) The countries are shown in ascending order of average female income.
Source: ECLAC. Social Panorama of Latin America 2008. Tables 21.1a y 21.1b.

Table 11. **Population employed in low-productivity sectors (%), urban areas of 17 countries, circa 2007 (in percentages of total employed urban population)**

Subregions and Countries	Total	Female	Male	F:M
CENTRAL AMERICA, MEXICO, AND LATIN CARIBBEAN				
Panama (2007)	36.5	39.3	34.4	1.14
Costa Rica (2007)	37.7	42.2	34.7	1.22
Honduras (2007)	43.9	41.9	45.4	0.92
Mexico (2006)	45.7	50.8	42.0	1.21
Dominican Rep. (2007)	48.9	45.5	51.0	0.89
El Salvador (2004)	54.7	62.6	47.8	1.31
Guatemala (2006)	58.1	65.4	52.5	1.25
Nicaragua (2005)	58.4	64.1	54.0	1.19
ANDEAN AREA				
Venezuela (national) (2006)	50.1	47.9	51.5	0.93
Ecuador (2007)	57.3	64.5	52.2	1.24
Bolivia (2007)	62.5	70.6	56.4	1.25
Peru (2003)	64.6	72.5	58.1	1.25
SOUTHERN CONE AND BRAZIL				
Chile (2006)	30.7	38.2	25.6	1.49
Argentina (Great B.A.) (2006)	41.0	42.9	37.7	1.14
Brazil (2007)	41.8	47.7	37.3	1.28
Uruguay (2007)	43.8	49.5	39.5	1.25
Paraguay (2007)	60.1	67.4	54.6	1.23

Note: Within each subregion the countries are shown in ascending order for both sexes combined.
Source: ECLAC. Social Panorama of Latin America 2008. Tables 18. 18.1 and 18.2.

Table 12. **Total households and indigent households headed by women (%), urban areas of 18 countries, circa 2006**

Country	% of the total households	% of the indigent households
Guatemala (2002)	22.1	29.6
Ecuador (2006)	23.3	24.7
Peru (2003)	24.5	29.9
Bolivia (2004)	25.5	26.6
Mexico (2006)	26.1	25.4
Panama (2006)	30.4	45.8
Chile (2006)	31.2	47.5
Brazil (2006)	31.3	36.3
Argentina (Great B.A.) (2006)	31.5	44.3
Costa Rica (2006)	31.7	54.3
Venezuela (national) (2006)	32.5	44.4
Colombia (2005)	32.7	38.0
Honduras (2006)	33.8	36.8
Dominican Rep. (2006)	33.9	49.5
Nicaragua (2001)	34.2	36.6
Paraguay (Asuncion) (2005)	34.3	38.9
Uruguay (2005)	34.3	34.3
El Salvador (2004)	35.3	34.9

Note: The countries are shown in ascending order of the total households headed by women.
Source: ECLAC. Social Panorama of Latin America 2007. Table 11.

Table 13. **Political participation: percentage of women in Parliament, 35 countries, 2007**

Country	Lower or Single House		Upper House of Senate		Both: Lower House and Senate		
	Total seats	Female (%)	Total seats	Female (%)	Total seats	Female	Female (%)
Haiti	98	4.1	18	11.1	116	6	5.2
Saint Kitts and Nevis	15	6.7			15	1	6.7
Brazil	513	9.0	81	12.3	594	56	9.4
Colombia	166	8.4	102	11.8	268	26	9.7
Belize	32	0.0	13	38.5	45	5	11.1
Guatemala	158	12.0			158	19	12.0
Uruguay	99	12.1	31	12.9	130	16	12.3
Chile	120	15.0	38	5.3	158	20	12.7
Paraguay	80	12.5	45	15.6	125	17	13.6
Jamaica	60	13.3	21	14.3	81	11	13.6
Barbados	30	10.0	21	19.0	51	7	13.7
Bolivia	130	16.9	27	3.7	157	23	14.6
Antigua and Barbuda	19	10.5	17	23.5	36	6	16.7
El Salvador	84	16.7			84	14	16.7
Panama	78	16.7			78	13	16.7
Dominican Republic	178	19.7	32	3.1	210	36	17.1
Saint Lucia	18	11.1	11	27.3	29	5	17.2
United States	431	17.4	99	17.2	530	92	17.4
Saint Vincent & the Grenadines	22	18.2			22	4	18.2
Nicaragua	92	18.5			92	17	18.5
Venezuela	167	18.6			167	31	18.6
Dominica	32	18.8			32	6	18.8
Granada	15	13.3	13	30.8	28	6	21.4
Mexico	500	23.2	128	18.0	628	139	22.1
Honduras	128	23.4			128	30	23.4
Canada	308	22.1	93	34.4	401	100	24.9
Bahamas	41	12.2	15	60.0	56	14	25.0
Ecuador	100	25.0			100	25	25.0
Suriname	51	25.5			51	13	25.5
Peru	120	29.2			120	35	29.2
Guyana	70	30.0			70	21	30.0
Trinidad & Tobago	41	26.8	31	41.9	72	24	33.3
Costa Rica	57	36.8			57	21	36.8
Argentina	255	40.0	72	38.9	327	130	39.8
Cuba	614	43.2			614	265	43.2

Note: Data provided by national parlaments as of November 2008. The countries are shown in ascending order of the (weighted) percentage of women serving in both chambers.
Source: http://www.ipu.org. Accessed on 18 February 2009.

III. Health, Disease, and Mortality

Table 14. **Life expectancy at birth (LEB) and life expectancy at 60 years of age (LE-60) (in years), 39 countries, 2005-2010**

Country	LEB Both Sexes combined	LEB Female	LEB Male	LE-60 Female	LE-60 Male
Haiti	60.9	62.8	59.1	17.0	16.6
Bolivia	65.6	67.7	63.4	18.8	16.7
Guyana	66.8	69.9	64.2	20.0	16.7
Grenada	68.7	70.4	67.0	17.9	16.1
Trinidad and Tobago	69.8	71.8	67.8	19.7	16.9
Honduras	70.2	73.7	66.9	22.4	19.1
Suriname	70.2	73.6	67.0	20.5	17.8
Guatemala	70.3	73.8	66.7	21.5	19.2
Peru	71.4	74.0	68.9	20.8	18.3
Saint Vincent & the Grenadines	71.6	73.8	69.5	20.3	16.1
Paraguay	71.8	73.9	69.7	21.3	19.4
El Salvador	71.9	74.9	68.8	21.9	18.6
Dominican Republic	72.2	75.5	69.3	22.7	20.3
Brazil	72.4	76.1	68.8	22.5	19.5
Jamaica	72.6	75.2	70.0	21.6	19.3
Colombia	72.9	76.6	69.2	21.9	19.3
Nicaragua	72.9	76.0	69.9	22.4	19.9
Bahamas	73.5	76.3	70.6	23.2	19.5
Saint Lucia	73.7	75.6	71.9	21.0	17.7
Venezuela	73.7	76.8	70.9	21.7	19.3
Aruba	74.2	77.1	71.3	20.7	17.2
Ecuador	75.0	78.0	72.1	23.5	21.2
Netherlands Antilles	75.1	78.8	71.3	22.7	19.1
Argentina	75.3	79.1	71.6	23.0	18.1
Panama	75.5	78.2	73.0	22.8	20.3
French Guiana	75.9	79.9	72.6	22.7	17.6

Continued...

Country	LEB Both Sexes combined	LEB Female	LEB Male	LE-60 Female	LE-60 Male
Belize	76.1	79.2	73.3	23.5	20.4
Mexico	76.2	78.6	73.7	22.9	20.7
Uruguay	76.4	79.9	72.8	23.5	18.5
Barbados	77.3	79.8	74.4	22.7	18.5
United States of America	78.2	80.8	75.6	24.2	20.3
Cuba	78.3	80.4	76.2	23.5	20.8
Chile	78.6	81.5	75.5	24.5	20.7
Puerto Rico	78.7	82.7	74.7	25.4	19.9
Costa Rica	78.8	81.2	76.5	24.4	21.6
Guadeloupe	79.2	82.2	76.0	25.1	20.9
Virgin Islands (US)	79.4	83.3	75.5	25.7	19.2
Martinique	79.5	82.3	76.5	25.2	21.1
Canada	80.7	82.9	78.3	25.2	21.7

Note: The countries are shown in ascending order of the LEB for both sexes combined.
Source: unstats.un.org/unsd/demographic/products/indwm/statistics.htm. Accessed on 3 May 2008.
LEB for both sexes http://esa.un.org/unpp. Accessed on 24 October 2008.

Table 15. **Healthy life expectancy (HLE) at birth and at age 60 (HL-60) (in years), 35 countries, 2002**

Country	HLE at birth, both sexes	HLE at birth, female	HLE at birth, male	HL-60, female	HL-60, male
Haiti	43.8	44.1	43.5	11.7	10.3
Bolivia	54.4	55.2	53.6	12.1	10.9
Guyana	55.2	57.2	53.1	12.2	10.2
Guatemala	57.4	59.9	54.9	13.3	12.3
Honduras	58.4	60.5	56.3	13.1	11.4
Suriname	58.8	60.8	56.7	12.8	10.6
Grenada	59.2	60.0	58.4	12.6	11.1
Dominican Republic	59.6	61.9	57.2	13.7	11.3
El Salvador	59.7	62.3	57.2	14.1	12.6
Brazil	59.8	62.4	57.2	13.7	11.6
Belize	60.3	62.2	58.4	13.3	11.5
Peru	61.0	62.4	59.6	14.4	12.7
Saint Vincent & the Grenadines	61.0	62.2	59.9	14.2	12.6
Nicaragua	61.4	63.1	59.7	14.5	13.0
Saint Kitts and Nevis	61.5	63.1	59.9	13.5	11.9
Antigua and Barbuda	61.9	63.6	60.1	13.8	11.6
Paraguay	61.9	64.2	59.6	14.6	11.7
Ecuador	61.9	64.1	59.8	15.2	13.2
Trinidad and Tobago	62.0	64.2	59.8	14.1	11.9
Colombia	62.0	66.3	57.8	15.4	12.6
Saint Lucia	62.7	64.2	61.2	14.4	12.5
Bahamas	63.5	66.0	61.0	16.2	14.4
Dominica	63.7	65.6	61.9	15.3	13.8
Venezuela	64.2	66.7	61.7	15.7	13.9
Jamaica	65.1	65.9	64.2	14.5	13.0
Argentina	65.3	68.1	62.5	16.5	13.0
Mexico	65.4	67.6	63.3	16.2	14.4
Barbados	65.6	68.2	62.9	16.6	13.1
Panama	66.2	68.0	64.3	16.8	14.9
Uruguay	66.2	69.4	63.0	17.1	13.0
Costa Rica	67.2	69.3	65.2	16.7	14.4
Chile	67.3	69.7	64.9	16.8	13.9
Cuba	68.3	69.5	67.1	16.7	15.2
United States of America	69.3	71.3	67.2	17.9	15.3
Canada	72.0	74.0	70.1	19.3	16.1

Note: The countries are shown in ascending order of the HLE for both sexes and then in ascending order of the HLE for women.
Source: WHO. World Health Report 2004. Annex Table 4.

Table 16. **Mortality from cerebrovascular disease in the population aged 25-44, 27 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both sexes	Female	Male	
Canada (2002-2004)	2.0	1.9	2.1	0.90
Costa Rica (2004-2006)	3.1	3.0	3.2	0.94
Puerto Rico (2003-2005)	3.3	3.4	3.1	1.10
United States (2003-2005)	3.6	3.4	3.8	0.89
El Salvador (2004-2006)	4.5	5.3	3.7	1.43
Mexico (2004-2006)	4.5	4.1	5.0	0.82
Chile (2003-2005)	4.7	4.4	4.9	0.90
Martinique (2003-2005)	4.7	2.3	7.3	0.32
Panama (2002-2004)	5.5	3.6	7.4	0.49
Colombia (2003-2005)	5.6	6.3	4.8	1.31
Guadeloupe (2003-2005)	6.2	5.5	7.0	0.79
Cuba (2004-2006)	6.4	6.0	6.8	0.88
Venezuela (2003-2005)	6.6	6.4	6.8	0.94
Argentina (2004-2006)	6.9	6.3	7.6	0.83
Peru (2002-2004)	7.0	6.7	7.4	0.91
Ecuador (2003-2005)	7.6	6.4	8.7	0.74
Uruguay (2001,03,04)	8.1	7.2	9.0	0.80
Nicaragua (2000-2002)	8.4	9.1	7.6	1.20
Paraguay (2004-2006)	8.4	9.2	7.7	1.19
Dominican Rep. (2002-2004)	8.8	9.0	8.6	1.05
Guatemala (2002-2004)	9.2	8.5	10.0	0.85
Trinidad and Tobago (2000-2002)	9.2	8.0	10.5	0.76
Guyana (2003-2005)	9.9	8.4	11.5	0.73
Brazil (2003-2005)	14.3	14.4	14.2	1.01
Haiti (2002-2004)	17.0	14.3	19.8	0.72
Suriname (2000,04,05)	18.6	14.1	23.1	0.61
Bolivia (2002,2003)	22.2	22.2	22.2	1.00

Note: The countries are shown in ascending order of the rate for both sexes combined. Countries included had at least15 deaths in population aged 25-44 years due to cerebrovascular disease.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 17. **Mortality from cerebrovascular disease in the population aged 45-64, 28 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both Sexes	Female	Male	
Canada (2002-2004)	14.1	12.3	16.0	0.77
Costa Rica (2004-2006)	20.3	17.8	22.7	0.78
United States (2003-2005)	23.0	20.1	26.1	0.77
Puerto Rico (2003-2005)	25.6	19.2	33.3	0.58
El Salvador (2004-2006)	27.1	27.3	26.8	1.02
Mexico (2004-2006)	32.5	27.5	37.9	0.73
Barbados (2000.2001)	35.8	26.0	46.8	0.56
Guatemala (2002-2004)	37.1	34.9	39.4	0.89
Martinique (2003-2005)	37.2	21.8	55.4	0.39
Ecuador (2003-2005)	38.4	33.0	43.9	0.75
Peru (2002-2004)	40.3	34.8	46.0	0.76
Chile (2003-2005)	41.9	34.3	49.9	0.69
Guadeloupe (2003-2005)	47.9	26.6	72.4	0.37
Panama (2002-2004)	50.8	39.3	62.4	0.63
Venezuela (2003-2005)	51.6	45.4	57.8	0.79
Cuba (2004-2006)	55.4	48.5	62.6	0.77
Colombia (2003-2005)	56.1	56.1	56.2	1.00
Argentina (2004-2006)	61.1	44.1	79.6	0.55
Nicaragua (2000-2002)	68.7	67.1	70.4	0.95
Uruguay (2001.03.04)	76.0	58.8	95.1	0.62
Bolivia (2002.2003)	87.0	77.2	97.6	0.79
Paraguay (2004-2006)	97.3	87.4	106.8	0.82
Trinidad and Tobago (2000-2002)	97.3	85.3	110.5	0.77
Dominican Republic (2002-2004)	99.0	82.0	115.8	0.71
Brazil (2003-2005)	101.4	87.7	116.4	0.75
Guyana (2003-2005)	151.6	126.2	175.3	0.72
Suriname (2000.04.05)	176.0	128.0	229.2	0.56
Haiti (2002-2004)	223.7	256.5	187.6	1.37

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 18. **Mortality from ischemic heart disease in the population aged 45-64, 28 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both Sexes	Female	Male	
Martinique (2003-2005)	18.6	9.8	29.1	0.34
Guadeloupe (2003-2005)	28.1	16.1	42.0	0.38
Ecuador (2003-2005)	32.8	20.9	45.0	0.46
Peru (2002-2004)	38.3	22.5	54.4	0.41
Guatemala (2002-2004)	39.7	30.3	49.8	0.61
Haiti (2002-2004)	46.3	41.6	51.6	0.81
Barbados (2000,2001)	52.3	27.7	79.9	0.35
Chile (2003-2005)	53.5	25.4	83.0	0.31
Bolivia (2002.2003)	57.4	40.4	76.0	0.53
El Salvador (2004-2006)	63.1	52.5	75.3	0.70
Argentina (2004-2006)	63.5	24.6	105.8	0.23
Panama (2002-2004)	65.6	36.7	94.5	0.39
Canada (2002-2004)	69.0	27.5	111.1	0.25
Costa Rica (2004-2006)	70.2	40.5	99.5	0.41
Mexico (2004-2006)	72.6	41.4	105.0	0.39
Uruguay (2001,03,04)	80.7	36.9	129.1	0.29
Paraguay (2004-2006)	84.3	50.1	117.2	0.43
Puerto Rico (2003-2005)	89.4	52.6	132.8	0.40
United States (2003-2005)	102.3	53.4	153.7	0.35
Colombia (2003-2005)	104.2	72.8	139.5	0.52
Cuba (2004-2006)	110.7	74.8	148.2	0.50
Nicaragua (2000-2002)	112.1	98.1	126.3	0.78
Brazil (2003-2005)	118.7	77.5	163.8	0.47
Venezuela (2003-2005)	125.7	74.6	177.6	0.42
Dominican Republic (2002-2004)	134.8	97.5	171.7	0.57
Suriname (2000,04,05)	136.5	75.8	203.8	0.37
Guyana (2003-2005)	197.2	144.6	246.2	0.59
Trinidad and Tobago (2000-2002)	226.3	157.4	301.6	0.52

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 19. **Mortality from diabetes mellitus in the population aged 25 to 44, 25 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both Sexes	Female	Male	
Uruguay (2001,03,04)	0.8	0.8	0.9	0.89
Chile (2003-2005)	1.2	1.1	1.2	0.92
Argentina (2004-2006)	1.7	1.6	1.9	0.84
Canada (2002-2004)	1.7	1.2	2.2	0.55
Peru (2002-2004)	1.9	1.8	1.9	0.95
Costa Rica (2004-2006)	2.1	2.4	1.9	1.26
Colombia (2003-2005)	2.4	2.5	2.3	1.09
Cuba (2004-2006)	3.1	3.1	3.1	1.00
United States (2003-2005)	3.3	2.5	4.0	0.63
Panama (2002-2004)	3.8	4.3	3.4	1.26
Paraguay (2004-2006)	4.1	3.7	4.5	0.82
Venezuela (2003-2005)	4.2	3.5	4.8	0.73
Ecuador (2003-2005)	4.4	3.9	4.9	0.80
Brazil (2003-2005)	4.7	4.0	5.4	0.74
Puerto Rico (2003-2005)	5.3	3.8	6.8	0.56
El Salvador (2004-2006)	5.6	6.3	4.8	1.31
Bolivia (2002,2003)	5.7	2.7	8.9	0.30
Dominican Republic (2002-2004)	5.7	5.7	5.8	0.98
Guatemala (2002-2004)	8.0	6.7	9.5	0.71
Guyana (2003-2005)	8.7	9.3	8.2	1.13
Suriname (2000,04,05)	8.8	8.6	9.0	0.96
Nicaragua (2000-2002)	8.9	9.5	8.3	1.14
Trinidad and Tobago (2000-2002)	9.5	8.0	11.0	0.73
Haiti (2002-2004)	9.7	10.8	8.4	1.29
Mexico (2004-2006)	11.6	9.3	14.0	0.66

Note: The countries are shown in ascending order of the rate for both sexes combined. Countries included had at least 15 deaths due to diabetes mellitus in population aged 25 to 44.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 20. **Mortality from diabetes mellitus in the population aged 45 to 64, 28 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both Sexes	Female	Male	
Martinique (2003-2005)	11.1	12.8	9.1	1.4
Canada (2002-2004)	14.9	9.8	20.1	0.5
Uruguay (2001,03,04)	17.7	15.2	20.4	0.7
Cuba (2004-2006)	19.8	23.8	15.7	1.5
Chile (2003-2005)	23.0	20.4	25.8	0.8
United States (2003-2005)	23.6	19.2	28.2	0.7
Bolivia (2002,2003)	25.0	18.2	32.4	0.6
Peru (2002-2004)	27.6	22.9	32.5	0.7
Costa Rica (2004-2006)	27.9	28.9	27.0	1.1
Argentina (2004-2006)	29.5	22.3	37.4	0.6
Guadeloupe (2003-2005)	29.6	23.8	36.2	0.7
Colombia (2003-2005)	39.7	41.1	38.2	1.1
Barbados (2000,2001)	46.0	45.3	46.8	1.0
Panama (2002-2004)	48.1	53.2	43.0	1.2
Brazil (2003-2005)	50.7	50.1	51.3	1.0
Ecuador (2003-2005)	50.8	50.7	50.9	1.0
El Salvador (2004-2006)	56.1	64.0	47.0	1.4
Dominican Republic (2002-2004)	57.5	53.8	61.1	0.9
Venezuela (2003-2005)	61.0	53.6	68.5	0.8
Puerto Rico (2003-2005)	70.2	54.3	89.1	0.6
Guatemala (2002-2004)	71.9	77.5	66.0	1.2
Haiti (2002-2004)	75.9	88.9	61.7	1.4
Paraguay (2004-2006)	79.4	88.5	70.6	1.3
Suriname (2000,04,05)	86.8	83.0	91.0	0.9
Nicaragua (2000-2002)	106.4	117.2	95.5	1.2
Guyana (2003-2005)	149.3	170.4	129.7	1.3
Mexico (2004-2006)	150.1	137.2	163.6	0.8
Trinidad and Tobago (2000-2002)	222.9	194.3	254.1	0.8

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 21. **Mortality from diabetes mellitus in the population aged 65 and over, 28 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both sexes	Female	Male	
Cuba (2004-2006)	121.1	157.7	79.8	2.0
Uruguay (2001,03,04)	143.3	131.3	161.5	0.8
Peru (2002-2004)	144.9	147.9	141.3	1.0
Bolivia (2002,2003)	146.1	139.9	153.7	0.9
United States (2003-2005)	152.1	145.7	160.9	0.9
Canada (2002-2004)	162.5	150.6	178.1	0.8
Argentina (2004-2006)	182.8	159.5	217.5	0.7
Chile (2003-2005)	210.3	196.6	229.2	0.9
Martinique (2003-2005)	222.5	245.8	190.3	1.3
Costa Rica (2004-2006)	227.7	249.1	203.3	1.2
Ecuador (2003-2005)	259.6	291.8	222.9	1.3
Guadeloupe (2003-2005)	276.3	311.7	227.1	1.4
Guatemala (2002-2004)	280.5	316.3	240.7	1.3
Colombia (2003-2005)	284.5	309.2	252.6	1.2
Brazil (2003-2005)	286.1	316.1	247.1	1.3
El Salvador (2004-2006)	291.8	330.1	241.7	1.4
Suriname (2000,04,05)	300.8	275.2	331.6	0.8
Dominican Republic (2002-2004)	344.1	402.4	285.3	1.4
Haiti (2002-2004)	397.6	459.0	324.4	1.4
Panama (2002-2004)	415.8	495.3	330.6	1.5
Venezuela (2003-2005)	419.2	452.8	379.6	1.2
Puerto Rico (2003-2005)	420.4	399.3	448.7	0.9
Nicaragua (2000-2002)	463.8	553.7	361.8	1.5
Guyana (2003-2005)	484.9	543.6	415.3	1.3
Barbados (2000.2001)	609.0	637.5	561.1	1.1
Paraguay (2004-2006)	640.9	754.2	512.1	1.5
Mexico (2004-2006)	728.5	759.1	690.7	1.1
Trinidad and Tobago (2000-2002)	1014.80	961.8	1083.8	0.9

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 22. **Mortality in women aged 25 to 44 from malignant neoplasms of the uterus and breast, 27 countries, circa 2004-2006**

Country	Rate per 100,000 women	
	Uterus	Breast
Canada (2002-2004)	2.0	7.0
United States (2003-2005)	2.4	7.2
Martinique (2003-2005)	2.9	9.4
Puerto Rico (2003-2005)	3.0	6.1
Costa Rica (2004-2006)	4.2	4.2
Guadeloupe (2003-2005)	4.5	10.0
Haiti (2002-2004)	4.5	4.8
Chile (2003-2005)	5.7	4.9
Dominican Republic (2002-2004)	5.7	6.9
Trinidad and Tobago (2000-2002)	5.9	12.0
Mexico (2004-2006)	6.4	6.4
Ecuador (2003-2005)	7.0	3.7
Argentina (2004-2006)	7.4	7.3
Brazil (2003-2005)	7.5	8.5
Uruguay (2001,03,04)	7.5	9.0
Suriname (2000,04,05)	7.6	8.8
Colombia (2003-2005)	8.9	6.1
Guyana (2003-2005)	9.8	6.5
Guatemala (2002-2004)	10.2	2.8
Panama (2002-2004)	10.4	5.7
Peru (2002-2004)	11.0	6.2
Venezuela (2003-2005)	11.7	6.7
Cuba (2004-2006)	12.7	8.8
Paraguay (2004-2006)	13.3	6.7
El Salvador (2004-2006)	16.1	5.3
Nicaragua (2003-2005)	17.7	6.0
Bolivia (2002,2003)	29.2	10.2

Note: The countries are shown in ascending order of the MN of the uterus.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 23. **Mortality in women aged 45 to 64 from malignant neoplasms of the uterus and breast, 27 countries, circa 2004-2005**

Country	Rate per 100,000 women	
	Uterus	Breast
Canada (2002-2004)	8.2	42.9
Puerto Rico (2003-2005)	9.2	34.0
United States (2003-2005)	10.0	40.5
Martinique (2003-2005)	10.5	41.3
Guadeloupe (2003-2005)	16.1	39.1
Costa Rica (2004-2006)	17.3	27.5
Chile (2003-2005)	19.5	27.8
Uruguay (2001,03,04)	22.0	57.1
Mexico (2004-2006)	24.7	24.8
Argentina (2004-2006)	26.1	53.7
Haiti (2002-2004)	26.5	30.1
Brazil (2003-2005)	27.5	40.5
Ecuador (2003-2005)	30.8	19.5
Cuba (2004-2006)	32.5	37.5
Dominican Republic (2002-2004)	32.9	36.4
Panama (2002-2004)	35.3	28.9
Trinidad and Tobago (2000-2002)	36.3	44.5
Colombia (2003-2005)	37.1	37.1
Venezuela (2003-2005)	37.4	36.4
Suriname (2000,04,05)	39.4	24.0
Guatemala (2002-2004)	41.5	10.8
Peru (2002-2004)	48.4	32.3
Guyana (2003-2005)	49.0	36.4
El Salvador (2004-2006)	49.3	17.5
Paraguay (2004-2006)	56.3	41.4
Nicaragua (2003-2005)	64.7	29.2
Bolivia (2002,2003)	70.8	21.7

Note: The countries are shown in ascending order of the rate of MN of the uterus.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 24. **Mortality in women aged 65 and over from malignant neoplasms of the uterus and breast, 27 countries, circa 2004-2006**

Country	Rate per 100,00 women	
	Uterus	Breast
Puerto Rico (2003-2005)	28.0	70.8
Canada (2002-2004)	29.5	130.5
United States (2003-2005)	30.1	113.5
Argentina (2004-2006)	49.4	139.8
Uruguay (2001,03,04)	51.0	147.9
Brazil (2003-2005)	54.9	74.3
Chile (2003-2005)	60.8	77.8
Mexico (2004-2006)	63.5	44.9
Martinique (2003-2005)	65.6	96.5
Guadeloupe (2003-2005)	67.0	69.9
Costa Rica (2004-2006)	67.6	96.9
Suriname (2000,04.05)	74.2	82.3
Cuba (2004-2006)	77.9	101.4
Colombia (2003-2005)	79.5	63.9
Guyana (2003-2005)	85.5	65.0
Ecuador (2003-2005)	86.5	29.6
Peru (2002-2004)	88.5	51.4
Guatemala (2002-2004)	89.3	22.9
Panama (2002-2004)	92.7	67.6
Venezuela (2003-2005)	97.9	81.9
Dominican Republic (2002-2004)	103.1	73.1
El Salvador (2004-2006)	110.5	30.2
Bolivia (2002,2003)	111.8	51.1
Haiti (2002-2004)	115.1	84.1
Trinidad and Tobago (2000-2002)	122.5	122.5
Nicaragua (2003-2005)	130.8	49.6
Paraguay (2004-2006)	163.8	114.0

Note: The countries are shown in ascending order of the rate of MN of the uterus.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 25. **Mortality from malignant neoplasms of the uterus and breast, women aged 45 to 64, 21 countries, circa 2004-2006, and per capita gross national income 2006, adjusted for purchasing power parity (ppp) in those countries**

Country	Rate per 100,000 women		GNIpc 2006 (ppp)
	Uterus	Breast	
Haiti (2002-2004)	26.5	30.1	1,070
Nicaragua (2003-2005)	64.7	29.2	2,720
Guyana (2003-2005)	49.0	36.4	3,410
Paraguay (2004-2006)	56.3	41.4	4,040
Guatemala (2002-2004)	41.5	10.8	5,120
Dominican Republic (2002-2004)	32.9	36.4	5,500
El Salvador (2004-2006)	49.3	17.5	5,610
Colombia (2003-2005)	37.1	37.1	6,130
Peru (2002-2004)	48.4	32.3	6,490
Ecuador (2003-2005)	30.8	19.5	6,810
Panama (2002-2004)	35.3	28.9	8,690
Brazil (2003-2005)	27.5	40.5	8,700
Costa Rica (2004-2006)	17.3	27.5	9,220
Uruguay (2001,03,04)	22.0	57.1	9,940
Venezuela (2003-2005)	37.4	36.4	10,970
Chile (2003-2005)	19.5	27.8	11,300
Argentina (2004-2006)	26.1	53.7	11,670
Mexico (2004-2006)	24.7	24.8	11,990
Trinidad and Tobago (2000-2002)	36.3	44.5	16,800
Canada (2002-2004)	8.2	42.9	36,280
United States (2003-2005)	10.0	40.5	44,070

GNIpc 2006 = Gross National Income per capita, 2006 US$ (ppp value).
Note: The countries are shown in ascending order of the GNIpc 2006.
Sources: PAHO. Health Information and Analylsis Project. (1) Data on mortality and population. Washington, DC, July 2008. (2) Data for GNIpc 2006: Health Situation in the Americas, Basic Indicators 2008.

Table 26. **Mortality in men aged 45 to 64 and 65 and over from malignant neoplasms of the prostate, 27 countries, circa 2004-2006**

Country	Rate per 100,000 men	
	45-64 years	65 years and over
El Salvador (2004-2006)	4.4	151.5
Costa Rica (2004-2006)	5.4	263.0
Ecuador (2003-2005)	6.1	187.7
Guatemala (2002-2004)	6.5	139.0
Mexico (2004-2006)	7.2	167.0
United States (2003-2005)	7.3	175.9
Canada (2002-2004)	7.4	194.5
Chile (2003-2005)	7.7	263.4
Nicaragua (2003-2005)	8.5	228.6
Puerto Rico (2003-2005)	8.7	228.6
Colombia (2003-2005)	9.5	243.5
Peru (2002-2004)	10.0	220.7
Paraguay (2004-2006)	10.3	327.9
Suriname (2000,04.05)	10.4	238.6
Brazil (2003-2005)	10.5	205.6
Panama (2002-2004)	10.6	314.2
Argentina (2004-2006)	10.9	233.7
Venezuela (2003-2005)	11.8	283.5
Guadeloupe (2003-2005)	12.3	531.3
Cuba (2004-2006)	15.6	362.0
Guyana (2003-2005)	15.7	327.4
Bolivia (2002.2003)	16.8	124.0
Haiti (2002-2004)	18.0	370.3
Uruguay (2001,03,04)	18.5	346.6
Martinique (2003-2005)	19.1	503.9
Dominican Republic (2002-2004)	22.7	608.5
Trinidad and Tobago (2000-2002)	24.4	626.6

Note: The countries are shown in ascending order of the rate for population aged 45 to 64 years.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 27. **Years of potential life lost up to age 75 (YPLL-75) for each death due to malignant neoplasms of the uterus and breast in women and the prostate in men, 27 countries, circa 2004-2006**

Country	YPLL-75 per death		
	Uterus	Breast	Prostate
Martinique (2003-2005)	7.4	12.0	2.0
Canada (2002-2004)	9.8	9.7	2.2
Guadeloupe (2003-2005)	10.7	16.0	1.6
United States (2003-2005)	10.8	10.3	2.3
Puerto Rico (2003-2005)	12.1	12.1	1.9
Uruguay (2001,03,04)	12.5	9.5	2.5
Trinidad and Tobago (2000-2002)	12.6	15.7	3.0
Haiti (2002-2004)	13.5	15.4	3.8
Chile (2003-2005)	13.7	12.5	2.3
Costa Rica (2004-2006)	14.3	13.5	1.9
Argentina (2004-2006)	14.6	10.3	2.7
Ecuador (2003-2005)	14.9	17.6	2.6
Cuba (2004-2006)	15.0	12.1	2.4
Dominican Republic (2002-2004)	15.9	18.8	3.2
Mexico (2004-2006)	16.3	18.1	3.0
Suriname (2000,04,05)	16.5	16.3	3.0
Brazil (2003-2005)	16.8	16.0	3.3
Guyana (2003-2005)	16.9	17.4	3.3
El Salvador (2004-2006)	17.0	17.6	2.3
Colombia (2003-2005)	17.1	16.6	3.0
Panama (2002-2004)	17.2	16.0	2.4
Peru (2002-2004)	17.3	17.3	2.9
Paraguay (2004-2006)	17.5	16.0	3.1
Guatemala (2002-2004)	18.1	18.2	3.7
Venezuela (2003-2005)	19.1	17.4	3.9
Nicaragua (2003-2005)	19.1	18.7	3.0
Bolivia (2002,2003)	21.1	20.0	5.2

Note: The countries are shown in ascending order of the YPLL-75 per death due to MN of the uterus.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 28. **Mortality from malignant neoplasms of the lung (including the bronchi and trachea) in the population aged 45 to 64, 27 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both sexes	Female	Male	
Guyana (2003-2005)	7.0	3.6	10.1	0.4
Ecuador (2003-2005)	8.4	7.5	9.3	0.8
Costa Rica (2004-2006)	9.1	6.1	12.1	0.5
Guatemala (2002-2004)	9.5	9.0	10.1	0.9
El Salvador (2004-2006)	9.9	8.7	11.2	0.8
Haiti (2002-2004)	11.0	13.7	8.0	1.7
Mexico (2004-2006)	12.8	8.0	17.8	0.4
Nicaragua (2003-2005)	13.0	12.3	13.7	0.9
Puerto Rico (2003-2005)	17.2	9.5	26.2	0.4
Peru (2002-2004)	17.7	15.4	20.2	0.8
Bolivia (2002.2003)	18.2	14.8	22.0	0.7
Panama (2002-2004)	19.1	10.8	27.4	0.4
Suriname (2000,04,05)	19.4	9.2	30.7	0.3
Martinique (2003-2005)	20.7	12.8	30.0	0.4
Trinidad and Tobago (2000-2002)	21.1	7.2	36.2	0.2
Dominican Republic (2002-2004)	21.3	17.8	24.7	0.7
Colombia (2003-2005)	21.5	16.4	27.2	0.6
Chile (2003-2005)	22.1	13.8	30.9	0.4
Paraguay (2004-2006)	24.7	7.1	41.7	0.2
Guadeloupe (2003-2005)	26.3	11.9	42.8	0.3
Venezuela (2003-2005)	28.5	20.4	36.7	0.6
Brazil (2003-2005)	29.3	19.8	39.7	0.5
Argentina (2004-2006)	50.6	22.7	80.8	0.3
Canada (2002-2004)	61.9	54.3	69.6	0.8
United States (2003-2005)	62.0	49.3	75.4	0.7
Cuba (2004-2006)	62.1	43.9	81.1	0.5
Uruguay (2001,03,04)	70.0	18.6	127.0	0.1

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 29. **Mortality from malignant neoplasms of the lung (including the bronchi and trachea) in the population aged 65 and over, 27 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both sexes	Female	Male	
Guyana (2003-2005)	26.5	9.2	47.0	0.2
Haiti (2002-2004)	41.6	34.6	50.0	0.7
Guatemala (2002-2004)	46.7	36.4	58.2	0.6
Martinique (2003-2005)	57.8	32.2	93.4	0.3
El Salvador (2004-2006)	57.9	54.9	61.9	0.9
Ecuador (2003-2005)	58.3	40.6	78.6	0.5
Guadeloupe (2003-2005)	60.7	27.7	106.7	0.3
Nicaragua (2003-2005)	63.9	55.2	73.8	0.7
Trinidad and Tobago (2000-2002)	70.2	32.9	118.6	0.3
Costa Rica (2004-2006)	78.8	49.5	112.4	0.4
Mexico (2004-2006)	84.9	48.5	129.7	0.4
Puerto Rico (2003-2005)	85.6	57.0	123.9	0.5
Suriname (2000.04.05)	91.4	50.5	140.3	0.4
Bolivia (2002.2003)	92.7	52.3	142.8	0.4
Peru (2002-2004)	93.9	74.8	116.4	0.6
Panama (2002-2004)	108.0	74.0	144.5	0.5
Brazil (2003-2005)	108.8	63.5	166.4	0.4
Chile (2003-2005)	116.9	73.5	177.0	0.4
Venezuela (2003-2005)	123.0	95.3	155.4	0.6
Colombia (2003-2005)	124.1	90.2	168.0	0.5
Dominican Republic (2002-2004)	124.7	90.8	159.0	0.6
Paraguay (2004-2006)	126.1	50.2	212.3	0.2
Argentina (2004-2006)	136.2	57.1	253.9	0.2
Uruguay (2001.03.04)	177.5	46.6	376.6	0.1
Cuba (2004-2006)	238.2	145.4	343.0	0.4
Canada (2002-2004)	304.3	215.2	421.6	0.5
United States (2003-2005)	312.1	237.9	414.6	0.6

Note: The countries ares shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 30. **Mortality from cirrhosis and other chronic diseases of the liver in the population aged 45-64 years old, 28 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both sexes	Female	Male	
Canada (2002-2004)	13.8	8.0	19.6	0.4
Barbados (2000,2001)	14.2	3.5	26.4	0.1
Martinique (2003-2005)	14.9	4.5	27.2	0.2
Colombia (2003-2005)	15.2	8.8	22.3	0.4
Argentina (2004-2006)	19.2	6.7	32.8	0.2
Cuba (2004-2006)	19.7	8.9	31.0	0.3
Uruguay (2001,03,04)	20.8	6.3	36.8	0.2
Paraguay (2004-2006)	21.4	6.1	36.1	0.2
Trinidad and Tobago (2000-2002)	21.9	9.3	35.6	0.3
Panama (2002-2004)	22.5	12.0	32.9	0.4
United States (2003-2005)	23.1	13.0	33.8	0.4
Haiti (2002-2004)	23.8	16.7	31.6	0.5
Venezuela (2003-2005)	27.1	9.7	44.8	0.2
Suriname (2000,04,05)	29.3	16.4	43.7	0.4
Guadeloupe (2003-2005)	30.1	11.2	51.9	0.2
Costa Rica (2004-2006)	31.8	16.4	47.1	0.3
El Salvador (2004-2006)	32.4	19.8	46.8	0.4
Puerto Rico (2003-2005)	35.1	10.9	63.6	0.2
Ecuador (2003-2005)	35.6	16.9	55.0	0.3
Brazil (2003-2005)	41.4	13.1	72.5	0.2
Dominican Republic (2002-2004)	48.0	33.0	62.9	0.5
Chile (2003-2005)	56.9	23.8	91.7	0.3
Peru (2002-2004)	58.8	32.8	85.2	0.4
Guatemala (2002-2004)	72.9	36.8	111.8	0.3
Guyana (2003-2005)	74.6	25.2	120.6	0.2
Bolivia (2002,2003)	77.1	53.7	102.6	0.5
Nicaragua (2000-2002)	80.2	32.9	128.1	0.3
Mexico (2004-2006)	83.4	30.1	138.8	0.2

Note: The countries ares shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 31. **Mortality from HIV disease in the population aged 25 to 44 years, 28 countries, circa 2004-2006**

Country	Rate per 100,000 population			F:M
	Both Sexes	Female	Male	
Bolivia (2002-2003)	0.9	1.1	0.6	1.83
Cuba (2004-2006)	2.4	0.9	3.9	0.23
Canada (2002-2004)	2.5	0.9	4.0	0.23
Chile (2003-2005)	5.5	1.4	9.6	0.15
Costa Rica (2004-2006)	6.0	2.0	9.9	0.20
Nicaragua (2000-2002)	6.7	3.4	10.1	0.34
United States (2003-2005)	7.8	4.6	10.9	0.42
Martinique (2003-2005)	8.1	4.1	12.6	0.33
Paraguay (2004-2006)	9.3	5.7	12.7	0.45
Argentina (2004-2006)	9.6	5.3	13.9	0.38
Ecuador (2003-2005)	10.9	3.5	18.4	0.19
Venezuela (2003-2005)	11.8	5.2	18.3	0.28
Guadeloupe (2003-2005)	12.0	6.0	18.6	0.32
Mexico (2004-2006)	12.1	3.8	21.0	0.18
Uruguay (2001.03.04)	12.1	5.7	18.7	0.30
Colombia (2003-2005)	12.8	6.3	19.5	0.32
Guatemala (2002-2004)	15.4	7.1	25.1	0.28
Peru (2002-2004)	20.3	10.0	30.6	0.33
Brazil (2003-2005)	20.4	13.0	28.1	0.46
El Salvador (2004-2006)	21.8	18.9	24.9	0.76
Puerto Rico (2003-2005)	25.0	13.2	37.6	0.35
Dominican Republic (2002-2004)	37.7	33.2	42.2	0.79
Panama (2002-2004)	38.7	21.1	56.0	0.38
Barbados (2000,2001)	44.7	27.4	62.3	0.44
Suriname (2000,04,05)	63.9	42.9	84.4	0.51
Trinidad and Tobago (2000-2002)	78.6	55.8	102.2	0.55
Guyana (2003-2005)	110.9	93.8	127.9	0.73
Haiti (2002-2004)	132.5	106.6	160.1	0.67

Note: The countries ares shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 32. **Mortality from HIV disease in the population aged 45 to 64 years, 28 countries, circa 2004-2006**

Country	Rate 100,000 per population			F:M
	Both Sexes	Female	Male	
Cuba (2004-2006)	1.0	0.1	2.0	0.05
Canada (2002-2004)	2.3	0.5	4.2	0.12
Nicaragua (2000-2002)	2.9	1.4	4.5	0.31
Bolivia (2002,2003)	3.6	2.2	5.0	0.44
Chile (2003-2005)	3.8	1.0	6.7	0.15
Ecuador (2003-2005)	4.9	1.3	8.6	0.15
Argentina (2004-2006)	5.0	2.2	8.1	0.27
Costa Rica (2004-2006)	6.0	2.0	10.0	0.20
Paraguay (2004-2006)	6.6	3.2	9.9	0.32
Uruguay (2001,03,04)	6.6	2.4	11.3	0.21
Mexico (2004-2006)	7.1	2.0	12.5	0.16
Venezuela (2003-2005)	8.0	2.8	13.2	0.21
Martinique (2003-2005)	8.3	3.8	13.6	0.28
United States (2003-2005)	8.6	3.8	13.6	0.28
Guatemala (2002-2004)	9.1	3.7	15.0	0.25
Colombia (2003-2005)	10.4	3.4	18.3	0.19
Guadeloupe (2003-2005)	11.8	4.9	19.8	0.25
Brazil (2003-2005)	12.6	7.8	17.9	0.44
Peru (2002-2004)	13.5	4.6	22.6	0.20
El Salvador (2004-2006)	18.0	11.1	25.9	0.43
Puerto Rico (2003-2005)	23.3	0.5	40.9	0.01
Panama (2002-2004)	31.9	12.7	51.1	0.25
Dominican Republic (2002-2004)	37.3	22.6	51.8	0.44
Barbados (2000,2001)	37.6	20.8	56.5	0.37
Suriname (2000,04,05)	64.7	42.3	89.7	0.47
Guyana (2003-2005)	65.1	43.1	85.6	0.50
Trinidad and Tobago (2000-2002)	65.5	33.7	100.2	0.34
Haiti (2002-2004)	138.0	98.5	181.5	0.54

Note: The countries ares shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 33. **Mortality from land transport accidents in the population aged 15 to 24 and 25 to 44, 26 countries, circa 2004-2006**

	Rate per 100,000 population aged 15 to 24				Rate per 100,000 population aged 25 to 44		
Country	Both sexes	Female	Male	M:F	Female	Male	M:F
Guatemala (2002-2004)	2.7	0.9	4.5	5.0	1.1	9.6	8.7
Haiti (2002-2004)	7.5	4.2	10.9	2.6	5.9	16.6	2.8
Peru (2002-2004)	8.2	3.9	12.4	3.2	5.8	21.4	3.7
Trinidad & Tobago (2000-2002)	11.0	5.4	16.5	3.1	6.8	29.4	4.3
Uruguay (2001,03,04)	11.3	5.6	16.8	3.0	5.2	18.0	3.5
Argentina (2004-2006)	11.8	5.4	18.0	3.3	5.0	19.5	3.9
Chile (2003-2005)	11.9	5.3	18.2	3.4	4.3	28.2	6.6
Costa Rica (2004-2006)	13.5	4.8	21.7	4.5	5.5	28.7	5.2
Suriname (2000,04,05)	14.5	4.6	24.4	5.3	5.2	32.4	6.2
El Salvador (2004-2006)	14.7	9.7	19.7	2.0	13.3	52.4	3.9
Colombia (2003-2005)	15.0	6.9	22.9	3.3	7.4	30.8	4.2
Paraguay (2004-2006)	15.1	7.6	22.4	2.9	5.6	29.5	5.3
Ecuador (2003-2005)	15.4	5.9	24.7	4.2	6.3	34.9	5.5
Nicaragua (2000-2002)	15.7	5.6	25.8	4.6	6.1	40.9	6.7
Cuba (2004-2006)	16.0	11.8	19.8	1.7	5.1	22.8	4.5
Canada (2002-2004)	17.1	9.2	24.7	2.7	4.6	14.6	3.2
Guyana (2003-2005)	18.8	7.9	29.8	3.8	5.8	38.1	6.6
Panama (2002-2004)	19.6	7.7	31.2	4.1	5.5	38.6	7.0
Mexico (2004-2006)	19.7	6.6	33.7	5.1	7.0	37.9	5.4
Venezuela (2003-2005)	19.9	10.0	29.6	3.0	10,4	46,1	4,4
Puerto Rico (2003-2005)	20.5	8.4	32.4	3.9	4.9	26.0	5.3
Guadeloupe (2003-2005)	21.7	5.8	37.3	6.4	6.2	44.7	7.2
Martinique (2003-2005)	23.4	7.3	39.2	5.4	3.2	31.2	9.8
Dominican Republic (2002-2004)	24.2	10.1	38.2	3.8	8.4	43.6	5.2
Brazil (2003-2005)	26.1	10.2	41.7	4.1	9.6	56.3	5.9
United States (2003-2005)	26.9	15.5	37.8	2.4	8.9	25.5	2.9

Note: The countries are shown in ascending order of the rate for both sexes combined of the population aged 15 to 24.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 34. **Male:female ratio of mortality from transport accidents in two age groups: 15-24 and 25-44 years, 26 countries, circa 2004-2006**

Country	Ages 15 to 24	Ages 25 to 44
Cuba (2004-2006)	1.7	4.5
El Salvador (2004-2006)	2.0	3.9
United States (2003-2005)	2.4	2.9
Haiti (2002-2004)	2.6	2.8
Canada (2002-2004)	2.7	3.2
Paraguay (2004-2006)	2.9	5.3
Venezuela (2003-2005)	3.0	4.4
Uruguay (2001,03,04)	3.0	3.5
Trinidad and Tobago (2000-2002)	3.1	4.3
Peru (2002-2004)	3.2	3.7
Colombia (2003-2005)	3.3	4.2
Argentina (2004-2006)	3.3	3.9
Chile (2003-2005)	3.4	6.6
Guyana (2003-2005)	3.8	6.6
Dominican Republic (2002-2004)	3.8	5.2
Puerto Rico (2003-2005)	3.9	5.3
Panama (2002-2004)	4.1	7.0
Brazil (2003-2005)	4.1	5.9
Ecuador (2003-2005)	4.2	5.5
Costa Rica (2004-2006)	4.5	5.2
Nicaragua (2000-2002)	4.6	6.7
Guatemala (2002-2004)	5.0	8.7
Mexico (2004-2006)	5.1	5.4
Suriname (2000,04.05)	5.3	6.2
Martinique (2003-2005)	5.4	9.8
Guadeloupe (2003-2005)	6.4	7.2

Note: The countries are shown in ascending order of the M:F ratio in population aged 15 to 24 years.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 35. **Mortality from accidents in children 1 to 4 years old, 27 countries, circa 2004-2006**

Country	Rate per 100,000 population			B:G
	Both sexes	Girls	Boys	
Puerto Rico (2003-2005)	5.0	4.4	5.7	1.3
Canada (2002-2004)	5.8	5.0	6.6	1.3
Guatemala (2002-2004)	8.2	7.2	9.2	1.3
Costa Rica (2004-2006)	9.0	6.4	11.5	1.8
United States (2003-2005)	10.5	8.5	12.4	1.5
Uruguay (2001,03,04)	10.9	9.7	12.1	1.2
Chile (2003-2005)	12.1	9.5	14.5	1.5
Cuba (2004-2006)	14.5	11.4	17.3	1.5
Argentina (2004-2006)	14.9	12.3	17.5	1.4
Trinidad and Tobago (2000-2002)	16.4	17.6	15.3	0.9
Martinique (2003-2005)	17.0	9.4	24.2	2.6
Guyana (2003-2005)	17.5	19.5	15.6	0.8
Panama (2002-2004)	23.4	17.6	29.0	1.6
Ecuador (2003-2005)	23.6	18.7	28.3	1.5
Brazil (2003-2005)	26.7	20.0	33.1	1.7
Haiti (2002-2004)	27.6	21.1	33.9	1.6
Suriname (2000,04,05)	27.8	23.9	31.4	1.3
Paraguay (2004-2006)	29.3	23.3	35.2	1.5
Dominican Republic (2002-2004)	30.4	29.4	31.3	1.1
Nicaragua (2000-2002)	34.5	22.8	45.8	2.0
Belize (1999-2001)	35.6	36.0	35.1	1.0
El Salvador (2004-2006)	38.2	28.2	47.8	1.7
Mexico (2004-2006)	38.7	28.2	48.8	1.7
Colombia (2003-2005)	40.0	41.0	39.0	1.0
Venezuela (2003-2005)	55.5	48.2	62.4	1.3
Bolivia (2002,2003)	62.3	57.3	67.1	1.2
Peru (2002-2004)	78.9	73.0	84.6	1.2

Note: The countries are shown in ascending order of the rate for both sexes combined. The countries with at least 10 deaths due to accidents in population aged 1 to 4 years are included.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 36. **Mortality from homicide in the population aged 15 to 24, 21 countries, circa 2004-2006**

Country	Rate per 100,000 population			M:F
	Both sexes	Female	Male	
Canada (2002-2004)	2.7	1.1	4.2	3.8
Uruguay (2001, 03, 04)	6.8	2.1	11.4	5.4
Costa Rica (2004-2006)	7.9	3.0	12.7	4.2
Chile (2003-2005)	8.5	0.9	15.8	17.6
Argentina (2004-2006)	8.9	1.8	15.8	8.8
Cuba (2004-2006)	9.9	6.1	13.6	2.2
Mexico (2004-2006)	11.7	2.9	21.1	7.3
United States (2003-2005)	12.6	3.5	21.3	6.1
Trinidad and Tobago (2000-2002)	14.1	5.1	22.9	4.5
Paraguay (2004-2006)	16.2	2.5	29.5	11.8
Guyana (2003-2005)	22.8	8.4	37.2	4.4
Haiti (2002-2004)	23.8	5.9	41.8	7.1
Panama (2002-2004)	24.3	3.4	44.5	13.1
Ecuador (2003-2005)	24.4	3.8	44.4	11.7
Nicaragua (2000-2002)	26.4	5.9	46.9	7.9
Puerto Rico (2003-2005)	46.7	4.0	88.6	22.2
Guatemala (2002-2004)	51.4	7.9	96.6	12.2
Venezuela (2003-2005)	57.1	6.1	106.5	17.5
Brazil (2003-2005)	62.3	8.7	114.8	13.2
El Salvador (2004-2006)	67.3	27.0	107.2	4.0
Colombia (2003-2005)	81.1	15.6	145.2	9.3

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 37. **Mortality from homicide in the population aged 25 to 44, 21 countries, circa 2004-2006**

Country	Rate per 100,000 populaton			M:F
	Both sexes	Female	Male	
Canada (2002-2004)	2.0	1.1	2.9	2.6
Uruguay (2001, 03, 04)	6.3	2.9	9.7	3.3
Argentina (2004-2006)	7.6	1.8	13.4	7.4
Chile (2003-2005)	8.3	1.4	15.2	10.9
United States (2003-2005)	8.9	3.6	14.2	3.9
Costa Rica (2004-2006)	10.8	2.5	18.8	7.5
Cuba (2004-2006)	11.4	6.2	16.6	2.7
Mexico (2004-2006)	17.9	3.3	33.4	10.1
Paraguay (2004-2006)	21.2	3.5	38.5	11.0
Panama (2002-2004)	22.2	3.7	40.6	11.0
Trinidad and Tobago (2000-2002)	22.7	6.0	40.0	6.7
Haiti (2002-2004)	28.1	7.0	50.6	7.2
Nicaragua (2000-2002)	28.6	6.3	52.2	8.3
Ecuador (2003-2005)	29.3	4.0	54.5	13.6
Puerto Rico (2003-2005)	34.3	5.1	65.9	12.9
Guyana (2003-2005)	34.6	8.9	60.1	6.8
Venezuela (2003-2005)	45.8	5.5	85.8	15.6
Guatemala (2002-2004)	50.9	8.0	101.1	12.6
Brazil (2003-2005)	52.2	8.4	97.6	11.6
El Salvador (2004-2006)	77.2	22.2	136.2	6.1
Colombia (2003-2005)	89.9	17.2	166.4	9.7

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 38. **Mortality from suicide in the population aged 15 to 24 years old, 18 countries, circa 2004-2006**

Country	Rate per 100,000 population			M:F
	Both sexes	Female	Male	
Puerto Rico (2003-2005)	5.3	1.0	9.5	9.5
Brazil (2003-2005)	5.5	3.0	8.1	2.7
Mexico (2004-2006)	6.6	2.7	10.9	4.0
Paraguay (2004-2006)	7.8	7.0	8.5	1.2
Cuba (2004-2006)	8.0	6.4	9.5	1.5
Costa Rica (2004-2006)	8.5	3.3	13.3	4.0
Panama (2002-2004)	9.4	3.6	15.0	4.2
Colombia (2003-2005)	9.5	7.1	11.9	1.7
United States (2003-2005)	9.9	3.3	16.2	4.9
Canada (2002-2004)	11.7	5.2	18.0	3.5
Chile (2003-2005)	11.8	4.3	19.1	4.4
Ecuador (2003-2005)	11.9	10.4	13.4	1.3
Argentina (2004-2006)	12.3	4.9	19.5	4.0
El Salvador (2004-2006)	12.3	14.5	10.2	0.7
Uruguay (2001,03,04)	12.8	5.2	20.2	3.9
Trinidad and Tobago (2000-2002)	13.9	7.8	19.9	2.6
Nicaragua (2000-2002)	25.2	18.8	31.6	1.7
Guyana (2003-2005)	31.3	26.2	36.4	1.4

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 39. **Mortality from suicide in the population aged 25 to 44, 18 countries, circa 2004-2006**

Country	Rate per 100,000 population			M:F
	Both sexes	Female	Male	
Paraguay (2004-2006)	5.4	3.4	7.2	2.1
Colombia (2003-2005)	6.5	2.9	10.3	3.6
Mexico (2004-2006)	6.7	1.8	12.0	6.7
Ecuador (2003-2005)	7.6	3.3	12.0	3.6
Brazil (2003-2005)	8.1	3.4	13.1	3.9
Argentina (2004-2006)	8.7	3.4	14.0	4.1
Puerto Rico (2003-2005)	9.2	1.6	17.4	10.9
El Salvador (2004-2006)	10.1	6.6	13.8	2.1
Costa Rica (2004-2006)	10.2	2.6	17.5	6.7
Panama (2002-2004)	10.2	2.8	17.5	6.3
Cuba (2004-2006)	12.9	5.9	19.7	3.3
United States (2003-2005)	13.7	5.7	21.6	3.8
Chile (2003-2005)	14.3	4.5	24.0	5.3
Canada (2002-2004)	14.8	6.6	22.9	3.5
Uruguay (2001, 03, 04)	15.1	6.7	23.7	3.5
Nicaragua (2000-2002)	18.4	7.6	29.7	3.9
Trinidad and Tobago (2000-2002)	18.8	5.8	32.2	5.6
Guyana (2003-2005)	43.0	17.1	68.8	4.0

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 40. **Mortality from injury of undetermined intent in the population aged 25 to 44, eight countries, circa 2003-2005**

Country	Rate per 100,000 population			M:F
	Both sexes	Female	Male	
Guyana (2003-2005)	11.0	3.7	18.2	4.9
Haiti (2002-2004)	11.1	5.8	16.7	2.9
Peru (2002-2004)	15.7	5.9	25.6	4.3
French Guiana (2003-2005)	24.7	2.5	48.0	19.2
Venezuela (2003-2005)	30.7	4.7	56.5	12.0
Dominican Republic (2002-2004)	31.3	8.0	55.0	6.9
Suriname (2000,04,05)	35.8	9.8	61.2	6.2
Guatemala (2002-2004)	45.5	11.5	85.3	7.4

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington. DC. July 2008.

Table 41. **Rank of suicide in mortality of women aged 15 to 24 and percentage of the deaths due to suicide, 18 countries, by sex, circa 2004-2006**

Rank of suicide, women aged 15 to 24	Country	Percentage of the deaths (15-24 years old)	
		Female	Male
First cause	Guyana (2003-2005)	22.2	18.3
	Nicaragua (2000-2002)	18.1	16.3
	Ecuador (2003-2005)	15.2	8.3
Second cause	Canada (2002-2004)	17.7	25.5
	Chile (2003-2005)	15.2	21.2
	El Salvador (2004-2006)	14.7	5.8
	Uruguay (2001,03,04)	14.6	19.4
	Argentina (2004-2006)	11.7	17.5
	Colombia (2003-2005)	10.3	5.0
	Costa Rica (2004-2006)	10.2	15.1
	Trinidad & Tobago (2000-2002)	9.6	14.8
	Cuba (2004-2006)	9.2	9.8
Third cause	Paraguay (2004-2006)	12.4	8.2
	United States (2003-2005)	7.9	14.3
Fourth cause	Panama (2002-2004)	6.8	9.6
	Brazil (2003-2005)	4.8	3.5
Fifth cause	Mexico (2004-2006)	5.4	7.8
	Puerto Rico (2003-2005)	2.9	5.7

Note: Countries presenting a high percentage of deaths due to injury of undetermined intent were omitted, as this indicates a likelihood of substantial underestimation of deaths due to suicide and homicide.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 42. **Mortality from nutritional deficiencies and anemia, children 1 to 4 years old, 17 countries, circa 2004-2006**

Country	Rate per 100,000 population			G:B
	Both sexes	Girls	Boys	
Costa Rica (2004-2006)	1.1	1.2	1.0	1.2
Argentina (2004-2006)	2.4	2.6	2.3	1.1
Guyana (2003-2005)	6.1	4.4	7.6	0.6
Mexico (2004-2006)	7.3	6.4	8.2	0.8
Brazil (2003-2005)	7.5	7.2	7.8	0.9
El Salvador (2004-2006)	7.9	7.8	7.9	1.0
Ecuador (2003-2005)	8.8	8.3	9.3	0.9
Suriname (2000, 04, 05)	8.8	12.1	5.7	2.1
Bolivia (2002-2003)	15.3	9.9	20.4	0.5
Paraguay (2004-2006)	16.8	19.2	14.5	1.3
Colombia (2003-2005)	17.8	21.9	13.8	1.6
Guatemala (2002-2004)	19.8	20.5	19.1	1.1
Nicaragua (2000-2002)	26.7	28.4	25.1	1.1
Peru (2002-2004)	30.8	28.8	32.6	0.9
Panama (2002-2004)	31.8	34.3	29.5	1.2
Venezuela (2003-2005)	32.1	32.0	32.2	1.0
Dominican Republic (2002-2004)	37.0	37.1	36.8	1.0

Note: The countries are shown in ascending order of the rate for both sexes combined.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington. DC. July 2008.

IV. Reproductive Health and Access to Services

Table 43. **Trend in percentage of adolescent women (15-19 years old) who are mothers or pregnant with their first child: total, those without education, and those residing in rural areas, four countries, circa 1995 and 2005**

Country	Year of the survey	Total adolescents	Adolescents without education	Adolescents in rural areas
Bolivia	1994	17.5	37.6	22.2
	2003	15.7	47.2	21.9
Colombia	1995	17.4	50.7	25.5
	2005	20.5	52.3	26.9
Haiti	1994/95	14.5	25.6	16.4
	2005/06	14.0	30.0	16.7
Dominican Rep.	1996	22.7	58.3	30.6
	2007	20.6	51.3	26.0

Source: Macro International Inc., 2009. MEASURE DHS STATcompiler.
http//:www.measuredhs.com. Accessed on 12 October 2009.

Table 44. **Currently married women (%) using contraceptives, by ethnic origin, Ecuador, 2004**

Ethnic group	Female sterilization	Pill	IUD	Injections	Male condom
Total national	24.2	13.3	10.1	5.9	4.3
Indigenous	9.0	3.5	7.6	3.6	1.8
Mestizo	25.7	13.5	10.3	6.1	4.7
White	22.0	17.0	10.7	7.1	3.8
Other	24.2	21.5	9.4	3.1	1.9

Source: CEPAR. Demograpihc and Maternal and Child Health Survey, ENDEMAIN 2004. Final Report, October 2005. Table 7.6

Table 45. **Changes in unmet need for family planning services to currently married women in four countries–total and women aged 15 to 19, circa 1995 and 2005**

	Total women living in a union		Women aged 15 to 19	
Country (year of the survey)	circa 1995	circa 2005	circa 1995	circa 2005
Bolivia (1994, 2003)	23.2	22.7	29.4	33.0
Colombia (1995, 2005)	7.7	5.8	16.2	16.2
Haiti (1994/95, 2005/06)	44.5	37.5	61.6	52.4
Dominican Republic (1996, 2007)	12.5	11.4	26.3	28.0

Source: Macro International Inc., 2008. MEASURE DHS STATcompiler. http://www.measuredhs.com. Accessed on 25 September 2008.

Table 46. **Total deaths from maternal causes, number and percentage of deaths from abortion and years of potential life lost up to age 75 (YPPL-75) for each death due to these causes, three-year periods, circa 2004-2006**

Country (triennium)	Total deaths in triennium		% due to abortion	YPPL-75 for each death	
	Maternal causes	Abortion		Total maternal	Abortion
Nicaragua (2003-2005)	289	12	4.2	47.5	50.4
United States (2003-2005)	2002	105	5.2	42.7	44.9
Canada (2002-2004)	58	4	6.9	43.7	46.3
Mexico (2004-2006)	3723	274	7.4	46.0	46.3
El Salvador (2004-2006)	66	5	7.6	45.8	46.5
Guatemala (2002-2004)	873	69	7.9	44.4	45.0
Ecuador (2003-2005)	411	37	9.0	46.1	50.1
Haiti (2002-2004)	288	26	9.0	41.5	45.9
Brazil (2003-2005)	4930	458	9.3	46.4	47.1
Peru (2002-2004)	639	61	9.5	44.1	43.1
Colombia (2003-2005)	1597	159	10.0	46.2	47.2
Dominican Rep. (2002-2004)	206	23	11.2	47.0	47.2
Chile (2003-2005)	123	16	13.0	43.6	44.1
Venezuela (2003-2005)	990	135	13.6	46.5	46.6
Guyana (2003-2005)	64	10	15.6	44.5	45.0
Cuba (2004-2006)	184	31	16.8	44.0	45.2
Panama (2002-2004)	95	19	20.0	45.3	44.1
Paraguay (2004-2006)	412	102	24.8	45.0	45.7
Argentina (2004-2006)	944	266	28.2	44.9	45.3
Uruguay (2001,03,04)	39	16	41.0	43.5	43.1

Note: The countries are shown in ascending order of the percentage of maternal deaths due to abortion.
Source: PAHO. Health Information and Analysis Project (HA), data on mortality and population. Washington, DC, July 2008.

Table 47. **Percentage of mothers who received prenatal and delivery care, by ethnic origin, Ecuador, 2004**

	Total	Indigenous	Mestizo	White	Other
Prenatal care					
- At least one prenatal visit	84.2	61.4	86.8	90.4	84.8
- Women meeting prenatal monitoring standards	52.0	17.7	55.5	65.6	54.0
Delivery care					
- Professional delivery care	74.2	30.1	79.6	86.2	69.2
- Caesarean deliveries	25.8	6.4	27.8	37.7	21.9

Note: (1) Data includes live births from July 1999 to June 2004. (2) Prenatal monitoring standards: first prenatal visit in the first three months and at least five prenatal visits.
Source: CEPAR. Encuesta Demográfica y de Salud Materna e Infantil, ENDEMAIN 2004. Informe Final. Quito, Octubre 2005. Cuadros 9.6, 9.8, 9.14, 9.18.

Table 48. **Percentage distribution of women by time elapsed since last Pap test, by ethnic origin, Ecuador (2004) and Guatemala (2002)**

Country	Ethnic group	Time elapsed since last Pap test (%)				
		1-11 months	12-23 months	24 and over	Never	Don't know Don't remember
Ecuador (2004)	Total	24.5	16.2	23.3	35.6	0.6
	Indigenous	11.8	6.8	10.6	69.8	1.4
	Mestizo	25.5	17.3	24.0	32.8	0.5
	White	27.5	14.7	25.7	31.4	0.7
	Other	22.1	12.4	27.1	38.1	0.5
Guatemala (2002)	Total	26.6	14.6	24.2	32.5	0.0
	Indigenous	12.1	9.3	18.6	57.7	0.0
	Ladino	30.2	15.9	25.6	26.3	0.0

Note: Data from Ecuador include sexually experienced women aged 15 to 49; data from Guatemala include women aged 30 to 49.
Sources: (1) Ecuador: CEPAR. Demographic and Maternal and Child Health Survey, ENDEMAIN 2004. Final Report, 2005 October, Table 9.28. (2) Guatemala: MSPAS/INE/UVG/CDC/USAID/ASDI/APRESAL/UE/PNUD/UNICEF/FNUAP/Proyecto POLCY II/CARE. GUATEMALA: Encuesta Nacional de Salud Materno Infantil 2002 [National Maternal and Child Health Survey 2002], October 2003, Table 10.11.

Table 49. **Estimates of total HIV-infected adults (aged 15 years and over) and percentage of women in that population, 2001 and 2007**

Country	Population (aged 15 and over)		% of women (aged 15 and over)	
	2001	2007	2001	2007
United States	1,000,000	1,100,000	18.0	20.9
Bahamas	5,600	6,100	23.2	26.2
Bolivia	6,100	7,900	24.6	27.8
Argentina	100,000	120,000	25.0	26.7
Guatemala	48,000	53,000	25.0	28.3
Uruguay	6,300	10,000	25.4	28.0
Nicaragua	4,300	7,500	25.6	28.0
Honduras	30,000	26,000	25.7	28.5
El Salvador	28,000	34,000	25.7	28.5
Ecuador	19,000	25,000	25.8	28.4
Chile	25,000	31,000	26.0	28.1
Paraguay	11,000	20,000	26.4	29.0
Jamaica	22,000	26,000	26.4	29.2
Canada	49,000	73,000	26.5	27.4
Peru	56,000	74,000	26.8	28.4
Panama	16,000	19,000	26.9	28.9
Colombia	130,000	160,000	26.9	29.4
Mexico	170,000	200,000	27.1	28.5
Costa Rica	5,100	9,600	27.5	28.1
Brazil	640.000	710,000	34.4	33.8
Haiti	94,000	110,000	45.7	52.7
Dominican Republic	63,000	59,000	54.0	50.8
Belize	2,800	3,400	57.1	58.8
Trinidad and Tobago	12,000	13,000	57.5	59.2
Guyana	12,000	12,000	58.3	59.2
Cuba	2,300	6,200	...	29.0
Suriname	3,400	6,700	...	28.4

Note: The countries are shown in ascending order of the percentage of women infected with HIV, 2001.
Source: Based on estimates published in: UNAIDS. 2008 Report on the global AIDS epidemic. http://www.unaids.org/en/HIV_data. Accessed on July 2008.

V. Violence against Women

Table 50. **Percentage of women who at some time suffered from intimate partner violence, by income quintile of the household, five countries, circa 2000**

Quintile	Colombia (2000)	Haiti (2000)	Nicaragua (1997-98)	Peru (2000)	Dominican Rep. (2002)
Lowest quintile	41.1	28.9	28.3	40.5	23.8
Second quintile	46.3	26.6	31.9	46.2	24.6
Third quintile	51.2	35.2	33.8	49.2	25.1
Fourth quintile	42.8	26.7	31.4	41.6	22.1
Highest quintile	38.1	26.8	25.8	33.3	16.3

Note: .Data from Peru include physical violence only; data from the other countries include physical and/or sexual violence.
Source: Kishor. Sunita and Kiersten Johnson. Profiling Domestic Violence - A Multi-Country Study. Calverton. Maryland: ORC Macro. June 2004, Table 3.4.1.

VI. Health Human Resources

Table 51. **Physicians and nursing personnel per 10,000 population, by country, circa 2005**

Country	Physicians	Nursing personnel	Nurses per physician	Physicians per nurse
Cuba	62.7	79.5	1.27	0.79
Uruguay	38.7	10.2	0.26	3.79
Argentina	32.1	3.8	0.12	8.45
United States	22.5	78.5	3.49	0.29
Puerto Rico	22.0	65.9	3.00	0.33
Costa Rica	20.0	15.3	0.77	1.31
Dominican Republic	20.0	3.9	0.20	5.13
Canada	19.1	77.2	4.04	0.25
Bahamas	16.7	23.8	1.43	0.70
Brazil	16.4	5.5	0.34	2.98
Nicaragua	16.4	1.4	0.09	11.71
Ecuador	15.4	5.2	0.34	2.96
Mexico	14.0	19.0	1.36	0.74
Panama	13.8	11.5	0.83	1.20
Colombia	12.7	6.1	0.48	2.08
El Salvador	12.6	8.1	0.64	1.56
Peru	11.5	7.6	0.66	1.51
Guatemala	9.7	3.6	0.37	2.69
Belize	9.3	15.7	1.69	0.59

Continued...

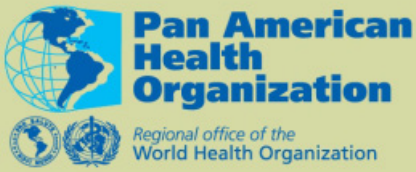
Country	Physicians	Nursing personnel	Nurses per physician	Physicians per nurse
Chile	9.3	4.3	0.46	2.16
Jamaica	8.5	16.5	1.94	0.52
Honduras	8.5	3.3	0.39	2.58
Saint Vincent & the Grenadines	6.9	19.8	2.87	0.35
Paraguay	6.0	2.8	0.47	2.14
Guyana	2.2	3.4	1.55	0.65

Note: The countries are shown in descending order of the ratio physicians per 10,000 population.
Source: PAHO. Health Situation in the Americas. Basic Indicators 2008. Washington, DC, 2008.

Table 52. **Physicians and nursing personnel, by sex, and female:male ratio for each profession, eight countries, circa 2000**

	Physicians			Nursing personnel		
Country	Female	Male	F:M	Female	Male	F:M
Costa Rica (2000)	1,817	3,387	0.54	2,988	643	4.6
Bolivia (2001)	2,962	7,367	0.40	15,015	2,980	5.0
Honduras (2000)	1,326	2,350	0.56	7,374	959	7.7
Panama (2000)	1,496	2,935	0.51	7,245	913	7.9
United States (2000)	205,139	525,662	0.39	2,497,424	172,179	14.5
Mexico (2000)	62,687	133,210	0.47	83,357	5,321	15.7
Brazil (2000)	71,221	126,932	0.56	...	...	
Canada (2003)	22,069	44,514	0.50	...	...	

Note: The countries are shown in ascending order of F:M ratio of nursing personnel
Source: WHO. Atlas Mundial de Salud, www.who.int/globalatlas/dataQuery. Accessed on 16 February 2009.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