

Gender Equality in Health: Improving Equality & Efficiency in Achieving Health for All



**Pan American
Health
Organization**

Regional Office of the
World Health Organization

<http://www.paho.org>



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I. The What and Why of this Booklet

This booklet offers information to help program staff improve their understanding of how social norms, roles, and inequities affect health outcomes for women, men, boys, and girls. The goal of this booklet is to assist staff to integrate gender in programs, products, and services so that these foster progressive changes in power relationships between women and men.

Women and men are empowered through transformative programs that:

- acknowledge different norms and roles for women and men and their impact on, access to, and control over resources and contribution to health work;
- take account of women's and men's specific needs;
- address causes of gender-based health inequities;
- include ways to change harmful gender norms, roles and relations; and
- aim to promote health equity and efficiency.

The next few pages suggest tools and approaches to integrate gender in every aspect of health programming. Annex I addresses some of the many misconceptions about gender integration in health programs.

GENDER DEFINED

- **GENDER** describes those characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined.
- **GENDER EQUALITY** in health means that women and men have equal opportunities for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results.
- **GENDER INEQUITY** in health refers to those inequalities between women and men in health status, health care, and health work participation, which are unjust, unnecessary, and avoidable. Equity is the means; equality is the result.
- **GENDER ANALYSIS** in health examines the interaction of biological and socio-cultural factors to highlight how they positively or negatively affect health behaviors, risks and outcomes, access and control over health resources, and contribution to care.

A. Why Do We Have to Integrate Gender into Our Health Programs, Products, and Services?

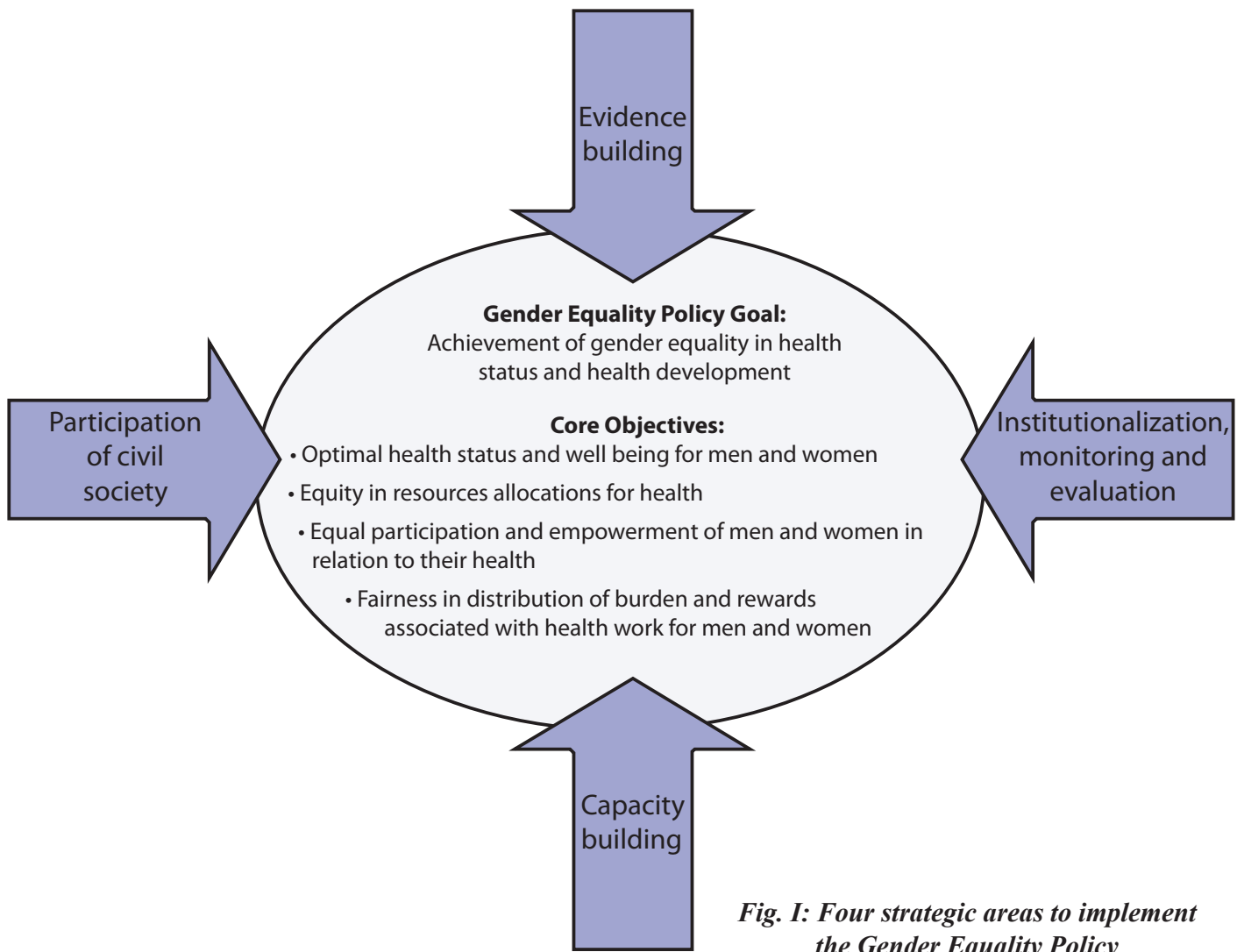
1. WHO and PAHO require us to do so

The PAHO Directing Council adopted the Organization's Gender Equality Policy to achieve gender equality in health status and health development. The Policy applies to all work throughout the organization and to all staff and Member States. The Policy is grounded in the WHO Gender Policy and WHO Constitution, which declares, "The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being."

You can read PAHO's Gender Equity Policy at:

<http://www.paho.org/English/ad/ge/PAHOGenderEqualityPolicy2005.pdf>

The five-year PAHO Plan of Action on Gender Equality supports the Secretariat and Member States to fulfill their commitments under the Gender Equality Policy. As shown in Figure I, a gender perspective will be integrated in all phases of policies, programs, projects and research.



2. Human rights conventions require us to do so

PAHO's Gender Equality Policy is consistent with United Nations and Inter-American human rights conventions and protocols. Human rights accords demand that health programs recognize and address women's and men's, and boys' and girls', different needs, unequal access to resources, and control over resources. In 2008, the Organization of American States called for protection of human rights regardless of sexual orientation or gender identity.

HUMAN RIGHTS DOCUMENTS SUPPORTING GENDER INTEGRATION IN THE RIGHT TO HEALTH

- International Covenant on Social, Economic, and Cultural Rights
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children
- Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belem do Para)
- United Nations Declaration on Sexual Orientation and Gender Identity (proposed)

3. Good programming requires us to do so.

Programs that address equality in health acknowledge and challenge social roles and discrimination that impact the health status of women and men, girls and boys. Health programs that promote gender equality do not aim to eliminate differences between women and men. However, removing preventable biases between the sexes will achieve fairness and justice in distribution of benefits, power, resources, and responsibilities.

Gender integration is not a separate health program; it is a way of looking at and addressing needs across sectors. Effective health programs are those that respond to the different needs and situations of women, men, girls and boys, and benefit everyone. Appreciating the implications and impact of gender roles, norms and discrimination on health will enable health practitioners and planners to serve the health needs of the populations targeted by a health program. Conversely, health programs that do not integrate gender cannot address adequately health conditions and, consequently, will fail.

SUGGESTED COMPONENTS OF A GENDER INCLUSIVE HEALTH PROGRAM

- A lifecycle approach to health of both women and men from birth onward.
- An integrated, comprehensive, holistic and multisectoral approach that looks beyond medical services to the whole human being.
- Research and clinical trials on women's diseases and responses and include women as healthcare decision makers and authors of this work.
- A solid evidence base that exposes gender-based differences and outcome indicators and consider gender as a cross-cutting issue alongside other sources of inequity in health, such as poverty, age, ethnic diversity, and socioeconomic development in a specific context.
- Control and decision making of women and adolescent girls over their rights and reproductive health, including FP, addressing unsafe pregnancies and abortions, spacing.
- Sensitization of health workers, government officials, PAHO staff, men and boys to the harm caused violence against girls and women, and on themselves.
- Education, counseling and empowerment of women and adolescent girls about their rights and how to exercise them.
- Extra services for the poorest women and men, including for culturally diverse peoples and minorities.
- Recognition of the contribution of women and men to the provision of paid and unpaid health care.

AN EXAMPLE OF A PROGRAM THAT SUCCEEDED BECAUSE IT INTEGRATED GENDER

Diabetes Prevention and Control in Mexico

In Mexico, diabetes mellitus is the leading cause of death for men and women and the primary reason men and women seek medical care. Diabetes is prevalent in ten percent of the Mexican population, but women with diabetes are more likely to die from it. In 2003, the Government designed and disseminated a gender-blind brochure to stress the importance of reducing abdominal fat, the main contributor to increased diabetes risk. Despite this campaign, however, mortality from diabetes continued to increase, especially for women.

A 2006 study revealed that women and men have different views and habits of nourishment, physical activity, and care of their bodies. Based on this study, the Mexican National Center for Gender Equity and Reproductive Health reformatted the informational brochure to create one targeted to women and another to men. The women's brochure and accompanying DVD sought to address stereotypes that exercise is not a feminine activity, and the brochure included a series of fun, simple, and no-cost exercises. The men's brochure and DVD highlighted stereotypes that lead men to adopt risky behaviors and to ignore disease symptoms. The brochures and DVDs are disseminated to male and female health service users.

The gender-specific brochures were a success. Focus groups praised the material, with both men and women reporting they remembered the health messages in the particular brochure targeted to them. By 2008, health authorities reported that men and women made specific requests for the brochure "for men" or "for women" and that overall brochure dissemination had increased.

FOR ADDITIONAL BEST PRACTICES ON GENDER MAINSTREAMING IN HEALTH PROGRAMS:

http://new.paho.org/hq/index.php?option=com_content&task=view&id=457&Itemid=259

B. How Gender Impacts Health Outcomes and Status

Health outcomes are shaped, on one hand, by biological considerations, and on the other hand, by socio-cultural considerations. The different biology of women and men has an obvious impact on health. Now, increasing evidence shows that roles and relationship based on male and female status, values, and behavior also can influence health.

PAHO's Gender Matrix can be used to sort through the biological and socio-cultural issues that affect women's and men's different health risks, access to health care, and health outcomes. By employing lenses of gender analysis to examine health challenges, one can determine whether there are gender differences in risk, care seeking, health provider responses, treatment compliance and completion, health outcomes, or social and economic consequences of the health problem. Analysis using the Gender Matrix, at Figure II, helps identify effective interventions that both respond to health needs and to promote gender equality.

Health Problem	Lenses of gender analysis	
	How do biological/physiological differences between sexes influence men's and women's:	How do gender norms/values affect men's and women's (boys' and girls'):
Health risks and vulnerability		
Ability to access and use health services/resources		
Health outcomes / consequences of health problem (e.g. economic, social)		

Fig. II: PAHO's Gender Matrix

Four examples that demonstrate the interplay of gender and health are health research, poverty, healthcare policy and laws, and stereotypes. Using the Gender Matrix to think about these examples illuminates the following:

1. Health Research

For decades, research and clinical trials involving only men were used to develop treatments and medications prescribed for men and women. Yet, it is a mistake to assume that women and men experience illness and react to medicine in the same way.

Female and male anatomy and physiology determine risk for different diseases and differing responses to the same diseases, medications, or treatment. For example, cervical cancer and childbearing are unique to women's reproductive function and anatomy, as prostate and testicular cancer relate only to men's anatomy. Female body structures place girls and women at higher risk for HIV transmission through heterosexual intercourse; men's physiology places them at greater HIV transmission risk through sex with men. And, although both sexes experience coronary disease, women's smaller arteries make angioplasty a riskier treatment.

Gender norms also influence men's and women's behaviors, risk factors, and disease response. As an illustration, men may smoke to be macho; women may smoke to feel attractive. Men disproportionately use alcohol and tobacco and are injured or die from traffic accidents or violent events. Women report more depression. Traditions that encourage sex between older men and adolescent girls lead to high rates of unplanned pregnancies and higher rates of HIV infection for girls.

Gender blind research might really be based on male physiology and norms, leading to inappropriate or ineffective treatment for women and men.

2. Poverty

The vicious cycle of poverty and poor health especially affects women, and is perpetuated by gender roles.

Latin America and the Caribbean (LAC) is a region where girls are better educated than boys. Usually, education rate correlate with more wealth. But in LAC, women earn one-third less than men and are disproportionately poor. Women work in the lowest paid and informal sectors and carry the heaviest burden of unpaid housework and home care. The region's 75 million indigenous women are poor and suffer dismal health outcomes. For example, maternal mortality in Panama is overall 70 out of 100,000 live births; but 658 indigenous women die for every 100,000 live births.

Compounding their economic disadvantage, women pay more for their health care. Health services provided to women are not more expensive than those provided to men. But women's employment is less likely to provide her health insurance, requiring women to pay out-of-pocket for healthcare. Women's greater longevity and reproductive role requires more total health care across their lifespan to manage childbearing and chronic conditions. These combined liabilities set in motion a downward spiral that lessens women's ability to afford medications and care, curtails their use of essential health services, and increases women's poverty. In turn, increased poverty further decreases women's ability to pay for needed services and worsens their health.

“PROGRAM FOR WOMEN” does not mean gender integration. Programs must address power imbalances and how women and men are affected.

3. Reproductive Health Policies and Laws

Nowhere do established gender roles have a larger impact than in reproductive health policy and laws. Ignoring the unique health needs of women and girls only further marginalizes them, and ignoring the needs of men and boys compromises their own health and the health of their sexual partners.

Although society supports reproductive roles and responsibilities for women, it often erects barriers to women's reproductive health. Thousands of women die each year in LAC due to unsafe abortions, bleeding, obstructed labor, eclampsia, and fistula. Most of these maternal deaths are entirely preventable through timely treatment, but investment remains limited in the transportation, clinics, and skilled birth attendants necessary to provide access to care.

ADOLESCENT GIRLS AND SOCIAL BARRIERS

Expectations of chaste behavior results in strict laws and denial of sexual health services and information to adolescent girls. Such restrictions are blind to the reality of adolescents' sexual activity and ensuing risks. The common and socially accepted practice of sex with older men leads to unwanted, unsafe pregnancy and, in many countries, a rate of HIV incidence that is double that of adolescent girls' male cohorts. The view, unmoored by supporting evidence, that providing information and services will only encourage promiscuity is responsible for limiting the development and health of many adolescent girls.

Health workers' attitudes may also reduce health seeking behavior. Men may avoid obtaining condoms or being tested for sexually transmitted infections because of contemptuous attitudes of health workers. Or, preferring to give birth in a more traditional standing position, indigenous women may refuse to go to a maternity clinic that insists on strapping labouring women into bed.

Many governments restrict reproductive health services by criminalizing abortion and prohibiting the provision of emergency contraception. These legal prohibitions of family planning information, contraception, and abortion not only violate the human rights to determine the spacing and number of children, but also contribute to many deaths.

4. Stereotypes

The health of men and women is harmed by stereotypical standards of masculinity that include uncontested power and aggressive risk taking.

As a result of this behavior, men and boys are at greater risk of injury and death from accidents and violence. Men also experience higher rates of substance abuse and its consequences, such as lung cancer, liver cirrhosis, and increased risky sex. The rigid rules of masculinity may discourage men from health-seeking behavior to protect them from injury to comply with disease treatment. Machismo also deprives men of exploring and enjoying nurturing and compassion, discouraging them from being active and involved with the planning and care of their family.

Prioritizing hypermasculinity further results in stigmatizing men and boys who do not live up to these standards. Homophobia in the LAC region exacts a heavy toll on the health of homosexual, bisexual, and transgendered men. Although no countries in the region criminalize homosexuality, men who have sex with men are still shamed, ostracized, fired from jobs, and barred from many activities, making them reluctant to seek health care. With sex between men the principle mode of HIV transmission in the region, homophobia is clearly a major stumbling block to effective response of the epidemic and to the overall wellness of men and boys.

Alarming, approximately one third of women in the LAC region have been victims of sexual, physical or emotional violence at hands of intimate male partners. Although all LAC countries have ratified CEDAW and Inter American Convention on Prevention, Punishment and Eradication of Violence against Women, countries have not vigorously prosecuted the perpetrators of gender-based violence. Society and legal systems incorrectly view violence as normal, not criminal.



C. How to Respond to Health and Gender Challenges: Transformative Health Programs

Gender transformative health programs take into account the unique biological and socio-cultural experiences and needs of women and men with the goal of equality. Achieving gender equality in health is a long-term process that will have to overcome many challenges, including resistance to change among individuals, institutions, structures and budgets. But maintaining the status quo will reflect, reinforce, and perpetuate norms that marginalize women and harm the health of all.

Gender analysis can be used to move health programs from being gender blind to gender transformative.

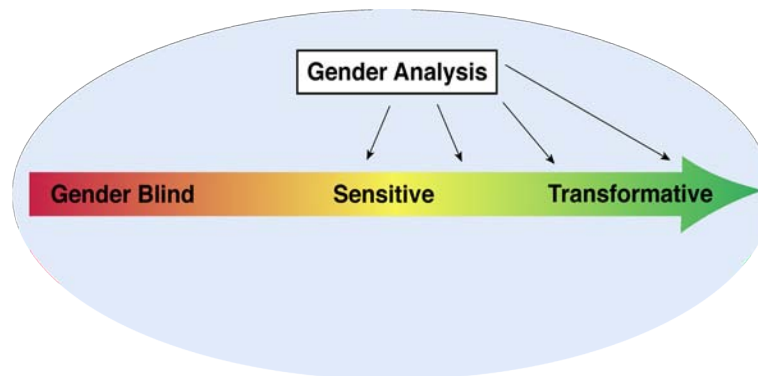


Fig. III: Gender Analysis contributes to understanding and transforming gender related issues

IS YOUR HEALTH PROGRAM GENDER BLIND, SENSITIVE, OR TRANSFORMATIVE?

Gender Blind programs...

- Do not consider gender relevant to development outcome
- Do not affect, for better or worse, gender norms, roles or relations
- Do not have interventions that address gender issues; instead, activities are aimed at the general population and carried out assuming equal access and participation of all

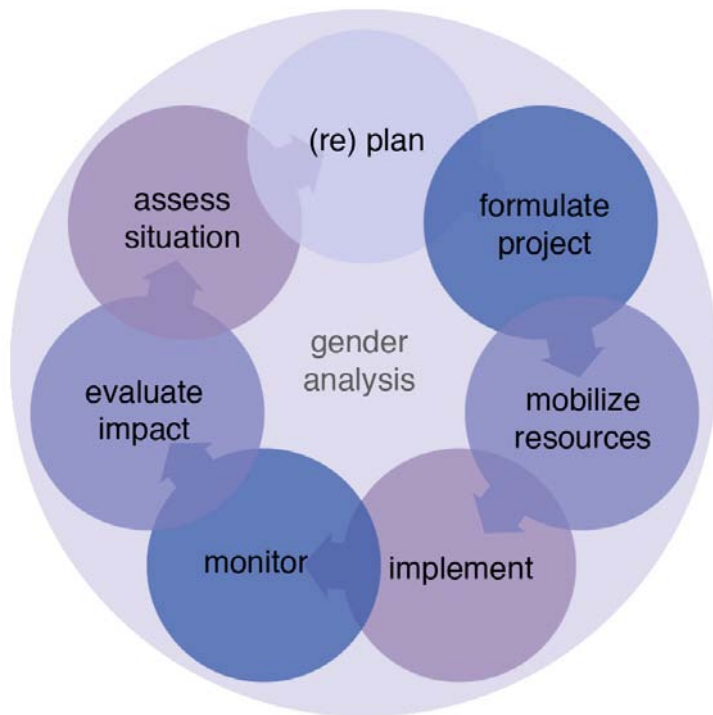
Gender Sensitive programs...

- Use gender to reach development goals
- Address gender roles, norms, and access to resources in so far as needed to reach project goals
- Introduce gender in interventions as needed to achieve project goals; activities made accessible to both women and men

Gender Transformative programs...

- Make central promoting gender equity and achieving positive development outcomes
- Change unequal gender relations to promote shared power, control of resources, decision making and support for women's empowerment
- Include interventions that raise consciousness about unequal balance of power to promote transformation of relations; activities promote women's increased authority/autonomy

II. Some Tools for Integrating Gender into Health Programs



Knowledge of how gender interacts with biological factors is a powerful tool for reducing the burden of illness, improving the health of women and men and improving the social and economic status of women. Gender must be integrated throughout a health program, from the program's initial data collection and design, to the program's implementation and resource mobilization, and through the program's monitoring and evaluation that include the active participation of men and women, as shown in Figure IV.

Fig. IV: Integrating gender throughout health programs

A. Planning and Formulating an Effective Program that Integrates Gender

Designing a health program that integrates gender takes five steps: identifying the health problem through collecting data disaggregated by sex; analyzing data with a gender perspective about this health problem; creating a program that is consistent with international gender standards; and selecting intended outputs (or products and services) to redress inequities and to improve health.

1. Data Collection and Gender

To integrate gender in data collection, different techniques should be used to gather quantitative and qualitative data: surveys, rapid appraisals, and focus groups. It is important to expand data collection beyond existing statistics. "Official data" may require improvement, as they may have historically ignored or undercounted women, indigenous groups, or other ethnic or sexual minorities.

Focus groups and personal interviews are particularly valuable methods of collecting data. Some women and men may be unable to write down their experiences and recollections, but these data can be elicited through conversation.

Who collects the data is also critical. Women might be more willing to provide information to a female interviewer, men to a male interviewer. Consider the power dynamics between

CONSIDERATIONS FOR DATA COLLECTION

- Did data collection allow for full participation of women and men of different ages and ethnic groups?
- Did data collection occur in a safe environment?
- Do data include information from women and men, civil society, community leaders, etc.?

women and men at the data collection site. Perhaps women and men should be interviewed separately, especially where men tend to dominate meetings or where women are hesitant to speak up. Interviewers must take care to ask appropriate questions, especially about gender-based violence, leaving room for opinions and feelings to emerge.

2. Data Analysis and Gender

Once data are collected, they must be analyzed to determine who is at risk for the health problem and why. From a gender perspective, a vital step of data analysis is disaggregation. Researchers should disaggregate data by sex, age, social and economic status, geographic location, ethnicity, and sexual identity to show multiple links.

Findings should be presented to key stakeholders, women and men, girls and boys in the community from which the data were collected. Encourage the community to comment on whether the findings mirror what the members know, or believe to be, the true health problems affecting them.

3. Program Development and Gender

Once data are collected and analyzed, then a health program can be developed to address gaps and optimize health access and response. Include women and men who will be affected by the program in the program's planning, design, and advocacy.

If the data reveal a gap in access to health services or concerning a health situation, first consult the wisdom of international laws and agreements for guidance. Human rights documents provide information that will allow health programs to acknowledge and challenge gender roles that result in poor health. Additionally, gender standards described as binding obligations may provide health programs the gravitas necessary to obtain funding and to reconfigure vertical programs.

The program should not merely give equal attention to women and men under the guise of gender neutrality. Instead, it should focus on the differing needs and experiences of women and men, as these needs and experience have been illuminated by the data and analysis underpinning the program. The program should seek to change gender attitudes and behaviors that imperil health or that lead to risk for the health problem or limit access.

The health program also should make extra efforts to include hard-to-reach populations, those people who have fallen through the cracks in previous attempts to address the particular health problem.

CONSIDERATIONS FOR DATA ANALYSIS

- Do data reflect the situations of women and men of different ages and cultures (ethnicities, immigrants, sexual orientations)?
- Do data reflect those who carry a greater burden of illness, whose health may be more vulnerable, and who are more at risk?
- Do data explain the influence of gender roles on health of males and females in these groups?

CONSIDERATIONS FOR PROGRAM DEVELOPMENT

- Is vulnerability to illness, disease, or health condition related to biology or gender roles?
- Where does this condition occur?
- Who becomes ill?
- What is the health seeking behavior of those affected by the condition?
- How do access to and control over resources affect provision of care?
- How do health services meet the needs of women and men affected by this condition?
- What are the predominant health and social outcomes of this condition?
- What do human rights documents say about this condition or the gender roles that affect it?

4. Products and Services Selection and Gender

In PAHO's biennial work plans, products and services are the intended outputs – activities, materials – of a health program. Selection of products and services is based on knowledge and information gained through evidence and program design.

Gender-integrating products and services improve health seeking behaviors and increase access to health services. Appropriate outputs of a gender-integrating health program include selection of women to health decision making positions, training on attitudes for health workers to change underlying biases, and health information and education materials appropriate for men, women, boys, girls of diverse populations.

A gender-integrating product or service is not a stand-alone activity for or related to women. It isn't merely a brochure for women or attendance at a conference. It is not a children's or infant health intervention, unless these activities are targeted to boys or to girls. And a gender-integrating product is not one that only addresses "discrimination."

Instead, a gender-integrating product or service addresses gender roles, relates to other activities, and is an integral component of a gender-transformative program. If seeking to combat discrimination, a gender-integrating product specifically addresses discrimination against women or against homo, bi, or transsexuals.

CONSIDERATIONS FOR PRODUCTS AND SERVICES

- Address different needs of men and women, girls and boys of diverse populations
- Target activities and information to address women's and men's specific vulnerabilities to a disease or health condition
- Change attitudes of health providers
- Address obstacles to access to care
- Address gender roles that affect health behaviors

5. Examples of Gender-Sensitive Products and Services

Here are some good examples, from 2010-11 biennial work plans, of gender transformative products and services.

SO/RER	Suggested Product or Service
<i>SO1: Reduce the health, social and economic burden of communicable diseases</i>	<ul style="list-style-type: none"> • Separate, private school sanitation facilities provided for girls.
<i>SO2: Combat HIV/AIDS, TB, and malaria</i>	<ul style="list-style-type: none"> • Laws, regulations, or policies that ensure men, women, and adolescents' equal access to male and female condoms.
<i>SO3: Prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence, and injuries</i>	<ul style="list-style-type: none"> • Funding mechanism to provide adequate services and access to justice and redress to victims of violence against women. • National plan of prevention and control of cervical cancer, with emphasis on rural women.
<i>SO4: Reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and health aging for all individuals</i>	<ul style="list-style-type: none"> • Maternal health professionals trained in family planning.
<i>SO5: Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact</i>	<ul style="list-style-type: none"> • Promotion of emergency contraception.
<i>SO6: Promote health and development, and prevent or reduce risk factors, such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions</i>	<ul style="list-style-type: none"> • Curriculum for men to educate about risks of substance abuse. • Technical cooperation for developing pictorial health warnings on tobacco products taking into account gender and ethnicity.
<i>SO7: Address the social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches</i>	<ul style="list-style-type: none"> • Adult education programs for women to improve health literacy.
<i>SO8: Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health</i>	<ul style="list-style-type: none"> • Studies of particular environmental threats to determine differing impact on women and men.

SO/RER	Suggested Product or Service
<p><i>SO9: Improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development</i></p>	<ul style="list-style-type: none"> • Programs that describe and address security risks that result in men or women’s loss of food.
<p><i>SO10 and SO11: Improve the organization, management, and delivery of health services; strengthen leadership, governance, and the evidence base of health systems</i></p>	<ul style="list-style-type: none"> • Community plans, supported with adequate communication, facilities and transportation systems, to connect laboring women with obstetric care, especially in areas where poverty, conflict, great distances and overloaded health systems obstruct such efforts.
<p><i>SO12: Ensure improved access, quality, and use of medical products and technologies</i></p>	<ul style="list-style-type: none"> • Procurement and equal distribution of contraception, drugs and equipment.
<p><i>SO13: Ensure an available, competent, responsive and productive health workforce to improve health outcomes</i></p>	<ul style="list-style-type: none"> • Promotions, incentives, and training for women health care workers.
<p><i>SO14: Extend social protection through fair, adequate, and sustainable financing</i></p>	<ul style="list-style-type: none"> • Social security payments for women’s non-reimbursed work at home or in the shadow workforce.
<p><i>SO15 and 16: Provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the UN system and other stakeholders to fulfill the mandate of PAHO/WHO;</i></p> <p><i>Develop and sustain PAHO/WHO as a flexible learning organization, enabling it to carry out its managed more efficiently and effectively.</i></p>	<ul style="list-style-type: none"> • Women’s participation, attendance at workshops, presentations, leadership at meetings and conferences.

B. Implementing a Gender Transformative Health Program

Once a gender-mainstreamed program is designed, implementers must allocate resources – both human and financial – and define specifics of rolling out the program. Each step of implementation should integrate gender.

1. Gender Analysis in Resource Mobilization

From their very inception, programs should anticipate the need to mobilize resources for gender integration activities. Too often, gender-related activities are added to a program at the last minute. Without budget or staff, such programs cannot have a meaningful impact on health outcomes or gender equity.

Proposals and fundraising efforts should specify ways the program will address gender. (If gender analysis has informed program design, it will be easy to describe to funders the program's gender aspects!) Although integrated, multisectoral programs best respond to gender concerns, funding these programs might be difficult. Funding is often dedicated to vertical, disease-specific programs. Perhaps funding from different sources could be mixed and used to support gender-integrating outputs across the program.

The program budget also must anticipate funding for staff time to achieve the program's gender activities and objectives. A concrete amount of staff time and salary must be allocated to gender products and services. If existing staff do not have time to implement gender activities, a salary must be budgeted for a staff person dedicated to gender projects and outputs.

Budget allocations should be made for involvement of local women and men, boys and girls in program implementation, monitoring, and evaluation. Anticipated expenses for community consultation include financial support to compensate for staff time, snacks, transportation, and child care. However, consider that incentives or benefits paid only to one sex may reinforce existing gender inequalities. On the other hand, investment in certain groups may be required so that equity may be achieved.

CONSIDERATIONS FOR BUDGETING

- Are budget lines included for activities on gender equality or women's health initiatives?
- Is there staff time and budget for carrying these?
- Is there parity in staff and are male and female staff entitled to equal benefits?
- Have women and men - from communities and partner organizations - been consulted to identify planned costs?
- Do resource mobilization plans include the importance of addressing gender equality in systematic ways? If not, how will funds be raised to implement gender equality or women's health activities?

2. Gender Analysis in Program Implementation

Program and communication strategies should not uphold stereotypes about men and women. Therefore, both women and men should assist with implementing health programs; and opportunities for leadership and professional advancement should be provided to both sexes.

The program team should agree upon common approaches to work that are acceptable to all involved. Program staff could develop a gender-sensitive code of conduct, addressing sexual harassment and violence within the program and field activities. Training sessions could build skills in gender analysis and address underlying beliefs about gender.

Implementers should consider constraints that beneficiaries, women and men, may face in accessing products and services. Program staff should consult the local community about what program sites are acceptable and how services might be provided. Sites must be accessible and acceptable to all, or multiple delivery sites could serve different populations. For example, men may refuse STI services that are located only within a maternity hospital or family planning clinic; locating men's services at workplace or sports clinics might be more successful.

AN EXAMPLE OF A COMMUNICABLE DISEASE PROGRAM THAT HAS BEEN DESIGNED TO BE GENDER TRANSFORMATIONAL

Data are collected and suggest a growing rate of AIDS infections in LAC. Data are disaggregated by sex and show men, especially those who have sex with other men, are the first infected. These men are often married to women and do not perceive of themselves as homosexual. Data are analyzed and show that risk factors for HIV infection include extramarital sex, including men with men. In planning for a health program, stakeholder interviews are conducted and find that men who have sex with men (MSM) appear to be especially vulnerable to HIV because preventive measures against infection are not used, not understood, or not available to this population. Although MSM's access to health services is poor because of social stigma against MSM, international standards demand no discrimination for access to prevention or treatment based on sexual orientation.

With these data, analysis, and knowledge, HIV prevention program targeting MSM is planned. Intended products and services for this program include bringing local laws and procedures into compliance with international norms of non-discrimination; targeting reproductive health care and AIDS programs to MSM; developing advocacy materials responsive to MSM needs; involving MSM as program leaders and in planning to ensure that reproductive health care and AIDS programs truly are MSM responsive and friendly; and promoting discussion of MSM needs, vulnerabilities, prevention, care, and treatment.

C. Monitoring and Evaluating Gender Integration in a Health Program

The purpose of any health program is that the program's benefits be sustained and integrated. Programs should be monitored to ensure that they are achieving their objectives and evaluated to determine whether goals might have been achieved better through other means. The beneficiaries of a health program are knowledgeable and valuable monitors and evaluators of the program's sustainability and gender transformative efficacy.

1. Gender Analysis in Stakeholder Communication

When assessing feasibility and appropriateness of the program, its activities, and outputs, include women and men, girls and boys in assessment conversations. Mechanisms for stakeholder participation should be created throughout the implementation of the program. As discussed in the data collection section above, women and men may need to be approached in different manners so to elicit their feedback about the program. Program communications only to national or international decision makers, the academic community, or written media may leave out community members who do not have access to these power structures. Instead, ensure that communication methods reach both women and men who stand to benefit from the health program.

Information sharing should occur in two-ways: from the program to the community about programmatic progress and outcomes, and from the community to the program about its impact. And the information sharing should not merely be pro forma. Stakeholders should have the opportunity to provide meaningful inputs on the feasibility and appropriateness of activities developed.

2. Gender Assessment Tool for Evaluating Programs

The Gender Assessment Tool (GAT) can be used by evaluators to provide a rapid assessment of a health program. The GAT asks 26 questions to allow for determination of the level of gender-responsiveness of a program. "Yes" answers to 11 questions or more within questions 1-20 meant that a program is gender transformative. "Yes" answers to two or more questions within questions 21-26 may indicate that the program is either gender blind or gender unequal. Technical staff can use the GAT results as part of quality control for the program. Where the GAT indicates immediate change should be made to ongoing programs, then these modifications can take place. GAT results also may be input into replanning for program continuation or follow-on. Lastly, the GAT may facilitate reporting on the achievement of gender integration within the program.

Gender Assessment Tool

1. Is there an explicit commitment to promoting or achieving gender equality as part of the vision, goals or principles?
2. Does the program include sex as important selection criteria for the target population?
3. Does the project demonstrate a clear understanding of the difference between sex and gender?
4. Does the target population purposely include both women and men?
5. Have women and men participated in design, implementation, monitoring and evaluation stages?
6. Have steps been taken to ensure women's participation equally with men (or vice versa)?
7. Do both male and female team members have an equal say in the direction of activities?
8. Does my project or program take into consideration the life conditions of women and men in the target population?
9. Have women's practical and strategic needs, and (changes in) access to and control over resources been analyzed?
10. Have men's practical and strategic needs, and (changes in) access to and control over resources been analyzed?
11. Have project methods / tools been piloted on both sexes?
12. Does my project or program consider family or household dynamics and anticipate different consequences and opportunities for individual members of the household (e.g., intra-household allocation of resources)?
13. If the program is targeting only men or women, is the ultimate goal designed to address health inequities driven by harmful gender norms and roles previously detected?
14. Are Government-Affiliated bodies, national NGO's or grassroots organizations with sound gender expertise project partners?
15. Is the evidence generated by, or informing, the program collected and reported by sex?
16. Is the evidence generated by, or informing, my program based on a gender analysis?
17. Does the program design and planning take into account the context of men's and/or women's lives and their different health needs?
18. Are there quantitative as well as qualitative output indicators that allow the monitoring of women's and men's participation in consultative and decision-making processes at project level?
19. Have the gender division of labor and changes in the gender division of labor been analyzed? (Reproductive, productive, community-managing and political roles; paid and unpaid labor)
20. Are family or household dynamics considered in terms of their different consequences and opportunities for individual members of the household (e.g., intra-household allocation of resources)?
21. Is a male norm adopted as the "standard"? (E.g., Are diseases discussed based on the existence of symptoms that have been identified in men only?)
22. Does the project exclude (intentionally or not) one sex but assume that the conclusions are applicable for both sexes?
23. Is one sex excluded in areas that are traditionally thought of as relevant only for the other sex (e.g., maternal health, occupational health)?
24. Are women and men treated as homogeneous groups when outputs could have differential outcomes on sub-groups of women and men (i.e., poor versus rich women, employed versus unemployed men, etc.)?
25. Do materials or publications, portray men as unemotional and women as submissive (or other gender-based stereotypes)?
26. Does the language exclude or privilege one sex?

Annex I – Some Misconceptions about Gender Integration

MISCONCEPTION: GENDER MAINSTREAMING IS A HUMAN RIGHTS, NOT A PUBLIC HEALTH ISSUE

REALITY: It is both. While gender sensitive health interventions may not pass laws, they present evidence that supports needed legal, social or economic changes. Moreover, the public health community has formidable skills, resources, and experience in collecting and analyzing data, looking at underlying causes of ill-health, and building the case for change. These skills are badly needed and can be easily transposed to understanding and addressing gender determinants of health. And just as economic and social determinants influence health of males and females, improving health for all has a great influence on economic and social development for women and men.

MISCONCEPTION: GENDER PROGRAMMING IS NOT RESULTS-ORIENTED.

REALITY: Seeking equality between the sexes is synonymous with seeking health and wellbeing for all. Discrimination, stigma, gender based violence, and gendered roles all directly impact health and the wellbeing of women and girls, who make up one-half the population, and directly affect the wellbeing of the entire community. Obtaining the health results sought, for example, decreasing the rate of teen age pregnancy, maternal mortality, and the discrepancy in HIV rates among adolescent girls and boys, lies in understanding and addressing underlying social, cultural and economic norms.

MISCONCEPTION: GENDER INTEGRATION IS TOO HARD TO MEASURE.

REALITY: We easily can measure whether we have produced the gender-integrating products and services we have planned to produce. Public health expertise in developing statistics about distribution factors of diseases also is easily translated into developing data disaggregated by sex and other social determinants of health. This will require a new kind of measuring focusing on qualitative data – interviewing women and girls men and boys to get their unique perspectives and experiences allows us to develop indicators that build evidence to support new approaches to prevention, care and treatment.

MISCONCEPTION: GENDER IS JUST A SYNONYM/CODE WORD FOR WOMEN.

REALITY: Taking a gender approach allows us to look at where health programs are not meeting the needs of women or men, girls or boys. Although gender programming began by exposing how gender norms affected women's health (and continues predominately to address women's health), there has been an increasing and significant understanding of the deleterious impact of social roles on the health of men and boys. These include both homophobia, that affect MSM and homosexuals, and machismo, that affects men who assert their power to dominate, resulting in violence and poor decision making.

MISCONCEPTION: GENDER WAS RELEVANT A DECADE AGO – IT'S NO LONGER AN ISSUE AND WE HAVE MOVED BEYOND IT.

REALITY: We are just beginning to understand and build evidence of the close links between health and gender relations. And we are just at the starting gate in designing and implementing effective programs that address gender roles. Only recently did we realize that "equitable" policies may marginalize women and men from specific racial and indigenous groups. Effective responses to health problems address all aspects of societal exclusion.

MISCONCEPTION: GENDER MAINSTREAMING MUDDIES THE WATERS AND DISTRACTS US FROM OUR REAL WORK OF PREVENTING, TREATING AND ELIMINATING DISEASES.

REALITY: Some still believe that gender is “soft,” feminine, and non-essential – despite evidence of its power to impact health behaviors and outcomes. Gender mainstreaming enables us to prevent, treat, and eliminate diseases by looking at health through a different lens. It means looking beyond the confines of epidemiological disease and medical causes and solutions to social causes and solutions.

MISCONCEPTION: GENDER MAINSTREAMING WILL ONLY INCREASE THE COST OF HEALTHCARE.

Reality: Gender mainstreaming may involve using data to justify transfer and use of resources in a more appropriate and effective manner. Targeted programs are the most efficient ways to conduct health programming. If you know which groups are at risk for various health conditions, you can work with them to prevent these conditions.

MISCONCEPTION: FOCUSING ON GENDER WILL ONLY ACCENTUATE THE DIFFERENCES BETWEEN THE SEXES, DRIVING THEM APART AND FAILING TO ACHIEVE “HEALTH FOR ALL.”

REALITY: The ultimate goal of health for all is not to eliminate differences, but to acknowledge them and eliminate those that engender inequity and poor health. Implementing fully gender mainstreaming is a long-term and gradual process, as changing attitudes and structures addressing underlying centuries old beliefs takes time. But changing health also requires changing basic roles. Gender integration and health promotion can occur together, one step at a time, so that health goals are achieved.

Annex II – Sources Consulted and Used

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