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DRAFT PROPOSED FIVE-YEAR REGIONAL PLAN OF ACTION FOR IMPLEMENTING THE GENDER EQUALITY POLICY

Introduction

1. The 46th Directing Council of the Pan American Health Organization (PAHO) approved the Gender Equality Policy (Resolution CD46.R16) in 2005. This resolution was issued in response to the ongoing challenges posed by gender inequities in the Region of the Americas, and to the United Nations resolution which called for all United Nations (UN) agencies to mainstream gender and women's empowerment throughout the UN system[1]. PAHO's policy aims "to contribute to the achievement of gender equality in health status and health development and actively promote equality and equity between women and men."[2] It calls for PAHO and its Member States to integrate a gender perspective in the planning, implementation, monitoring, and evaluation of policies, programs, projects, and research in order to attain optimal health status among women and men, equitable allocation of resources, and equality and fairness in the distribution of the rewards and burdens of health care and wellness.

2. Resolution CD46.R16 urges Member States to implement the Policy and, specifically, the Director of PASB to develop a Five-Year Plan of Action that includes a system for accountability and monitoring performance. As requested by the 46th Directing Council, the proposed Five-Year Plan of Action aims to guide the Bureau and the Member States in the implementation of the Gender Equality Policy, thereby contributing to reducing gender inequities in health.

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[1] United Nations Economic and Social Council resolution E/1997/L.30 adopted by ECOSOC 14. 7. 97 : http://www.un.org/documents/ecosoc/docs/1997/e1997-66.htm.

[2] **PAHO Gender Equality Policy** http://www.paho.org/English/ad/ge/PAHOGenderEqualityPolicy2005.pdf.

Situation Analysis[3]

3. Although the Region of the Americas has greatly improved the health of its women and men, inequities remain among and within countries, especially among excluded populations. Gender—along with social class and ethnicity—is a key structural determinant of equity in health that results in differential opportunities for women and men, and girls and boys, to enjoy optimal health. Even though gender conditions emerge from women's unequal position in society, they have come to be seen as a true relational category that also can help to understand men's condition. In terms of health, as gender interacts with biological characteristics and with social and economic determinants, the result is different—often inequitable—patterns of exposure to health risks, health outcomes, and access to and use of health services. Gender also plays a decisive role in how women and men contribute to health development and how they share its benefits.

4. Gender inequality in the Americas—the most unequal region of the world—interacts with other socioeconomic inequalities to limit women's and men's opportunities to enjoy optimal health, to be free from preventable diseases. In the Region, some gender inequities are reflected in high maternal mortality rates, unmet needs for family planning, adolescent pregnancies, cervical cancer rates, and an increase of HIV infection among young women in many Caribbean countries. While one-third of women in the Americas continue to suffer violence at the hands of their partners, mortality rates due to violence among men are predominantly related to traffic accidents, homicide, occupational accidents, suicide, and substance abuse.

PASB Staff Parity

5. In line with World Health Assembly and UN resolutions on gender equality in the work force,[4] the 46th Directing Council Resolution also calls on the Secretariat to strive for parity between sexes in matters of recruitment and career development, including employment in management-level positions.

6. In regards to staff parity, PAHO has been recognized as one of the most successful UN agency in reaching parity in staffing. However, a recent survey showed that although overall sex parity among professionals was reached at PAHO/HQ, at country level women made up only 30% of professional staff, and one of the highest professional categories, P4, stood out as the most unequal category with the lowest female representation for long term or new appointments. These findings show that

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[3] See annex A1: Gender Inequalities Persist in the Americas for a detailed situation analysis.

[4] WHA50.15 Recruitment of International Staff in WHO Geographical Representations (1997) and Resolution 55/69, Improvement of the Status of Women in the UN System adopted by the UN General Assembly (A/RES/55/69, 2001). WHO's Medium Term Action Plan for Employment and Participation of Women in Work of WHO (2000-2005) requires that measures be established for improving the flow of women in WHO and for their retention, with a view to attaining gender equity.

challenges remain and PAHO needs to sustain efforts for reaching sex parity on all levels and for implementing and enforcing work life balance policies.

Background

7. Through the Millennium Summit Declaration (2000), Member States agreed that improving gender equality and empowering women are essential for achieving the Millennium Development Goals (MDGs), including the gender equality objective and those objectives that directly or indirectly relate to improving health[5]. In the coming decade, the Americas will increasingly face the challenge of achieving the MDGs and responding to the renewed pledge of providing quality primary health care.

8. The proposed Five-Year Plan of Action for implementing PAHO's Gender Equality Policy, seeks to achieve the MDGs and the gender equality mandates that have emanated from global and Inter-American conferences. The Plan calls for a dynamic, strategic approach that will consolidate PAHO's commitment to reducing gender inequities in health in the Americas, thereby contributing towards the fulfillment of international and regional commitments to achieve gender equality. It is grounded in the World Health Organization's (WHO) Constitution, which states that, "*the enjoyment of the highest attainable* standards *of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,*"[6] and is in line with the WHO 2002 Gender Policy and the Strategy for Integrating Gender Analysis and Action into the Work of WHO (May 2007.) It is also consistent with UN and Inter-American human rights conventions and protocols[7] such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[8] the Protocol to Prevent, Suppress and Punish Trafficking in Persons,

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[5] Millennium Development Goal 3: Promote Gender Equality and Empower Women http://www.un.org/millenniumgoals/gender.shtml.

[6] Stated in the World Health Organization Constitution's Preamble and adopted by the International Health Conference, New York, 19 June-22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no.2, p. 100) and entered into force on 7 April 1948. See also PAHO 47th Directing Council Technical Document CD47/15 (Disability: Prevention and Rehabilitation in the context of the Right to the Highest Attainable Standard of Health and other Related Rights) of 16 August 2006, pp. 10-15. Available from http://www.paho.org/ english/gov/cd/CD47-15-e.pdf.

[7] See PAHO's Regional Strategy for Improving Adolescent and Youth Health, Technical document CD48/8, 48th Directing Council, Pan American Health Organization, Washington D.C., 29 September-3 October 2008. Available from http://www.paho.org/english/gov/cd/CD48-08-e.pdf.

[8] Entered into force in 1979 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

Especially Women and Children,[9] and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Pará).[10]

Proposed Five-Year Regional Plan of Action

9. The proposed Plan of Action provides a roadmap and monitoring indicators for PASB and the Member States to implement the Gender Equality Policy. Its framework for technical collaboration with the Member States aims to operationalize the commitment to include a gender perspective in planning, implementation, monitoring and evaluation of health policies, programs, projects, and research. Execution of the roadmap will also ensure that there is greater ownership of gender equality considerations within PAHO, and that the Organization's leadership position in ensuring Health for All will be consolidated. The Plan takes into account the Health Agenda of the Americas and will be implemented within the context of PAHO's Strategic Plan 2008-2012, specifically the Regional Expected Results. The Plan has come about through extensive consultations and consensus with Member States, UN agencies, and regional civil society organizations.

Strategic Areas

10. The proposed Plan of Action is organized around four interdependent strategic areas derived from the Gender Equality Policy.

11. ***Strategic Area 1:*** Strengthen the Organization's and Member States' capability to produce, analyze, and use information disaggregated by sex and other relevant variables (*See Annex*).

Specific Objectives

- PASB will incorporate gender sensitive indicators, disaggregated by age and sex, for developing plans and programs, and for pursuing technical collaboration and other initiatives;

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

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[9] Entered into force on 3 September 2003 and has been ratified by Argentina, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Uruguay and Venezuela.

[10] Entered into force on 5 March 1995 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

- Interagency collaboration will be strengthened to fulfill international commitments of Member States related to gender indicators and statistics.

12. ***Strategic Area 2:*** Develop tools and increase capabilities in PASB and Member States for integrating a gender equality perspective in the development, implementation, monitoring and evaluation of policies and programs (See Annex).

Specific Objectives

- Strengthen capabilities and commitment within PASB and the Member States to support the integration of gender analysis with a human-rights approach in health sector policies, programming, monitoring, and research;

- Support PASB and Member States in including gender in the formulation and review of staff policies and processes;

- Establish a knowledge platform on gender and health (tools, fact sheets, publications, best practices etc.), and ensure that it is accessible to PAHO, Member States, and civil society organizations for supporting the implementation of the Gender Equality Policy and Plan of Action.

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

Specific Objectives

- Leaders of regional civil society organizations, especially women's organizations and gender-equality advocate groups, will serve as members of PASB's Technical Advisory Group on Gender Equality and Health (TAG GEH), and advise on the implementation of the Gender Equality Policy within PASB and in Member States;

- Civil society organizations (of women, men, ethnic groups, and human rights, among others) will be empowered to participate at national multisectoral teams that support the ministries of health in implementing, monitoring and evaluating gender equality in health policies and programs;

- Knowledge and capability regarding gender and health issues and advocacy will be increased among gender equality civil society organizations.

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

Specific Objectives

- Ensure PAHO's alignment with WHO's approach to monitoring and evaluating gender mainstreaming**,** in order to develop appropriate capacity building and gender analysis strategies based on the results;

- PASB will have systems in place for implementing and monitoring the Gender Equality Policy and the Plan of Action;

- Mechanisms will be established to monitor Member States' progress in implementing the Gender Equality Policy and Plan of Action;

- Special initiatives will be carried out for mainstreaming a gender perspective within PAHO which integrates the four strategic areas—evidence, capacity building, civil society participation and evaluation— to strengthen ownership and provide concrete lessons.

15. The four strategic areas will ensure the achievement of measurable results at the regional, subregional and national levels.

Action by the Subcommittee on Program, Budget, and Administration

16. The Subcommittee is invited to review the Proposed Plan of Action to implement the Gender Equality Policy and to present comments for enhancing its application and monitoring. The Subcommittee is also asked to urge Member States to support the implementation, monitoring and evaluation of the Plan of Action through regular progress reports.

Annexes

PAN AMERICAN HEALTH ORGANIZATION'S (PAHO) DRAFT PROPOSED FIVE-YEAR REGIONAL PLAN OF ACTION FOR IMPLEMENTING THE GENDER EQUALITY POLICY

DRAFT PROPOSED FIVE-YEAR REGIONAL PLAN OF ACTION FOR IMPLEMENTING THE GENDER EQUALITY POLICY

Background and Justification

1. Although the Region of the Americas has made great strides in improving the health of its women and men, inequities persist among and within countries, especially among excluded populations. Gender—along with social class and ethnicity—is a leading structural determinant of equity in health that determines the differential opportunities to enjoy optimal health for men and women, for girls and boys [1] Although considerations of gender differentials initially emerged from the analysis of women's struggles, they have now come to be considered as a relational category that can also help to understand men's conditions. Gender interacts with biological characteristics and with social and economic determinants to produce different—sometimes inequitable—patterns of exposure to health risks, health outcomes, and access to and use of health services. Gender also plays a decisive role in differences in how much women and men contribute to health development and the extent to which they share its benefits.

2. In response to persistent gender inequities throughout the Region, Member States agreed, through the Millennium Summit Declaration (2000), that improving gender equality and empowering women are essential for achieving the Millennium Development Goals (MDGs), including attaining the "gender equality" objective and those objectives that directly and indirectly relate to improving health. In the coming decade, the Americas will face ongoing challenges to achieve the MDGs, as well as to meet the renewed pledge to provide primary health care for all by the year 2015. In order to reach these goals, PAHO must pursue a dynamic and strategic approach to consolidate its commitment to reduce gender inequities in health in the Americas. PAHO's Gender Equality Policy and this proposed Five-Year Plan of Action for its implementation aim at guiding the Pan American Sanitary Bureau (PASB)[2] and its Member States to meet this challenge.

3. The emphasis of this document will be on eliminating gender inequities in health. Here gender inequities refer to those inequalities between men and women in their health status, health care, and health work participation paid and unpaid, which are unjust, unnecessary, and avoidable. It focuses on gender equity strategies for attaining equality[3]. Given the historical and unfair discrimination that women have experienced in achieving equal human rights and

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[1] Throughout this document women and men will implicitly refer to boys and girls, as well as adolescents.

[2] The Pan American Sanitary Bureau (PASB) is the Secretariat of the Pan American Health Organization (PAHO). The Bureau provides technical support and leadership to PAHO Member States as they pursue their goal of Health for All: http://www.paho.org/english/paho/mission.htm.

[3] Gender equity and equality are both used throughout this document. PAHO's Gender Equality Policy defined **gender equality in health to mean** "*that women and men have equal conditions for realizing their full rights and potential to be healthy, contribute to health developments, and benefit from the results. Achieving gender equality will require specific measures designed to eliminate gender inequalities*". **Gender equity in health "refers** *to those inequalities between men and women in their health status, health care, and health work participation, which are unjust, unnecessary, and avoidable. Gender equity strategies are used to eventually attain equality. Equity is the means, equality is the result*". **PAHO Gender Equality Policy** http://www.paho.org/English/ad/ge/PAHOGenderEqualityPolicy2005.pdf.

opportunities, this document highlights these inequities, while adhering to the mandate of achieving gender equality and "Health for All[4]".

Global and Regional Context for Gender Equality

4. This proposed Five-Year Plan of Action (PoA) to implement PAHO's Gender Equality Policy is grounded in the preamble of the World Health Organization's (WHO) Constitution which states, "the enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"[5] and follows the longstanding commitment of the PAHO and its Member States to the health and well being of the women and men of the Americas. In addition, the PoA conforms to the WHO 2002 Gender Policy, and the recently adopted Strategy for Integrating Gender Analysis and Action into the Work of WHO (May 2007). Furthermore, it is consistent with UN and Inter-American human rights conventions and protocols[6] such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[7], the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children[8] and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention "Belem do Pará").[9]

5. The universal and regional global commitments mentioned above, stress the importance of increasing and refining evidence that highlights differences in socioeconomic situation, needs, and opportunities between women and men that result in differential possibilities for enjoying optimum health; of raising awareness and capacity among policy makers and service providers to

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[4] Primary Health care Concepts and Challenges in a Changing World: Alma-Ata. Revised. WHO/SHS/CC/94.2.

[5] Stated in the World Health Organization Constitution's Preamble and adopted by the International Health Conference, New York, 19 June-22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no.2, p. 100) and entered into force on 7 April 1948. See also PAHO Directing Council Technical Document CD 47/15 ("Disability: Prevention and Rehabilitation in the context of the Right to the Highest Attainable Standard of Health and other Related Rights") of 16 August, 2006, 47th Directing Council, pp. 10-15. Available from http://www.paho.org/english/gov/cd/CD47-15-e.pdf.

[6] See PAHO's Regional Strategy for Improving Adolescent and Youth Health, Technical document CD48/8, 48th Directing Council, Pan American Health Organization, Washington D.C., 29 September-3 October 2008. Available from http://www.paho.org/english/gov/cd/CD48-08-e.pdf.

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[8] Entered into force on 3 September 2003 and has been ratified by Argentina, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Uruguay and Venezuela.

[9] Entered into force on 5 March 1995 and has been ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

redress persistent inequalities; of empowering women and men to make decisions and influence policies regarding their health; and of monitoring progress in achieving gender equality. These elements also constitute the strategic areas of PAHO's Gender Equality Policy and the proposed Plan of Action.

6. PAHO's Gender Equality Policy, which was approved by the Directing Council in 2005 (CD46.R16), was issued in response to UN Resolution (ECOSOC/1997)[10] calling for all UN Agencies to mainstream gender and women's empowerment as a way to institutionalize the international commitments throughout the UN System. The goal of PAHO's Policy is "to contribute to the achievement of gender equality in health status and health development and actively promote equality and equity between women and men." In order to achieve this goal, the Policy calls for PASB and its Member States to integrate a gender perspective in the planning, implementation, monitoring, and evaluation of policies, programs, projects, and research, so as to attain optimal health status among women and men, equitable allocation of resources, and equal participation and fairness in the distribution of the rewards and burdens of health care and wellness. The Resolution adopting the Policy urges Member States to implement it and PASB's Director to develop an Action Plan for its implementation with a performance monitoring and accountability system.

Panorama/Situational analysis

7. In the Americas, the world's most socially unequal Region, gender inequality interacts with other socioeconomic inequalities to limit women's and men's opportunities to enjoy optimal health, live free from preventable diseases, gain equitable access to health resources, and contribute equally towards health care and wellness. Increasingly aware of these different needs and opportunities, the Region's countries are seeking to improve and increase evidence and monitoring of the problem; they also are including the participation of these constituents and strengthening the capacity of health workers to better address these differences, so that their health policies, programs, services, laws, research, and information can to reduce existing inequities in health and increase the efficiency of their health systems.

Persisting Gender Inequalities in Health (see Annex A1)[11]

8. Although women have achieved improvements in terms of education, in some countries[12] gender norms and gender discrimination disadvantage women's control over health resources. Gender discrimination affects women's economic status, by limiting their opportunity to participate equally and fairly in the formal labor market. In addition, it also restricts their access to the social protection provided through pensions and insurance—including health resources—provided by these markets. Almost half of women who work devote their time to

[10] United Nations Economic and Social Council resolution E/1997/L.30 adopted by ECOSOC 14. 7. 97: http://www.un.org/documents/ecosoc/docs/1997/e1997-66.htm.

[11] Most of the indicators are obtained from the PAHO publication *Gender, Health, and Development in the Americas, Basic Indicators, 2007* and the unpublished document by Elsa Gomez, "Género como un determinante estructural de inequidad en salud," AD/GE's contribution to Chapter 1 of *Health in the Americas, 2007*.

[12] Idem.

caring for others without remuneration. Moreover, women use health services more and pay more out of pocket for access. Gender roles also often limit men's willingness and capability to care for their own health and to nurture their families.

9. Women live longer than men and have lower mortality than men throughout their lifetime. Their added years of life are not necessarily quality years, however, given that older women have less access to social protection and resources and they experience more poverty, loneliness, and disability. Gender also adversely affects health and life expectancy among men, given that men engage in more risk taking behaviors beginning with childhood, as well as the negative health outcomes related to men's risky sexual encounters, violence, alcohol, substance use, and unwillingness to seek prevention and health care.

10. Gender inequities are even more apparent when illness and death are caused by health conditions that are preventable and that disproportionably affect poor, adolescent, minimally educated, and ethnic women, as well as their partners and marginalized men in these populations. In the Americas, these persistent inequities translate into high maternal mortality rates, unmet family planning needs, adolescent pregnancy and cervical cancer rates, and an increase in HIV infection among young women in many Caribbean countries. One-third of women in the Americas continue to suffer violence at the hands of their intimate partners. In addition, men's mortality rates due to HIV, violent deaths (traffic accidents, homicide, work-related accidents and suicide), and substance abuse are higher than women's. It is extremely important for boys and young men to understand these risks and how they can influence women's health.

Evidence and analysis of gender inequalities

11. The situation outlined above highlights the importance of applying a gender analysis to health statistics and research. Information on gender inequalities and gender gaps has increased over the years, but many countries simply disaggregate data without analyzing the underlying reasons that contribute to the differences shown by the data. Those who produce and use data, such as health planners, quality-control specialists, and advocates should be able to analyze and apply this information to better target and monitor policies and interventions to reduce existing gender inequities. Gender-based analysis will bring to light inequities in health status and health outcomes based on lack of equal opportunities, imbalances in the distribution of resources, power, and responsibilities, and it will highlight the contributions of women and men to human and economic development. Evidence is also fundamental for monitoring and evaluating progress on fulfilling international and regional commitments, on achieving gender equality within the MDGs objectives, meeting the goals of Health Agenda for the Americas, and on implementing PAHO's Gender Equality Policy.

12. PAHO's Gender Equality Policy aims at building an evidence base on gender and health to inform the development, implementation, monitoring, and evaluation of health programs. It includes the collection, analysis, and sharing of data disaggregated by sex and other relevant variables and pursues the building of networks with UN agencies, academia, and the private sector to promote gender sensitive research. The Policy also calls on all Member States to generate this data and to include in their National Health Accounts indicators that measure the unremunerated health care provided by women and men in the home. It calls on PASB to give

priority to the generation and analysis of these data, and to support efforts by Member States and civil society to monitor the impact of health policies, programs and laws on gender equality, including their impact on the reduction of maternal mortality and of gender-based violence.

13. Producing better evidence for improving health and for technical collaboration to countries has always been a priority for PAHO. For example, PAHO's flagship publication, *Health in the Americas 2007* includes in almost all the chapters data disaggregated by sex and gender based analysis, however gender based analysis is missing from some countries' chapters. when data are available. Furthermore, in June 2007, the 142nd Session of the Executive Committee approved Resolution CE142.R4, *Plan of Action for Strengthening of Vital and Health Statistics,* for the countries of the Americas. However, the analysis of the differences and gaps between women and men needs to be enhanced and strengthened, and this should become a priority of PASB's technical collaboration. Country Collaboration Strategies (CCS), which form the basis for PASB collaboration with Member States also should include an analysis by gender of the targeted national health conditions, thereby setting a precedent for addressing gender inequities throughout the technical cooperation.

14. PASB has strengthened capacity of national producers and users of health information through training and providing publications that show practical evidence on gender and health, including more than 40 country profiles on women and men's health. These efforts have resulted in the establishment of groups dealing with gender in statistics in seven Central American countries as a way to improve information systems on health and other issues, as well as the establishment of two gender-and-health observatories in Chile and observatories on gender-based violence in three Central American countries. PASB has been at the forefront on quantifying women's unpaid contribution to health care, and has supported efforts in Chile to include this information in National Health Accounts. At the Regional level, PASB is supporting subregional coalitions of National Women's Ministries (NWM) that are working to include gender equality in the health agendas of their regional integration processes. PAHO is a partner of the inter-agency collaboration on MDGs coordinated by the Economic Commission for Latin America and the Caribbean (ECLAC), and has contributed to the Regional MDG Progress Report, as well as the report related to MDG 3. The Organization also participates in the Interagency and Intergovernmental Observatory on Gender Parity, by including and monitoring health indicators and contributing to provide related training for national partners.

Capacities for Mainstreaming Gender

15. There have been clear advances in the Region towards achieving gender equality, as Member States have enacted legislation and instituted policies to redress inequalities. The majority of Member States have laws to prevent and penalize gender-based violence; many of them have enacted equal opportunity laws that include health; an increasing number have quota laws to ensure women's political participation; and almost all have established NWMs to monitor and guide the implementation of these policies. Some countries have included achieving gender equality in their health plans and reform processes and have set up gender units within the health sector to guide and monitor these processes. A few countries are actually analyzing their health budgets to improve targeting for gender equity in health programs. Despite this progress, however, implementation has been limited by a lack of political will, insufficient allocation of

national resources, and the absence of accountability processes to ensure implementation. It is, therefore, important to strengthen the knowledge and capacities of health policy makers, providers, and advocates to implement these policies, assign resources, and develop systems to monitor the implementation, as well as their effects in reducing gender inequities in health.

16. PAHO's Gender Equality Policy calls for organizational support for advancing knowledge and skills of staff for efficient gender mainstreaming. Gender Focal Points will be identified and trained in each of PASB's technical and administrative areas, as well as in each country office and ministry of health, to facilitate the implementation and evaluation of the commitments to gender mainstreaming. PASB area managers will also be expected to institutionalize mechanisms for building capacity among their staff and to provide financial resources, information, training and technical support to ensure the policy's implementation. The policy specifically calls on Member States to include a gender perspective in their training programs, and for PASB to develop training materials and programs that promote gender equality.

17. Surveys on gender mainstreaming carried out by UN agencies[13] and the World Bank[14] have pointed to the importance of on-the-ground expertise for achieving results. While most PAHO staff are receptive to reducing gender and other inequities in health, many confess that they do not have the skills to do so, as pointed out by a recent WHO survey. In fact, during interviews, PASB staff suggested that capacity building on gender and available sustained gender expertise are key to integrating gender.[15] PAHO's extensive experience in training on "Gender and Health"[16] during the mid 1990s included hundreds of staff. However, the lack of an integrated approach for applying the skills learned hampered effectiveness. In Central America, where training was followed up with gender programming, advances in gender mainstreaming, especially related to gender-based violence and health sector reform have been well documented (See Annex 2). This PoA builds on these experiences, as well as on WHO's capacity building strategy, to strengthen the skills of its staff, of Member States, and of gender equality advocate partners. Capacity building will focus on strengthening analysis and programming skills to integrate gender, and on developing and implementing collaboration plans for providing long-term follow up.

18. Perhaps the most important lesson learned from mainstreaming evaluations, is the need to base results on incentives rather than on mandates. In 2008, PASB launched a competition for mainstreaming gender in the health sector as part of the Director's annual International Women's Day celebration. Winners are rewarded during a special event at Headquarters, and their experiences are included in PAHO's Best Practices Database on Gender Mainstreaming in Health. This competition is widely disseminated throughout PAHO's networks, UN agencies, and health and women's networks; a prize is awarded for the best experience at PASB and among partners.

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[13] UN Development Groups, Gender Equality Task Force, UN resolution A/RES/59/250.
[14] World Bank, Gender Equality as Smart Economics, 2006.
[15] WHO, 2008 baseline study for the evaluation of gender mainstreaming.
[16] Workshop on Gender, Health and Development: Facilitator's Guide—Washington, D.C: PAHO, 1997.

19. PASB technical staff and their national partners have identified a lack of easy access to information and technical support as a reason for not optimally including gender in their work. Making practical tools and information readily accessible through a virtual gender and health knowledge platform should be made a priority and should be incorporated into PAHO's knowledge management and information system. This includes providing user friendly learning packets with tailored training tools, best practices, an expert database, fact packets pertaining to technical areas, as well as targeted campaigns to inform users of these resources.

Partnerships with Civil Society Organizations and others

20. Civil society organizations (CSO) play a critical role in monitoring progress and achieving the MDGs. At the same time, the universal and regional human rights conventions mentioned above stress that empowerment of women is indispensable for achieving gender equality. Empowering women should be central to all strategies for reducing gender inequities in health. Equally important for achieving these goals is forging partnerships with men and gender equality organizations. Providing these stakeholders with the skills, opportunities, and information to participate in decisions about their own health, as well as information on related policies and programs, is key. It is especially important to actively reach out to women and men from rural and poor areas, from ethnic populations, from sexual minorities, of different age groups, who are living with HIV/AIDS, and with disabilities, who are particularly susceptible to gender and other inequalities and who are often excluded from decision making processes that directly affect them. Greater involvement of constituents and their organizations, in partnership with gender advocates from government, civil society, and international agencies, ensures that policies, programs, and resources will address their differential needs, realities, and opportunities to enjoy and contribute to health.

21. PAHO's Gender Equality Policy emphasizes the importance of equal participation of men and women in decision making within their homes, communities, and countries. It places special emphasis on creating and strengthening linkages between governments and civil society organizations, especially women's groups. The related Resolution calls for Member States to promote and support the active participation of men and boys in programs aimed at achieving gender equality in health.

22. The Americas have a long history of CSO involvement in shaping local, national, and even international health agendas. Women's organizations in particular have played a key role in advancing human rights, including reproductive rights and in placing gender-based violence on the human rights and public health agendas. Recently, men have joined these efforts and formed partnerships to eliminate gender-based violence and inequities in health. These partners have played an important role in shaping PAHO's policies and programs at the country level, as well as through the former Subcommittee on Women, Health, and Development of the Executive Committee, and currently as members of PAHO's Technical Advisory Group on Gender Equality and Health. Latin American and Caribbean Women's Health Network (LACWHN) with affiliates throughout the Region, is an officially recognized NGO partner of PAHO and actively collaborates with the Gender, Ethnicity, and Health Office in implementing its work plan.

Institutionalizing accountability processes

23. One of the challenges in measuring the effectiveness of gender mainstreaming has been the lack of monitoring indicators and systems to gauge impact. The CEDAW Convention does commit Member States to report on advances, including health. National Women's Machineries have a mandate to monitor the implementation of international agreements and national policies, but in many countries they do not have the influence or resources to do so. In a few countries where NWMs have political stature, they have identified indicators and set up functioning monitoring, and accountability systems, including gender budgeting, that involve gender departments in the health sector.

24. The Resolution adopting PAHO's Gender Equality Policy urges Member States to include a gender perspective in the development, monitoring, and evaluation of policies and programs. It also requests PASB to include a performance monitoring and accountability system in the Plan of Action for implementing the Policy. Successful implementation of the Policy and, thus, of its PoA requires that PASB commit itself to including gender equality in institutional policies, programs, and systems, such as the biennial work plans, with earmarked funding and resources to ensure that these commitments are adequately implemented and monitored. It calls for Country Offices to strengthen or create resources to promote the integration of gender issues in health systems, working with Member States and CSOs. In addition, it commits PASB senior management to ensure that the Policy is transmitted into action in technical and management areas, and to monitor its implementation throughout the work for which they are responsible. The Gender, Ethnicity, and Health Office (GEH), as designated by the Policy, will coordinate the formulation, implementation, and monitoring and evaluation mechanisms to track mainstreaming into work programs.

25. This PoA includes indicators to monitor its implementation that were defined in consultation with PASB staff, Member Countries and CSOs (in process). The indicators conform to existing evaluation mechanisms of PAHO's 2008−2012 Strategic Plan and will include a gender marker for operational plans, budgeting, and reporting processes. In line with WHO's global strategic objectives (SOs), PAHO Strategic Plan includes 16 SOs, among those, SO7 specifically **"integrates pro-poor, gender-responsive, and human-rights−based approaches."** Each SO has Regional Expected Results (RER) with specific indicators. RER 7.5 relates to gender and ethnic equality with the following indicators:

RER 7.5	**Gender and Ethnicity analysis and responsive actions incorporated into PAHO/WHO's normative work and Member States supported through technical cooperation for the formulation of gender and ethnic-sensitive policies and programs**
Indicator 7.5.1	Number of PAHO publications that contribute to building evidence on the impact of gender inequalities in health
Indicator 7.5.2	Number of tools and guidance documents developed by PASB for Member States on using gender analysis in health
Indicator 7.5.3	Number of AMPES entities that address and incorporate gender perspectives, including mainstreaming, in the design and implementation of their programs

In addition to the above RER 7.5, Gender Equality is also included in two other RERs (Infectious disease, disaggregation of data) as well as in ten RER indicators.[17] This framework provides the basis for developing and monitoring PASB's biennial work plans, results, and designated resources, which will be analyzed to assess the inclusion of gender and to develop a baseline for monitoring and reporting.

26. Monitoring indicators will also be refined based on the baseline data collected by WHO's organization wide strategy for evaluating the progress of gender mainstreaming within WHO and PAHO; the strategy includes a staff survey on gender knowledge and practice, in-depth interviews with managers, and a review of key documents. It involves three phases: the baseline, an assessment in 2010, and the final evaluation in 2013.

Gender Parity in Health

27. Parity achievements have been at the forefront in the Region, as several countries have elected their first woman president and have attained gender parity in the their cabinets, with an increasing number of women being named ministers of health. The situation analysis (Annex 1) reminds us, however, that while more women are taking leadership positions within their health sectors, women continue to make up the majority of informal and unpaid health providers.

28. The Policy resolves that Member States and the Secretariat should strive for parity between the sexes in matters of recruitment and career development, including employment in decision making positions. It points out that, in addition to Member States and PASB technical collaboration, the gender approach also applies to PASB's own human resource policies: **"PAHO is committed to advancing gender equality in its own work force, particularly at decision making levels, as well as in scientific and technical advisors and consultants."** This commitment is in line with World Health Assembly UN resolutions ensuring gender equality in the work force.[18]

29. During the 2008 meeting of the Task force on Gender Equality, a report of the Division of the Advancement of Women recognized PAHO as one of the most successful UN agencies in reaching gender parity in staffing. The Director, Assistant Director, and Deputy Director are women, and according to PAHO's 2007 human resource report, parity was almost reached for international professionals in country offices and centers, including among PAHO/WHO country representatives, as well as at Headquarters. Among national professionals, women predominate at lower levels, while men occupy more of the higher positions. In 2007, of the 41 new professionals who were appointed to positions in PAHO, 20 (49%) were men and 21 (51%) were

[17] 10 RER Indicators under 7 different RERs mention G/E: HIV/AIDS, TB, malaria – HIV/AIDS focus (2); PED – % of needs assessments conducted contain gender-responsive (1); GEH (4); HRM – new recruits/gender balance (1); HR – corporate policies and staff performance reflect institutional development approaches (1);surveillance of sexual/repro health disaggregated by sex/ethnicity (1).

[18] WHA50.15 Recruitment of International Staff in WHO Geographical Representations (1997) and Resolution 55/69 Improvement of the Status of Women in the UN System adopted by the UN General Assembly (A/RES/55/69, 2001). The Medium Term Action Plan for Employment and Participation of Women in Work of WHO (2000-2005) forces on measures to improve the flow of women to WHO as well as their retention, with a view to attaining gender equity.

women. This represents a consistent increase in the number of women appointed to posts within the Bureau during each of the previous four years.[19] A report based on interviews with over 50 stakeholders involved in the development of PAHO's Plan of Action on Gender Equality also stresses the importance of developing family friendly employment policies and strengthening leadership capabilities of women in the organization.[20]

The Strategy

30. PAHO, as do all other UN agencies, adheres to the UN/ECOSOC resolution calling for the use of mainstreaming as a strategy for implementing the international commitments to gender equality and women's empowerment within the UN system.

The United Nation's ECOSOC Resolution defines gender mainstreaming as:
The *process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring, and evaluation of policies and programs in all political, economic, and social spheres so that women and men can benefit equally and so that inequality in not perpetrated*.[21]

31. Based on international consensus, this strategy includes building capacity, gathering evidence, and creating an environment for including a gender perspective in all health and related policies and programs at all levels. It builds on evidence, empowerment, partnership and knowledge sharing to ensure that women and men have the necessary information, access to quality services, and opportunities to equally and optimally participate in decision making about their own and their families' health, while recognizing their formal and informal contribution to health. The strategy aims to reduce inequities in health, to improve the efficiency of health services that are integrated and culturally appropriate, and to develop surveillance and monitoring mechanisms to assess progress.

[19] The percentage of women in P categories and above in Country Offices and Centers increased from 35% to 38% (76 to 89). At Headquarters, the increase was 47% to 49% (97 to 101). Overall, the percentage of women in P and D categories increased from 41% to 43% (from 173 to 190 women). In the countries, women predominate in the lower professional levels P.1/NOA (58%) and P.2/NOB grade levels (69%), the P.3/NOC level (55%), while men predominate in higher levels—P.4/NOD through D2 grade levels (64% at P.4/NOD, 58% at P.5, 63% at P.6, 61% at D.1 and 100% at D.2). Of the 27PAHO/WHO Representatives 48% (13) are female.

[20] GEH, Draft Report. "Information from Key Stakeholders toward Development of PAHO's Plan of Action on Gender Equality", Joanne Spicehandler, Nov. 3, 2005.

[21] This definition comes from the United Nations Economic and Social Council's agreed conclusions 1997/2.

The Five-Year Plan of Action to Implement PAHO's Gender Equality Policy

32. The PoA provides a roadmap and monitoring indicators for PASB and its Member States to implement the Gender Equality Policy. It provides the framework for PASB's technical collaboration with Member States to put into practice the commitment to include a gender perspective in planning, implementation, monitoring, and evaluation of health policies, programs, projects, and research. Execution of this roadmap will give gender equality more traction within PAHO, and it will consolidate the Organization's leadership in ensuring Health for All. As mentioned, the Plan takes into consideration the Health Agenda of the Americas and PAHO's Strategic Plan, with its cross-cutting commitments to gender, human rights, indigenous populations, social protection, primary health care, and health promotion. It also fits within the WHO's Framework on Gender Equality that includes its gender policy, the strategy for its implementation, and the global evaluation on gender mainstreaming. The PoA is the result of widespread consensus with PAHO colleagues, Member States, UN agencies, and partners among Regional civil society organizations.

33. Specifically the Plan will assist PAHO and it Member States to reach the goal of its Gender Equality Policy, to "contribute to the achievements of gender equality in health status and development through research, policies and programs that give due attention to the gender differences in health and its determinants and actively promote equality and equity between women and men." Its implementation strategy builds on the objectives and mainstreaming components defined in the Policy and included in the graph below.

Strategic Areas

34. The Plan of Action includes four interdependent strategic areas:

(a) Strengthening the Organization's and the Member States' capabilities to generate, analyze, and use information disaggregated by sex and by other relevant variables;

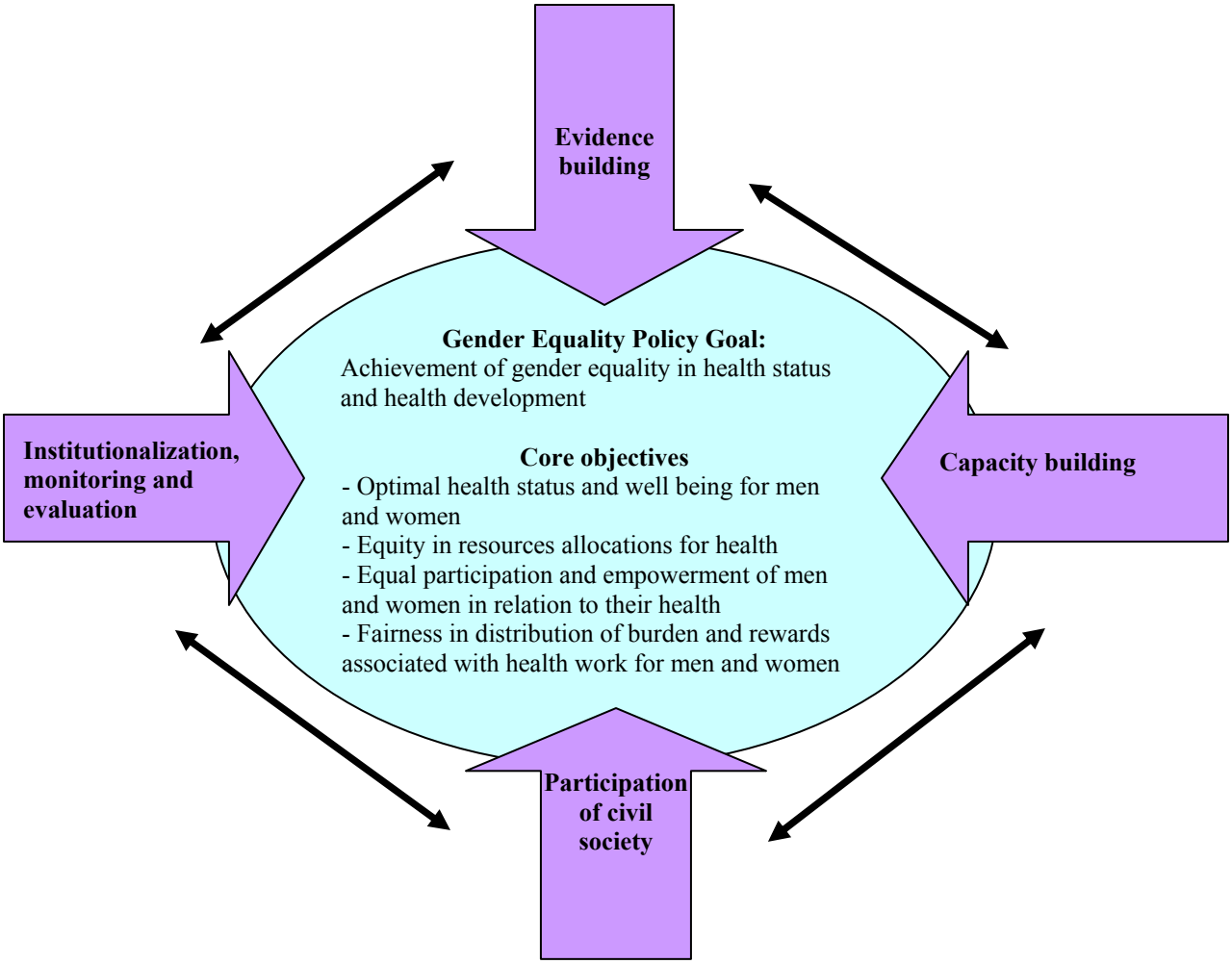
(b) Developing tools and building capabilities in PASB and Member States for the integration of a gender equality perspective in the development, implementation, monitoring, and evaluation of policies and programs;

(c) Increasing and strengthening the participation of civil society, with emphasis on women's groups and other gender-equality advocates, in the identification of priorities, formulation of policies, and monitoring of policies/programs at all levels; and

(d) Institutionalizing gender-responsive policies as well as monitoring mechanisms to track specific mainstreaming results, in line with results-based management methodologies, and evaluating the effectiveness of gender interventions on health outcomes.

The four strategic areas will ensure the achievements of measurable results at the national, subregional, and regional level.

Four Strategic Areas to Implement the Gender Equality Policy[22]:



Guiding principals

35. The following core guiding principles set the direction for the PoA:

- Incorporates principles of the PAHO Gender Policy: gender equity, equality, diversity, and the empowerment of women;[23]

- Aims at ensuring "Health for All"[24] and at reducing inequities in health;

[22] Graph adapted from the World Bank Group Action Plan: "Gender Equality as Smart Economics" 2006.
[23] PAHO Gender Equality Policy, p. 10.
[24] As defined by the Declaration of Alma-Ata (1978).

- Takes into consideration PAHO's cross-cutting priorities: gender and ethnic equality, human rights, participation, health promotion, and primary health care;
- Is tailored to individual country realities and needs;
- Is grounded in evidence and good practices;
- Is oriented to results that can be monitored and evaluated;
- Is based on incentives to improve equity and efficiency, rather than on mandates; and
- Builds on partnerships and participation.

<u>Strategic Area 1:</u> Strengthening the Organization's and the Member States' capabilities to collect, present, analyze, and use information disaggregated by sex and by other relevant variables		
Specific Objective	**Actions**	**Indicators**
1.1.PASB incorporates gender sensitive indicators, disaggregated by age and sex, in developing plans, programs, technical collaboration and other initiatives	• Disaggregation of all health data produced by PASB, by sex and other relevant variables and incorporation of a gender perspective • Baseline analysis of all Country Collaboration strategies for 2008 • Integrating gender analysis in Country Collaboration Strategies • Baseline analysis of existing regional health surveys in 2008 • Technical collaboration to centers and country offices to include gender analysis in key documents and surveys	**PASB** **Health in the Americas Publication (HoA)** • **Baseline**: 2008 WHO assessment of 2007 HoA • **Indicator**: 2012 HoA includes gender analysis in the regional volume, as well as in all national chapters **Strategy for Strengthening Vital and Health Statistics in the Countries of the Americas** • **Indicator**: By 2009, Guidelines call for disaggregation of data by sex and age for all information systems **Country Collaboration Strategies (CCS)** • **Baseline**: proportion of 2008 CCS include analysis using data disaggregated by sex and age, using WHO analysis tool • **Indicator:** By 2010, all new CCS include analysis based on data disaggregated by sex and age, and strategies to address differences **Health Analysis publications** • **Indicator:** By 2013, all Health Analysis publications will include analysis based on data disaggregated by sex and age **Regional Health Surveys** • **Baseline:** Proportion of Regional Health Surveys carried out in 2008 that include a gender analysis • **Indicator:** By 2013, all regional surveys disaggregate data by sex and include gender analysis

Specific Objective	Actions	Indicators
1.2 National and local producers and users of health statistics with capacity to produce, analyze, and use gender sensitive information for decision making, advocacy, monitoring and evaluation	• Tools and training to key national and local producers and users of health information to conduct gender analysis on health data and apply results • With stakeholders improve country profiles on health of women and men, applying advocacy or planning. Apply questionnaire regarding use of profile during workshop and for follow up • Provide technical collaboration to health sector to include data disaggregated by sex and other relevant variables in health information systems • Support national research to increase knowledge on gender inequities in health and related issues • Support application of time use studies and efforts to include unpaid home health care in national health accounts • Strengthen and support national mechanisms of analysis and monitoring gender equity in health (Observatories) • Develop best practice on Gender and Health Observatory in Chile	***PASB*** **Tools on Gender and Health Analysis** • **Indicator**: Number of tools on Gender and Health analysis available and accessed on Gender and Health Knowledge Platform ***PAHO*** • **Baseline:** Number of existing health profiles • **Indicator:** By 2014 trained producers and users of information of ten countries develop or improve national health profiles on women and men and use them for planning and advocacy (survey of workshop participants) **Contribution of unpaid work in national health accounts** • **Indicator:** By 2013 three countries have national health accounts that include contributions of unpaid health care provided in the households **National mechanisms for analysis and monitoring gender equity in health** • **Baseline:** Number of health or gender observatories that have received PAHO support to include gender and health indicators • **Indicator:** By 2013 three national or local observatories on gender have integrated health/gender indicators and have published issue papers including gender equality in reform processes

Specific Objective	Actions	Indicators
1.3. Inter-agency collaboration strengthened to fulfill international commitments of Member States related to gender indicators and statistics	• Contribute to the interagency coalition to develop the health and gender indicators to be integrated in the Regional Observatory on Gender Parity • Provide gender and health indicators to the Interagency MDG Monitoring mechanisms • Provide and support regional inter-agency trainings and events on gender indicators, statistical analysis and time use for national producers and users of information • Publish and disseminate regional and subregional documents on gender and health with a diversity approach • Support CFS and subregional NWM coalitions in using the evidence on gender inequities in developing subregional health agendas of the economic integrations processes	**PASB** **Interagency Regional Observatory on Gender Parity** • **Indicator:** Health indicators included and monitored in Regional Gender Parity Observatory, and support provided in training national partners in their application **Evidence on Regional Situation of Women and men in LAC** • **Indicator:** By 2009, one Regional Health Profile on women and men published with UNIFEM, UNFPA and UNICEF and widely disseminated • **Indicator:** By 2014, two biannual statistical brochures published with UNIFEM and UNFPA and widely disseminated **New and existing International and Regional monitoring mechanisms on MDG** • Interagency collaboration on monitoring of MDG includes gender and health ***PAHO*** **Strengthen Subregional coalition of NWM to include Gender Indicators in Subregional Health Agendas** • **Indicators:** By 2010, two subregional (Central America and Andes) profiles on men and women's health developed by subregional coalitions of NWMs to advocate for inclusion of gender indicators in subregional health agendas of the integration processes (COMMCA, and the Andes Group of Women's Ministers)

Specific Objective	Actions	Indicators
		• **Indicator:** By 2009, Gender indicators included in the Caribbean Cooperation in Health Initiative CCH3 **Regional statistical Conferences promote time use studies** • **Indicator:** By 2013, three national time use studies related to unpaid work include health care
<u>Strategic Area 2</u>: Strengthen capacity of PAHO and Member States for integrating a gender equality perspective in the development, implementation, monitoring, and evaluation of policies and programs		
Strategic Objective	**Actions**	**Indicators**
2.1 Capacity and commitment strengthened of PASB and Member States to support PASB and health sector in integrating a gender analysis with human right based approach in policies, programming, monitoring and research	• Develop, implement and monitor collaboration plans for integrating gender analysis and interventions with indicators, with selected PASB Technical and Country Offices • Finalize training tools on Gender and Health (adapted from WHO Modules) and make tools and training packets available on Knowledge Platform • Provide subregional training in Gender and Health with human right based approach for national teams of PAHO Gender Focal Points and representatives from the health sector, and gender advocates partners to build capacity, develop national gender and health strategies, and build support networks for implementing these	***PASB*** **Collaboration plans for integrating gender in Technical Areas and Country Offices developed and implemented** • **Baseline:** Number of Collaboration Plans developed.[35] • **Indicator:** Number of PASB Offices reporting on advances of Collaboration Plans, as part of annual reporting process **Training PAHO staff on Gender and Health** • **Baseline:** 2008 WHO baseline survey on knowledge and capacity of PAHO Staff and managers

[35] In 2008 GEH started to develop Collaboration Plans to mainstream gender in 10 AMPES entities, and with country teams during subregional training. The plans are drafted with the selected partners and will form the baseline for future collaboration and evaluation.

Specific Objective	Actions	Indicators
	• Establish and train a network of GEH in Technical Areas and Country Offices (COs) to provide training and technical collaboration to their teams and Member States on integrating a gender analysis and programming in their work • Include gender in induction training for new staff and develop/apply strategy for engaging Managers • Establish and train external Technical Advisory Group to support PAHO in implementing the Plan of Action. Members include experts from Member States, UN agencies and CSO	• **Indicator:** By 2010, WHO Mid-term assessment shows 50% increased number of staff and managers responding to have received training in gender equality and applying concepts to work. • **Indicator:** By 2013, evaluation, 75% of staff apply concepts **PAHO technical gender networks functioning to support implementation of PoA and National Gender and Health Plans** • **Indicator:** By 2009, Internal Gender Working Group (IGWG) of designated representatives of technical areas and subregional GFP trained and supporting Technical Areas and PWRs on implementing and monitoring the Plan of Action • **Indicator:** By 2009, Technical Advisory Group of experts has workplan that guides PASB's Director on gender mainstreaming and reporting on progress • **Indicator:** By 2009, Subregional Gender Networks of PAHO trained GFPs and other partners, coordinated by regional GEH advisor and providing technical support to Countries in developing and implementing Plans within Health Sector for integrating gender ***PAHO*** **Integrating Gender Equality in Health Sector** • **Baseline:** Number of preliminary gender and health plans developed in 2008-2009 by participating country teams during the Gender and Health training workshops (see footnote 18)

Specific Objective	Actions	Indicators
		• **Indicator:** Proportion of national gender and health strategies defined during workshops actually developed and implemented with national partners • **Indictor:** Number of Intersectoral Technical Advisory groups formed after workshop that support PWR and MOH in developing, implementing and monitoring Gender and health plans in health sector
2.2: Support PASB and Member States in including gender in the formulation and review of policies and processes related to staffing	• Support development of mechanisms and processes that ensure parity and equal advancement of PASB staff at all levels • Support development of strategies for improving work life balance, and strengthening leadership capacities of women staff • Support inclusion of gender in staff competencies and in staff assessment tools • Technical support to review national laws, support NWM in integrating parity in health sector in the National Plan of Equal Opportunities • Collaboration to include gender indicators in Regional Human Resources database	***PASB*** **Human Resource Policies attain gender parity and positive work environments that promote gender equality in the workplace** • **Baseline:** 2008 HR staff report and WHO baseline • **Indicator**: By 2011, WHO assessment and 2013 evaluation, parity reached at all staff levels, especially in CO • **Indicator**: By 2013, Work Life Balance Policy approved and operational within PAHO • **Indicator**: By 2010, gender competency included in corporate competencies, and in staff assessment tools • **Indicator:** At least 5 countries supported to incorporate equal opportunities rules in their Health Sector Human Resources policy by 2014

Specific Objective	Actions	Indicators
2.3: Knowledge platform on gender and health established and accessible for PASB, Member States and CSO to support implementation of the Gender Equality Policy and Plan of Action	• Renew gender and health knowledge platform website for accessing gender and health training tools, information, gender and health expert database, and best practices, and increase accessibility to and contributions by PAHO, Member States, UN agencies and other partners • Launch annual regional competition to award best practices in mainstreaming gender in health for practices database (awarded in International Women's Day) • Present lessons learned on gender mainstreaming in health during international and regional conferences	***PASB*** **Knowledge platform set up on Gender, Ethnicity and Health to support Country Offices, Technical Areas and Partners** • **Indicator:** By 2010, Knowledge platform set up and fully operational (accessed by 1,000 users/month) on gender and health as part of PAHO's Information Strategy and includes: training tools and information packets, database of experts, best practices and links to networks • **Indicator:** Two best practices on integrating gender in health awarded yearly, one internal and one external during International Women's Day Celebration and virtual-forum, and included in PAHO database of Best Practices on Gender and Health ***PAHO*** **Access and contribute to G/H knowledge platform** • Half of all contributions to knowledge platform provided by Member States and other partners (CSO and UN)

<u>Strategic Area 3.</u> Increasing and strengthening the participation of civil society organizations (CSOs), with emphasis on women's groups and other gender-equality advocates, in the identification of priorities, formulation of policies, and monitoring of policies/programs at all levels.		
Strategic Objective	**Action**	**Indicators**
3.1: Leaders of regional CSOs, especially women's organizations and gender equality advocates groups, serve as members of PAHO's Technical Advisory Group on Gender Equality and Health (TAG GEH), and advice on implementation of the Gender Equality Policy within PAHO and its Member States	• Select three CSO members (in addition to 3 Member States, and 3 UN agencies) to PAHO's TAG GEH • Biennial collaboration plan with regional partner CSO, the Women Health Network for Latin America and the Caribbean (WHNLAC), as the NGO representative to PAHO's Executive Committee (EC) • National CSO in consultations on development and monitoring of the Plan of Action	**PASB** **CSO actively participate and support PAHO's gender equality strategy and PoA** • **Indicator:** By 2009, Technical Advisory Group includes three CSO members from women's or gender equality advocacy organizations • **Indicator:** By 2009, Biennial Plans with WHNLAC developed, implemented and monitored with progress reported to EC • **Indicator:** Number of CSO's consulted in development of PoA
3.2: Civil society organizations (women, men, ethnic groups, Human Rights etc.) empowered to participate in national multi-sectoral teams, to support the MOHs in implementing, monitoring, and evaluating gender equality in health policies and programs	• Include representatives of CSO in subregional and national intersectoral capacity building workshops on gender and health, and in developing gender equality strategies for the health sector • Facilitate national mechanisms that promote CSO participation in health decision and policy making • Support strengthening the capacity of CSOs to influence health policy, including the analysis and allocation of national health budgets to reflect and address women and men's differential health needs and opportunities	***PAHO*** **CSO participate in national health policy making and monitoring processes** • **Indicator:** Number of CSO participating in national advisory groups for developing and implementing the national gender equality health plans developed during the subregional training workshops • **Indicator**: By 2013, processes supported, facilitated and documented in three countries that have included CSO participation and resulted in the allocation of health budgets to better address gender inequalities

Strategic Objective	Action	Indicators
3.3: Increased knowledge and capacity among gender equality CSOs on gender and health issues and advocacy	• Implement and evaluate regular advocacy campaigns to increase awareness regarding PAHO's Gender Policy, as well as mainstreaming of gender resources available on knowledge platform	**PASB** **Advocacy campaigns implemented to increase awareness on gender equality in health** • **Indicator:** Annually, regional information campaign carried out on Women's Health Day • **Indicator:** By 2009, PoA widely disseminated and accessible to CSO for comments
<u>Strategic Area 4:</u> Institutionalizing gender-responsive policies and monitoring mechanisms to track specific mainstreaming results, in line with results-based management methodologies, and evaluating the effectiveness of gender interventions on health outcomes		
Strategic Objective	**Action**	**Indicators**
4.1 Ensure PAHO alignment with the WHO approach to monitoring and evaluating gender mainstreaming to develop appropriate capacity building and gender analysis strategies based on the results	• Institutionalize periodic internal reviews, complemented by external evaluation at baseline (2008), mid-term (2010) and final (2013), and disseminate results: Staff knowledge, attitude and practice survey, interview of managers, review of key documents (Health of the Americas, CCS, Directors speeches)	**PASB/WHO** • **Baseline**: 2008 WHO baseline study carried out • **Indicator**: By 2013 Results of WHO evaluation reported to PAHO staff and to the Executive Committee, and guides PAHO GMS strategy and implementation
4.2 PASB has in place systems for implementing and monitoring the Gender Equality Policy and Plan of Action	• Carry out baseline gender assessment of 2008 strategies and action plans submitted to the Executive Committee, to monitor progress • Develop tools for including gender in PAHO strategies and action plans • Develop tools and a marker for including gender analysis and differential health interventions in the planning, budgeting and reporting on Biannual Work Plan (BWP) • Develop baseline on gender analysis of BWP and budgets for monitoring progress	***PASB*** **Strategies presented to PAHO Governing Bodies** • **Baseline**: 2008 number of strategies and action plans presented to GOB and percent that included gender analysis • **Indicator**: By 2010 all presented strategies and action plans include gender in the situation analysis and differential interventions **Planning and reporting process include gender marker** • **Baseline:** 2009 baseline analysis of reporting and budgets of BWP using gender marker

Strategic Objective	Action	Indicators
		• **Indicator**: By 2013, all PABS offices report on gender marker and budget allocations in BWP, that include gender collaboration strategies and the implementation of national plans for integrating gender in the health sector • **Indicator:** By 2013, 75% of BWP include gender indicators • **Indicator:** Director reports on progress of PoA implementation in 2010, 2013 to Governing Bodies
4.3 Mechanisms agreed to and in place at PASB to monitor Member States advances in implementing the Gender equality Policy and PoA	• Develop monitoring mechanisms on gender mainstreaming in Member States, as part of PoA • Carry out a gender equality scan of national health plans in 2008 and 2012 • System in place to track development and implementation of gender equality plans defined during GEH workshops	***PAHO*** **Member States progress in implementing the Gender Policy and the PoA** • **Indicator:** PASB report to Governing Bodies in 2010 and 2013 on Member States progress on developing, implementing and monitoring gender equality plans in health sector
4.4 Special program initiatives implemented with Technical Areas on integrating gender, that integrate the four strategic areas - evidence, capacity building, civil society participation and evaluation - to increase ownership and demonstrate concrete lessons	• With a Technical Area develop and fundraise for a specific program that analyzes and addresses the differential health effects on women and men • Implement and evaluate program to document and disseminate lessons learned and increase ownership of the GMS process	**Special GMS programs developed with Technical Area** • **Indicator:** By 2013, GEH and three technical areas will develop innovative programs to include gender to be developed, funded and evaluated and lessons learned documented and widely disseminated as Best Practices in Gender Mainstreaming in Health

Implementing the Plan of Action

36. The Directing Council called for PAHO's Director to develop and implement the Plan of Action, in consultation with Member States and the Governing Bodies. PAHO's Gender, Ethnicity, and Health Office (GEH) has worked with the Director and Assistant Director in developing this Plan, with guidance from PAHO Gender Focal Points in Technical Areas and Country Offices that form the Internal Gender Working Group, and from the Director's Technical Advisory Group on Gender Equality and Health with members from civil society, UN agencies, and Member States. The Plan of Action has been widely consulted with PAHO Gender Focal Points and their national partners from MOH and gender equality advocates from 19 countries. The Plan of Action will be presented to the Executive Committee in June 2009 for subsequent approval by the Directing Council. The Director will present the progress of the Plan's implementation to the Executive Committee on a biannual basis.

37. GEH will support the Director in the day-to-day implementation of the Plan, with regular guidance from the internal and the external gender working groups, and in regular consultation with Member States. The GEH Office will provide technical collaboration and training to selected Technical Areas and Country Offices to strengthen their capacity to implement the Gender Equality Policy Plan of Action in their work and their technical collaboration to Member States. The GEH Office at Headquarters will be primarily responsible for providing this support to Technical Offices, while the decentralized team of a regional coordinator and subregional gender focal points will provide support to countries. The implementation of the Plan will require additional funding during initial stages and to implement its evaluation, though mainstreaming costs will be primarily covered by the Technical Offices and Country Offices, as part of the mainstreaming process.

Annexes

Gender Inequalities Persist in the Americas[1]

1. Despite considerable progress made, gender-based socioeconomic inequities remain deeply entrenched in the Region and are exacerbated among some subpopulations, particularly the poor, rural inhabitants, and some ethnic groups. In the Americas, the most socially unequal Region of the world, gender inequalities interact with other socioeconomic inequalities to limit opportunities for women and men to enjoy optimal health, live free from preventable diseases, gain equitable access to health resources, and be equal contributors to health care and wellness.

2. Women continue to experience social and economic disadvantages, with their attendant health consequences. While women have equaled and even surpassed men in educational levels, this progress is not reflected in their economic situation. Women and their households continue to be overrepresented among the poor, and while women have joined the workforce in unprecedented numbers, women's employment rates and income continue to be lower than men's, and women predominate in the informal sector.[2] More than 50% of women devote their time to caring for others without earning an income. This unequal situation not only limits women's access to resources and information for health care, but also limits their pension and health-insurance coverage that accrue through employment in the formal sector.

3. In all countries of the Region, women live longer than men, and have lower mortality throughout their lifetime, with the exception of some countries where especially poor women experience higher mortality during childbearing years. In these countries the gap in life expectancy between women and men also is narrower, erasing the alleged biological advantage that women enjoy under more optimal health and development conditions. Even in the more developed countries, the added years to women's lives are not necessarily quality years, given that older women have less access to social protection and resources and experience more poverty, loneliness, and disability.

4. Gender inequities are even more explicit when illness and death are caused by health situations that are preventable, and that disproportionably affect poor, adolescent, minimally educated and ethnic women. Lack of access to simple, low-cost reproductive health services to prevent pregnancy complications has resulted in persistently high maternal mortality rates in the Region, averaging 94.5 per 100,000 live births (1997-2004), and ranging from a low of 5.6 in Canada to over a hundred-fold difference of 630 for Haiti. And while fertility rates have decreased substantially over the last decades, 10%-40% of uneducated women continue to have unmet needs for family planning; this need is even higher among adolescents (17%-58%) and contributes to pregnancies among 10%-25% of teenage girls. Post-abortion complications continue to be a leading contributor to maternal mortality. Cervical cancer, which is easily preventable with low-cost screening and treatment, continues to kill more than twice as many women in poor communities. While men make up the largest proportion of people living with

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[1] Most of the indicators are obtained from PAHO Publication, "*Gender, Health and Development in the Americas, Basic Indicators 2007*", and the unpublished document by Elsa Gomez", "*Genero como un determinante estructural de inequidad en salud: contribuicion de AD/GE al capitulo 1 de Salud en las Americas*", 2007.

[2] CEPAL (2006), Panorama Social de la America Latina 2005, Santiago, CEPAL.

HIV/AIDS in the Region, in some Caribbean countries new infections are reported among young women 15-24 years old at more than twice the rate of young men in the Barbados, Dominican Republic, and Jamaica, and at six time the male rate in Suriname.

5. The persistently high rates of gender-based violence that one-third of the Region's women experience at the hands of their partners, attest to the continued tolerance for gender discrimination, impunity of perpetrators, and lack of screening for prevention. Even though the majority of countries in the Americas have passed legislation prohibiting inter-family violence, these laws are rarely implemented due to a lack of political will and insufficient allocated resources for prevention, care, training, and protection.

6. Overall, women have a greater need for health services than men, mainly, but not exclusively, due to their reproductive role, which some estimate account for 34% of women's burden of disease. It is not surprising, therefore, that women use health services more often, which has been shown to translate into 16%-50% higher out-of-pocket expenditures for women, as well as interrupted earnings. This makes it more difficult for women to become eligible for health care coverage and increases their risk of slipping into poverty as a consequence of illness, especially during old age.

7. Women shoulder most of the care for children, the sick, and the disabled in their families and communities. More than 80% of health care is provided informally by women, much of it without any support or remuneration. Recent health reform processes have exacerbated gender inequalities in health care through the promotion of cost recovery, privatization, reduction of public services, and regressive systems of financing care. All of these have affected women's access to services and employment in the health sector, while at the same time increasing their burden of providing health care at home and in the community.

8. Gender norms also have negative health consequences for men, and are related to their risk taking behaviors that have negative health outcomes. These behaviors begin during childhood and eventually result in 3.5 times higher mortality rates than women experience for accidents and homicides, in higher use of tobacco and alcohol with related illness and mortality from lung cancer and cirrhosis of the liver, and an increase in sexual risk taking with resulting higher rates of sexually transmitted infections, including HIV/AIDS. Gender norms discourage men from using reproductive health and other services, from complying with treatment regimens, and from protecting themselves against injury, infection, and disease. Aggressive roles also contribute to discrimination against women and, at worst, to violent behaviors that undermine the rights, welfare, and health of women and girls.

Gender Approach in PAHO 1980-2006: Elements for a corporate policy

1. Since the 1975, International Women's Year Conference, PAHO's Directing Council has issued a series of resolutions aimed at improving women's health and achieving a more equitable participation with men in higher levels of decision making, both within the health sector and in the Secretariat itself. In 1980, the Directing Council urged Member States to eliminate all forms of discrimination against women and to introduce the concept of "equality between the sexes" (CD27.R17) as a goal. That same resolution requested that the Director designate a focal point on Women, Health, and Development at the highest level of the Secretariat, and approved the constitution of a Special Subcommittee of the Executive Committee on Women, Health and Development. In 1982, the Pan American Sanitary Conference approved the designation of focal points at the country level and recommended that the Director strengthen with resources, technical cooperation in this area. During the last 10 years, several recommendations emanating from the Subcommittee and endorsed by the Executive Committee, stressed the importance of mainstreaming a gender equity perspective throughout the work and organizational arrangements of both the Member States and the Secretariat. Some specific areas were designated for that purpose: Gender-based violence, information management in situation analysis and policy monitoring, and health sector reform policies. The following table highlights some of PAHO accomplishments and prospects:

Date		**Themes**
1980's—Provided support with information on women's health and development	1980 Creation of the Subcommittee of Women, Health, and Development	- The first Five-Year Regional Plan of Action on Women Health and Development was established - Other related objective set up at the same period: recruitment and development of senior career posts to attain 30% women
	Recruitment policies	- Promoted the inclusion of women candidates in all the recruitment competitions in order to achieve equality in HRS - Promoted participation of women staff in seminars and training
	Creation of a Special Program on Women, Health, and Development	Initially located in the office of Assistant Director, it functioned more as an information center for the offices and partners in health of woman
	Establishment of a focal point on Women and Health in HQ	
	Creation of an Internal Committee on Women (CAM) as advisory group to the Director	Monitoring of professional women's promotion; development of policies against sexual harassment

1990s—Programs in violence, evidence, data information and health sector reform	Location of the Unit in Human Development Division, with an approach to equity in Health	
	1993. Resolution recognizing violence against women as a public health priority problem and human rights abuse 1994. The Unit was awarded a Regional project to address violence against the women in 10 countries which was funded by SIDA/NORAD/Netherlands	- Development and implementation of the comprehensive model to address violence against women in the 10 countries (7 CA, BOL, PER, ECU) and in 6 countries by the Inter-American Development Bank - Results: **Regional Level**: Conducted interagency campaigns against violence; 2001 Regional Conference; evaluation of the Model "'Violence Against Women: The Health Sector Responds;" PAHO focal points on Gender established in the 10 countries **National:** Legislation and policies to prevent and penalize violence against women. Building National intersectorial coalitions Health sector: intersectoral capacity building , protocols, and information Systems **Community:** Networks support, referral systems
	Strategic planning resulted in the expansion of the Unit agenda: - Implementation of the Comprehensive Model of Violence - Strengthen the evidence and health information systems with producers and users - Incorporation of gender equality in health policies, especially in the health sector reform - Establishment of a communication strategy (GENSALUD) to assist partners and countries	Results - Consolidated the achievements of the Model Attention in CA at the national and community level. Included Violence Against Women Policies in the agendas of the Health Sector Reform - Debates with government partners and NGO on health sector reform in CA. Project in Chile/Peru to include gender equality policies in the health sector reform process and to include the NGOs of women in the debates of the process. - Two Observatories on Gender and Health established in Chile to

		monitor Health Sector Reform. - Training of producers and users of information on health in CA, that resulted the preparation of health profiles of men and women in all CA countries - GENSALUD reaches more than 1,000 users with fact sheets and another information on gender and health
	Directive on inclusion of a section on Women, Health, and Development in the publication "Health of the Americas" (1990 and in all the successive editions)	Health in the Americas disaggregates a proportion of health data, includes a chapter on "Women, Health and Development and the countries encouraged to include gender in their chapters
2000-2008 Toward Mainstreaming	2002 Election of the first women as PAHO Director	The Director prioritize gender equality: - Promotion of corporate policies on gender equality - Gender as one of the 6 cross-cutting priorities of PAHO Strategic Plan 2008-2012 - Establishment of a breastfeeding room in Headquarter - Proposal of a conciliation policy (unapproved) in 2007 reaches the parity in professional staff
	- Creation of the Unit Gender, Ethnicity and Health (GEH) and is relocation with the Assistant Director (AD) GEH expected result under strategic objective 7 (PAHO Strategic Plan 2008-2012) - Number of PAHO publications that contribute to building evidence on the impact of gender inequalities in health - Number of tools and guidance documents developed by PASB for Member States on using gender analysis in health - Number of AMPES entities that address and incorporate gender perspectives, including	The priority of GEH is to mainstream gender and ethnicity in PAHO. Violence against women is transferred to the Office of Risks Assessment

	mainstreaming, in the design and implementation of their programs	
	2005 Adoption by the Governing Bodies of the Gender Equality Policy	- The policy has for objective achieving gender equality in health and the integration of gender in the policies, programs, research in PAHO and its member states - The directing Council requested the Director to develop an action plan for its implementation and to establish a Technical Advisory Group in order to guide in the process of mainstreaming
	Synchronization with WHO gender mainstreaming process through the policy, strategy, modules for capacity building and monitoring/evaluation	Evaluation Strategy: - 2008 Implementation of the baseline survey on capacity/knowledge of the staff and area managers and review of key documents - 2010 Medium term review - 2013 Final evaluation Adaptation of WHO training modules on gender mainstreaming in health and subregional training of gender focal points, ministry of health partners and civil society

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WORLD HEALTH ORGANIZATION

SPBA3/5 (Eng.)
Annex B

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL AREAS

1. Agenda Item: 3.4	**2. Agenda Title:** Five-Year Regional Plan of Action for Implementing the Gender Equality Policy

3. Responsible Unit: AD/GE

4. Preparing Officer: Dr. Marijke Velzeboer and Saadia Lakhdim

5. List of collaborating centers and national institutions linked to this Agenda item:

Ministries of Health, Latin American and Caribbean Women's Health Network, Universities, Civil Society Organizations, National Women machineries, Canadian Centre of Excellence for Women's Health, OAS/CIM, UN agencies.

6. Link between Agenda item and Health Agenda of the Americas:

Address health determinants and reduce inequities in health among and within countries.

7. Link between Agenda item and Strategic Plan 2008-2012:

Strategic Objective 7: To address the underlying 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, and other gender related indicators included in other strategic objectives.

8. Best practices in this area and examples from other countries within AMRO:

In 2008, PAHO initiated the first competition for best practices on gender and health to build a data base for use. Two experiences, 1 in Mexico and 1 in Bolivia, won the competition and will be used as examples, as well as those for 2009 and the coming years.

9. Financial implications of Agenda item:

See the Report on the financial and administrative implications.

PAN AMERICAN HEALTH ORGANIZATION
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THIRD SESSION OF THE SUBCOMMITTEE ON PROGRAM, BUDGET, AND ADMINISTRATION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 11-13 March 2009

SPBA3/5 (Eng.)
Annex C

Report on the Financial and Administrative Implications for the Secretariat of the Resolutions Proposed for Adoption by the Executive Committee

1. **Resolution:** Five-Year Regional Plan of Action for implementing the Gender Equality Policy

2. Linkage to program budget

Area of work	Expected result
AD/GE	RER 7.5 Gender and ethnicity analysis and responsive actions incorporated into PAHO/WHO's normative work and Member States supported through technical cooperation for the formulation of gender and ethnic-sensitive policies and programs.

3. Financial implications

a) **Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US$ 10,000; including staff and activities):** This plan of action will be implemented through collaboration plans with technical areas and country offices in PAHO who will be co-financing the integration of gender in their biannual work plan. The estimation has been developed based on the 2008-2009 operational budget for the Gender, Ethnicity and Health Office.
US $6,500,000 (operational budget including the hiring of new staff)

b) **Estimated cost for the biennium 2008-2009 (estimated to the nearest US$ 10,000; including staff and activities):** $2,460,000.

c) **Of the estimated cost noted in *(b)* what can be subsumed under existing programmed activities?** $1,230,000 planned budget for 2009.

4. Administrative implications

a) **Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions, where relevant):** All technical areas, Country Focus Support Office, PED and HRM have been identified as priority for the integration of gender.
Gender mainstreaming at country level will start with 4 countries and 2 additions every year.

b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):** P3 fixed term with expertise on gender mainstreaming in health.

c) **Timeframes (indicate broad time frames for the implementation and evaluation):** 2009-2014.

List of Acronyms

AD: Assistant Director (PAHO)
AECID: *Agencia Española de Cooperación Internacional para el Desarrollo* (Spanish Agency for International Development Cooperation)
BWP: Biennial work plan (PAHO)
CA: Central America
CARICOM: Caribbean Community and Common Market
CEDAW: Convention on the Elimination of all Forms of Discrimination against Women
CCS: Country Collaboration Strategies (PAHO)
CFS: Country Focus Support (PAHO)
CIDA: Canadian International Development Agency
COs: Country Offices (PAHO)
COMMCA: Consejo de las Ministras de la Mujer de Centroamérica
CSO: Civil society organizations
D: Director (PAHO)
EC: Executive Committee (PAHO)
ECLAC: Economic Commission for Latin America and the Caribbean
FCH: Family and Community Health Area (PAHO)
GBV: Gender-based violence
GEH: Gender, Ethnicity, and Health Office (PAHO)
GEMLAC: Gender and Economics Network for Latin America and the Caribbean and Health Office
GFP: Gender focal point (PAHO)
G/H, GH: Gender and health
GMS: Gender mainstreaming
HDM/HA: Health Surveillance and Disease Management /Health Analysis Office (PAHO)
HoA: *Health in the Americas* (PAHO publication)
HR: Human Resources
HRM: Human Resources Management Area (PAHO)
HQ: Headquarters (PAHO)
IGWG: Internal Gender Working Group (PAHO)
UN-INSTRAW: United Nations International Research and Training Institute for the Advancement of Women
LAC: Latin America and the Caribbean region
LACWHN: The Latin America and the Caribbean Women Health Network
MDGs: Millennium Development Goals
MOHs: Ministries of health
MS: Member States (PAHO)
NGO: Non-governmental organizations
NWM: National Women's Machineries
OECD: Organization for Economic Cooperation and Development
PASB: Pan American Sanitary Bureau
PoA: Plan of Action (PAHO)
PRB: Planning, Budget, and Resource Coordination Office (PAHO)

PWR: PAHO/WHO Country Representative
PWR/GFP: Gender focal points in the Country Offices
RER: Regional Expected Results (PAHO)
SIDA: Swedish International Development Cooperation Agency
SOs: WHO's global strategic objectives
TAG GEH: PAHO's Director Technical Advisory Group on Gender Equality and Health
TC: Technical collaboration
UN: United Nations
UN/ECOSOC: United Nations Economic and Social Council
UNIFEM: United Nation Development Fund for Women
UNFPA: United Nations Population Fund

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