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Director, PAHO\*  
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**POLICIES IN THE AMERICAS AND THEIR IMPACT ON WOMEN'S HEALTH\*\*  
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Madame Chairperson, first let me thank you for the invitation to address you this morning and I am pleased that we managed to overcome the minor difficulties of scheduling. I accepted your invitation for both professional and personal reasons. Professionally, because it is useful to have the opportunity to speak to influential audiences about the Pan American Health Organization and what it does in support of its Member States. Personally, because the issue of gender discrimination in health is one that has occupied my thinking for some time and it is always helpful to be able to explore my ideas with interested groups.

Perhaps I should begin by indicating the level of interest of the Pan American Health Organization in this field. We are the oldest international health organization in the world — now 94 years old and over the years we have consolidated a set of principles and practices that we believe allow us to work more effectively as we try to improve the health of the Americas. In recent times I have articulated the two most important principles for our work, in light of the changes that have taken place in our hemisphere and our perception of the orientations that are likely to benefit our people most. The first principle is that we should search for equity in health and the second is that we should foster Panamericanism. The first is rather difficult to define accurately, but at its most basic level implies fairness in terms of access to facilities that make for better health. Panamericanism represents the ideal of the countries of the Americas working together to achieve shared health goals.

Our structure allows us to focus on the primary health problems of the Americas, both in terms of specific interventions and approaches that seek to strengthen the position of the health sector. Thus, we have programs in health and human development, health services and systems development, health promotion and protection, environmental health, disease prevention and control and a special program on vaccines and immunization. We have devoted a great deal of thinking to the relationship between health and human development as we see the health of people as an important contributor, component, indicator and expression of human development. We view women's issues and specifically the aspect of women's health in this light and propose that attention to women's health issues is important for human development. I will refer to this again.

When the title of this address was suggested to me, it included consideration of the health of women and children and I elected to remove children from our discussion. I did this not because I

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am insensitive to the plight of children and do not believe that there is a great deal more to be done to improve their health. I did it deliberately because I am always concerned when women are included with children, the poor, the halt and the disadvantaged as a single group of the vulnerable of our society. I react very negatively to the concept that women should be classed with others as a part of a vulnerable group. The perpetuation of this idea is inimical to the development of policies that will address the health problems of women.

This categorization hides what is the genuine vulnerability of women which in fact is derived from the discrimination that is socially determined and perpetuated. Attention to women's problems as if they were part of a helpless group, blinds us and prevent us from addressing those issues that are derived not from the biological fact of being women, but because there is gender based discrimination. There are health concerns of children as a group and there are health problems of children that are seen mainly in girls because of gender discrimination.

We should examine what is known of the health problems of women before addressing any policy issues. These problems are not always easy to find because in many instances the data are inadequate both quantitatively and in terms of sex disaggregation. The most common approach to health status is through mortality data which are somewhat more reliable, given the absoluteness of the final event. In the Americas, as in all other regions of the world, women's life expectancy at birth is consistently higher than that of men. The size of this differential obviously varies with the absolute life expectancy of the individual countries, and life expectancy of females in the poorest countries such as Haiti, differs from that of males by only half as much as in the richest countries such as the United States of America and Canada.

There is continuing debate on the nature of this life expectancy advantage of females in the face of the evidence of there being more female morbidity. There are compelling arguments for biological, behavioral and genuine gender mediated causes for the differential. There is evidence that in recent years, at least in the United States, this differential may be narrowing as females adopt more of the behaviors that contribute to excess male mortality.

Studies have been carried out on mortality at various age groups and it is now accepted that there is a genetic evidence of excess early male mortality and in the Americas more males than females die under the age of one year. However, our attention has been drawn to the fact that in many countries there is excess female mortality in young children from ages 1 to 4 years. This may indicate significant discrimination against girls in this age group. The health problems that account for this excess female mortality are principally malnutrition and respiratory illnesses. Malnutrition is important, not only because it is a contributing factor to other illnesses, but because its long-term effects can be so disastrous. There is no evidence to suggest that respiratory infections are more prevalent or more severe in girls than boys, and the fact that more girls die as a result of these infections is probably a genuine gender issue in that mothers tend to bring male children for medical attention more promptly than they do girls.

Cancer is one of the principal causes of adult female mortality, but there is no consistency in the male/female mortality ratios. The more developed countries of the Americas tend to show a higher mortality rate in men although there is a trend towards equalizing the rates. This may be due in part to the decline of smoking in the developed countries and its relative increase in females in the developing ones.

Cancer of the breast and uterine cervix are the most important female malignancies. The highest incidence rate for cancer of the breast is found in the United States of America and it is estimated that 1 out of 10 women is at risk of developing breast cancer. It seems that breast cancer is increasing in Latin America and the Caribbean as well. There are several theories and many associations, some of which may be causal and some simply epiphenomena. It is shown, for example, that in one group of countries there is an association between dietary fat and breast cancer.

Cervical cancer is now accepted as one of the sexually transmitted diseases. There is great variation among countries and our data show that whereas in La Paz, Bolivia, the probability of a woman developing cervical cancer is about 8 in 100, the risk in the United States of America is one tenth that figure. This differential is associated with social conditions and perhaps with smoking, since the risk of cervical cancer is 1.5 to 2 times higher in smokers than those who do not smoke. A differential of this size is more probably a manifestation of the inadequacy of services, since there is growing evidence that proper screening and treatment should make this cancer disappear from any list of fatal diseases.

The problem of maternal mortality is of increasing concern in our Region, as we take the view that no woman should die in the course of a normal physiological event. There is a notorious difficulty with underreporting, but we believe that the rates are declining. The differences among countries is stark and we have published data in 1994 to show that maternal mortality rates in Haiti, Bolivia and Peru are 75 times greater than that of Canada and 12 times greater than that of Costa Rica. The leading cause of this mortality is abortions and approximately one of every four maternal deaths in Latin America is the result of an illegal abortion. But even maternal mortality may have a gender component. I still recall, with much sadness and some horror, the story told to me by a woman in charge of one of the Centers we support. This was how a pregnant lady began to hemorrhage at home and died because she did not get to the hospital in time. She could not leave home until her husband returned from work and gave her permission.

Anemia is a common problem in women because of early malnutrition, the iron losses that result from menstruation and pregnancy and deficient dietary intake. Good data for our countries are again difficult to acquire, but there are reports of prevalence rates as high as 74% in pregnant women and in one study carried out in the Caribbean, there were six countries with prevalence rates greater than 50%.

As a result of increased longevity and the epidemiologic transition that has occurred or is occurring in most countries of the Americas, the chronic degenerative diseases represent major sources of mortality and morbidity in women. The problems of cardiovascular disease are common in women in their post reproductive years where hypertension and obesity contribute significantly. The male/female gap in cardiovascular disease mortality closes after the menopause, and in some populations older women are more at risk than older men. Indeed, in the Caribbean, cerebrovascular disease, hypertension and diabetes kill more women than men. This Subregion has the dubious distinction of having mortality rates from these diseases higher than in any other part of the Americas and it is pointed out there that heart disease is no longer the exclusive province of males.

Diabetes mellitus affects women more frequently than men and as pointed out above is a risk factor for cardiovascular disease. Osteoporosis is typically the woman's disease, and increasing longevity heightens the probability of serious consequences of this disease. In the United States of America, for example, 89% of women over the age of 75 suffer from osteoporosis and here, as in other countries, hip fractures are twice as common in females when there are accidental falls.

Violence against women is another issue that is increasingly causing concern in health circles and is being seen as a matter that should be addressed outside of as well as within the criminal justice system. Data are even more difficult to collect than in the traditional health areas as many cases are not reported and perhaps many more are unrecognized. But where there have been systematic attempts to record data, even though they may not be population based, they show a horrible picture of large numbers of women physically and mentally abused, most often within their domestic settings. In one country of this hemisphere, 70% of all crimes reported to the police were of women beaten by their husbands and another study showed that up to one third of women in hospital emergency departments were there because of injuries sustained as a result of domestic violence.

I have been selective in describing some of the health problems of women. I have deliberately omitted the issues related to adolescence, the communicable diseases, particularly AIDS, mental health, substance abuse and the health problems related to work and the work environment. It is possible to find examples of problems peculiar to women in all of these areas.

I propose to examine now these manifestations of ill health more globally in the light of the known determinants of health. What are the factors that determine women's health generally? Most of the data given above relate to mortality but we should be equally interested in those factors that make for healthy citizens and not only those that kill them. The seminal work in this area was the health fields concept elaborated by Lalonde, in which lifestyles, environment, human biology and health care were said to be the major determinants of health status. This served a very useful purpose for a while, but its rigid application led to an undue focus on individual risk factors, victimization of individuals for *unhealthy* practices and the rapid incorporation into the health care system of interventions aimed at correcting these apparently deviant individual behaviors. These concepts have been extended by Robert Evans and his co-workers and much more attention paid to the social environment and incorporation of the findings of close relationships between health and well-being and social class. Their work has dwelt more on the heterogeneities in health status and how they are determined and some of the most important for this discussion are differential susceptibility, individual lifestyle, physical environment, social environment and the differential access to care.

If these do affect health status of all persons, it is useful to examine how they apply to women and the extent to which gender rather than biology affects such health status. I would speculate that much of what is given as differential susceptibility to illness between men and women, apart from those aspects related to reproductive functions are gender determined. Gender discrimination may be such as to create the perception of social class differential that is known to find expression in health outcomes. It may well not be the actual class but the perception and practice resulting from the differences that may militate against women.

The social environment is another area in which gender biases many conspire against women. Levels of social support, emotional isolation, loss of self-esteem may all be gender driven. Women have differential access to health services. In most countries of Latin America and the Caribbean, the pride of the health services is the component dedicated to maternal and child care. Rarely do the services pay specific attention to the needs of women that are not related to their reproductive roles and it has often been suggested that women, in exercising their traditional maternal and caring role, neglect to care for their own needs. When services are readily available, economic circumstances often determine their use. It may well be that the rich are better informed and therefore appreciate more keenly the need for care: it may also be because there is more leisure time available to them. To the extent that women predominate among the poor, they will tend to use the services less often to address their own health problems.

There is a rich literature on client provider relationships in health care and the impact of gender in the care setting and we have encountered several attempts in our region to create what are called alternative women's health services, which are in general staffed by women and address women's needs. I confess for obvious reasons to a deep distrust of anything that smacks of separate but equal services. Experience has taught me that separate in these kinds of contexts usually means inferior and I am more attuned to advocating for changes in the normal services to make them more sensitive and friendly to women than to seek refuge in separation.

The burden of my argument is that there are several determinants of health status of women that are biologically driven, but those that are gender driven are not well elucidated. It is interesting to note in the work by Evans and his co-workers, one of the most exciting and authoritative presentations on the determinants of health, that the role of gender as influencing the social environment and the host response to various stresses that lead to one or other change in health was not explored. It is shown quite clearly that the place in the social hierarchy determines control and level of empowerment, but this is not addressed in relation to women's ability to adopt healthy habits or change unhealthy ones. An apparent paradox is that although there is widespread gender discrimination and downward displacement in the social hierarchy, women's life expectancy is still higher than that of males, which probably says a great deal for those other influences on male health that make for the male/female disparity.

The countries of the Americas have attempted to address some of these issues, and the Pan American Health Organization, over the past twenty-two years, has worked steadily to develop a program of technical cooperation in this area. In 1974, the XIX Pan American Sanitary Conference, recognizing the importance of 1975 as the International Women's Year, requested that PAHO promote the participation of women in the affairs of the Organization. Over the course of the years there were several reports on the activities related to women's health, and in 1981, a Special Subcommittee on Women in Health and Development was established. Indeed, a Regional Plan of Action on Women in Health and Development was designed and adopted that outlined activities for PAHO and for the Member States.

The focus of activities has changed with time and while the Organization has maintained attuned to the health problems of women in its program structure and activities, it has become clear that an equally important approach must be to demonstrate the gender biases in health and seek to address them. Thus, attention has been paid more recently to sensitizing PAHO staff itself to the importance of a gender perspective in our programs. By extension, we promote similar approaches

in Member States by working with a wide range of partners - private organizations, non governmental organizations and women's groups, in addition to the recognized government authorities, to stimulate the formation and acceptance of gender sensitive health policies.

We have initiated activities or collaborated with others in such fields as addressing the health impact on women and society of domestic violence, the communicable diseases and the health of indigenous women. This latter group is doubly affected — marginalized for ethnic and gender reasons with undoubted negative repercussions on its health.

As I indicated before, we believe that the issue for women's health and particularly that aspect that is gender determined is an important human development issue. The 1995 UNDP Human Development Report deals with the revolution for gender equality and has coined the felicitous phrase *Human development if not engendered, is endangered*. It points out the inequality between men and women that still exists in spite of the substantial progress made. This report says that it would appear that there has been more progress in education and health, but less with regard to political and economic opportunities. However, it is difficult to separate the gender discrimination in health from that in economics — they are inter-related in the same way as health and economic growth are related. To the extent that one can strive for and hopefully reach more gender equity in health, this will also contribute to an increased appreciation for economic gender equity. These considerations are apart from the obvious ones that the burden of ill health women bear makes them less than optimally productive members of a society. The apparent gains in health conditions of women should not diminish the intensity of the struggle for true gender equity. You will note that I use the word equity rather than equality as used in the United Nations Development Program (UNDP) report. This is deliberate, as there is a fine and important distinction in my mind in that I incorporate the notion of fairness in the term equity and see some notion of injustice in inequity which inequality does not quite transmit.

The policies that may impact on women's health and on health in general may be seen in relation to the determinants of health to which I have already alluded, and many of these will naturally arise outside the health sector. Most attention has been paid recently to the economic policies and the effect to which they have affected the individuals and their abilities to cope.

One of the best analyses of the economic experience of Latin America and the Caribbean has been developed by the Economic Commission for this Region. It describes how in the last part of the 1970's and early into the 1980's, the region prospered because of improvements in terms of trade and a spectacular inflow of external funds from institutions that found themselves embarrassingly liquid. Economies grew, but this situation could not continue indefinitely and in the mid 1980's the region was plunged into an economic recession with rapid deterioration of its economic and social indicators. Governments, as a part of their initial stabilization and subsequent adjustment programs, adopted measures that resulted in greater unemployment and a reduction in public expenditure overall.

The economic downturn led to a deterioration in health services, but in the majority of the countries it was difficult to find data that showed significant deterioration in the traditional health indicators. But we know that the number of the poor increased and given the preponderance of women in this group and the clear relationship between poverty and ill health, it is not unreasonable to assume that there was deterioration in the health status of women.

With the advent of the 1990's there was clear evidence of the success in economic terms of the policies adopted, and the economies of the region began to grow again. However, all the indicators point to an increase in the number of the poor as the benefit of economic recovery did not spread evenly through the population. Thus, we find many countries adopting programs that are directed towards alleviation of the social consequences of the economic changes. We find the major financial institutions lending more for the so called social sectors in the attempt to reduce poverty or to mitigate its impact. To the extent that poverty is alleviated, women should benefit automatically. However, there is a general perception that specific attention must be paid to the situation of women and we find targeted efforts at improving the earning capacity of women and their access to education with direct effects on them and collateral effects on the health of their children.

The policies related to the health services will affect women mainly in terms of care because, as has been noted, health care services *per se* have little impact on the overall health status of the population. The most important policy change in all the Americas is seen in the attempts to reform the health care system.

The reasons for this are multiple, but the most compelling one is that there should be more equity in the system. The most important aspects of the reform are the reorganization of the services and the search for better methods of financing. The key aspects of the reorganization include decentralization and the provision of a basic package of clinical services to all the population.

It is not immediately apparent that decentralization will have a specific impact on women's health, but with increased local autonomy, there is perhaps greater possibility of female involvement in decisions. Most of the approaches to basic services include maternal and child care and family planning which all relate to women's reproductive role and I have not detected in any of the proposals for essential clinical services, provisions for making them more friendly or attuned to women's needs.

One of the major problems with regard to policies and their effect on women's health is that in the majority of instances there is little appreciation of the gender implications at the levels and instances where policies are developed. It is not always even clear that there is appreciation of what policies are or are not healthy, and one of the major tasks of the health sector is precisely to argue for healthy public policy as was articulated so clearly in the Ottawa Charter on Health Promotion. An advance in that thinking is to ensure that healthy coordinated public policy is gender sensitive.

In theory, the majority of the Member States should be incorporating into law and practice the agreements that derive from the Women's Convention of 1979. This Convention obliges States parties to it *to pursue by all appropriate means and without delay a policy of eliminating discrimination against women*. Specific mention is made of discrimination in the field of health care and ensuring access to health services. The UN Human Rights Commission and the World Health Organization have elaborated general principles for the promotion and protection of women's health that address health status factors, health service factors and conditions affecting the health and well-being of women.

If these principles were observed, there would of course be implementation of the kinds of policies that would improve women's health. My distinct impression in viewing the health policies of our countries is that there is no shortage of appreciation of the importance of the factors that impact on the biologically determined aspects of women's health. It is in those aspects that are gender driven that there is weakness. Much of this is due to ignorance and it is here that I would challenge a group such as this. The change that we require can only come about when there is advocacy based on a cold appreciation of the need to view women's health problems differently. This is important not only for the health of women themselves — the health of women is not solely a women's issue. Self interest makes it imperative that it be an issue of human development, and I can ask you to engage in fewer things that are more important — the search for the melding of efforts of many people from many sectors to try to ensure that all of us have the best possible chance of exercising those options that should be open to us humans.

Your network is dedicated to health awareness, but I am sure that your concept of awareness is not a passive one and you believe that awareness is the first way-station on the road to understanding and action — I hope that my comments may have moved you a little way along that road. And let me urge you also to avoid that most pernicious of social diseases — complacency and to avoid the temptation to be mere potatoes on the couch of disengagement. Be involved!

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