

**GUIDE FOR THE FORMULATION OF PUBLIC BUDGETS IN
THE HEALTH SECTOR USING A GENDER PERSPECTIVE**

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The Guide is a contribution to the task of incorporating gender perspective in the design and formulation of public policy and constitutes one of the first steps in the area of programming and budget planning.

It has consolidated now in the development of a method for the elaboration of budgets using a gender perspective in the health sector, and in the knowledge and experience collected and shared in the last few years by different organizations in general, women's organizations in particular, and some individual women to whom we owe our infinite gratitude, some, for having paved the road before us, and others, for walking next to us on our way.

We would equally like to thank the financial support provided by the United Nations Development Fund for Women, **UNIFEM**, for making this project, now materialized as the present Guide, possible.

Finally, it is important to mention all the participants in the Workshop in which the main concepts found in this document were discussed, because their input was fundamental to the conclusion of this document; we express our gratitude to all of them; for their huge contributions, they deserve special recognition. Their names follow:

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Presentation

The first strategy of the 2001-2006 National Health Program is about “linking health with economic and social development”. It includes a line of action dedicated to the promotion of gender perspective in the health sector, in which the National Centre for Gender Equality and Reproductive Health is the organism in charge of providing technical advice and support to the areas responsible for the design, regulation, execution and evaluation of the health programs, so that they may incorporate said perspective in their activities.

So, in compliance with the values and principles defined in the aforementioned Program, it was established as a goal, within the “Woman and Health” Action Program, that by the year 2015 the programs, projects, and services in the health sector must be designed, budgeted and evaluated with a gender equality perspective, so that men and women’s particular health needs may be seen to, in function of their assigned social roles, and allowing each one of them may take on their full responsibility in the prevention, attention to and eradication of sexual and family violence.

As a part of this process, gender sensitive budgets are an essential tool in the making of policy directed towards reaching equality between men and women. An analysis that considers the different needs, conditions and positions of men and women allows the design of policy and programs that provide real solutions to social problems, as well as making the best of existing resources.

Gender sensitive health budgets provide the opportunity to identify differences in risk exposure, state health perception, access, use and quality of health services associated to gender condition, as well as possible actions for reducing said differences through efficiently focused programs.

Formulating gender sensitive budgets for health issues does not mean, as it is commonly perceived, to quantify the amount spent on services for women, but rather to assign resources to activities that allow the elimination of the barriers that gender imposes, mainly on women, on the access to health protection services.

Besides the ethical principles and social justice that this vision implies, the cross-referencing of gender perspective in the budget must translate into more efficient policies and programs, because it allows the identification of needs and appropriate solutions for different segments of the target population, resulting in more equality in health issues for all Mexicans.

In Mexico, government efforts towards budgets using a gender equality perspective in the health sector started in 2001. Before this date, several civil organizations had performed an analysis of gender perspective in budgets for health issues, among them: Fundar: Centro de Análisis e Investigación (FUNDAR, Centre for Analysis and Research), Equidad de Género: Ciudadanía, Trabajo y Familia (Gender

Equality: Citizenship, Work and Family), and Milenio Feminista (Feminist Millennium). Worldwide, there have been similar analysis projects applied to public social development budgets from this perspective; nevertheless, we did not find a valid method for the elaboration of government budget that took into consideration the impact of gender on education, health, labour or housing needs.

In 2002, the Ministry of Health, in collaboration with the three aforementioned organizations, and with technical and financial support from the United Nations Development Fund for Women, UNIFEM, made its first attempt at designing a methodology with that goal. At this moment, and with the participation of Cover Amplification Program officials, we managed to create a document that brought the basic concepts and elements of gender sensitive budgets closer to health professionals.

For 2003, we have taken on the challenge of elaborating a methodological instrument that allows those who are responsible for the programs to build, step by step, a budget Project that incorporates a gender equality perspective. To this end, we have looked for strategic association with those responsible for a program in which gender agenda was relevant, and who, because of this, would be interested in collaborating with this Inter-institutional workgroup, as was the case of the National Centre for the Prevention and Control of HIV/AIDS (CENSIDA).

The result of this effort is presented now; we are convinced that we have taken one more step towards the construction of practical tools that will allow the decision makers and those who are responsible for programs in the public health field, to take into account gender impact as part of the axis of analysis in their future programming and budgeting activities, and provide them with the elements necessary to include this vision in the health issues that it is their duty to attend.

This Guide is made up of five chapters, the first of which presents the basic concepts surrounding gender and gender sensitive budgets, for those readers who have not had access to our former document, or others of a similar subject. Chapter two is, in a manner of speaking, the heart of this Guide. The path towards the establishment of a budget project that includes gender equality perspective through a six step sequence is shown. A series of questions is proposed to develop each step, so that the user may identify gender inequalities associated to the problem at hand and the possible means for reducing these, a prioritization exercise, budget assignment or reassignment and finally, the creation of follow-up indicators to see if the measures implemented have reduced the detected gender inequalities. In the third chapter, there is a summary of the implementation of the Guide's method in the process of budget projection for the HIV/AIDS prevention and control program in the state of Michoacán. The fourth chapter mentions a series of factors necessary for the extension of gender sensitive budgets to government management in Mexico, and finally, chapter five presents a series of recommendations for those responsible of management units, through which gender equality perspective may be incorporated into the budget programming process.

The National Centre for Gender Equality and Reproductive Health is committed to the promotion of gender equality in all health issues, and hopes that this Guide contributes to the formulation of gender sensitive budgets, not only within the Ministry of Health and State Health Services, but in all institutions in the health sector, and that it functions as a much needed tool to achieve this purpose.

Dr. Patricia Uribe Zúñiga
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Introduction

The 2001-2006 National Development Plan and the corresponding National Health Program establish, as their criteria for the definition and design of public policy, the inclusion of gender perspective, and they both show that the actions developed in healthcare services must strive to diminish the inequalities found among the Mexican population.

With this in mind, and the fact that the objective to place into effect this definition of public policy shows the president's decision to incorporate gender perspective in health programs, this Guide has been developed so that the "Budget Projects"¹ can be completed using a gender perspective.

This document's main goal is to guide those in charge of Budget Projects in the Ministry of Health and other state run organisms in the inclusion of a gender perspective into all health programs and budgets.

Thus, the Guide becomes an aid towards the fulfilment of the purpose determined by the Ministry of Health of attaining greater equality in the impact of its programs for different population groups that require their service: women, men, boys, girls, youth, the elderly, the handicapped, and groups of diverse sexual orientation.

The proposal presented here to incorporate a gender equality perspective in the programming and budgets of the Ministry of Health has its own methodology for the elaboration of budgets and programs and includes, as a part of this process, a series of questions from a gender point of view for further reflection.

The inclusion of gender perspective in public policy must help define the activities necessary to close the existing gender inequality gap, and assign the corresponding resources for proper execution. We are convinced that the persistent exercise of new resource distribution based on this perspective will achieve a substantial favourable impact on the population benefited by these programs.

This new perspective seeks, as well, to improve the efficiency of the exercise of available resources, by tending to the needs of the objective population by specific groups, and to therefore achieve a more complete coverage of the benefiting population. In consequence, it is a means for the Ministry to reach its goals of lessening inequalities and attaining a more efficient exercise of its budget.

We must point out that the proposal presented here is merely one more step on the road towards the inclusion of gender perspective and one of the existing alternatives to reach this goal, and we must accept that the inclusion of gender

¹ Starting in 2004, the Annual Operative Programs (*Programas Operativos Anuales*, or POA) will be called Budget Projects (*Proyectos Presupuestales*), and are the basis for the formulation of the government Budget for 2005.

perspective in public policy is a long term process that requires a great number of cultural and institutional changes, which can only be thought of as “on the horizon”.

The Guide for the formation of gender sensitive budgets in the Ministry of Health seeks to offer a new possibility and step towards our goal: a fairer and more equal society in our country.

1. What We Understand by Gender and by Budgets with a Gender Perspective

Gender is the cultural construction of sexual difference in any given society, and must be thought of as a construction of what is masculine and what is feminine, expressed as the ideas and practices of that which society believes, accepts and expects of the conduct of men and women².

Gender is, all in all, the system of representations, symbols, values, norms and practices that societies determinately build and impose on men and women, stemming from their sexual difference³, and it is the basis for the assignment of different roles, functions and attributions to men and women.

Now, we must also clearly define the meaning of incorporating the gender factor in the formulation of plans, programs and budgets⁴.

This process includes, in the first place, the observation of the way men and women relate in our society and question said relationships from three fundamental aspects⁵:

1. Recognition of an unequal distribution of power between men and women.
2. Recognition of the value of women's work and their input to income formation and family patrimony, and thus, to national income.
3. The differentiated impact that public policy has on women and men.

Questioning these three aspects refers to the following:

1. In examining the effects of public policy, we must recognize that there is an unequal distribution of power in our society, because in social as well as personal relationships, women usually occupy a position of subordination. As a result of this, women experience discrimination in many spaces and limitations on their capacity to make decisions concerning their person, economic resources in the home, and even the distribution, use and priorities of their own time.

In the context of reproductive health, many women depend on the decision of their partner (or other members of the family) to use any contraceptive method

² See LAMAS, Martha (1986) and REVELO B., Patricia (1996).

³ Said system is part of the culture of a certain time period, which means that it is a dynamic and ever-changing process, and always susceptible to transformation.

⁴ See SEN, Gita (2001).

⁵ See HIMMELWEIT, Susan (2002).

or to determine when to become pregnant, which is a clear example of a way this unequal power distribution manifests itself.

2. It should be taken into consideration that, in most cases, women take care of domestic work and child rearing, in other words, activities that include attending, cleaning and maintaining the family, as well as the children's education, and all of these activities take place in the home. Thus, their contribution is of great importance to the economy of a country. Nonetheless, these tasks are not valued in economic terms, and are usually not even considered work. In consequence, it is assumed that women's time, in the case of those who do not work outside of the home, lacks "social value" and could be destined to waiting time or used for voluntary community work.

It is fundamental to keep this aspect in mind when analyzing public health policy, because it can be extremely relevant, i.e., in the definition of epidemiological profile and the writing up of patients' clinical histories. For example, when, under the occupation heading, women answer that they are full time housewives, this is not considered work, and when they are not the patients, it is assumed that they have the time to tend to sick relatives because they "do not work".

3. It is necessary to carefully study the differentiated impact of public policy on men and women. For example, reduction of public spending on health, which implies less hospitalization time for ill people, has a different impact on men and women, due to the caregiver role assigned to women in our society. They are responsible for tending to the children, the elderly, and the ill in the family, and even the community, so reduction in public spending on health produces a different effect on women, which manifests itself as extra work for them.

In general, it is important to reiterate that sexual division of labour and gender roles assigned to it have a differentiated impact on exposure to health risks, the perception of healthcare needs and the use of the corresponding services, facts that can generate major inequalities. Because of this, for example, women are exposed for longer periods of time than men to pollutants in the home environment, such as the emissions of gas stoves or even worse, wood stoves in rural areas, and to accidents in the home.

Men, as part of their gender role, "must" be capable of taking risks and coming out on top, show their abilities as income providers in an increasingly unstable labour environment and permanently show their virility and be able to keep up a "satisfactory" sexual performance. Meanwhile, women's gender role gives a greater importance to their condition as caretakers and to the attention they give to family health, associated with their reproductive function and capacity.

Gender perspective does not only seek to identify existent inequalities based on gender differences, but more importantly, once they have been recognized, to find

a way of eliminating them, especially in the designing of public policy, which must propose concrete actions for attending the differentiated needs of men and women, recognizing existing inequalities in order to eliminate them.

At this point, it is convenient to emphasize that gender perspective has the purpose of pointing out and trying to suppress not only the inequalities that affect women, but also those that affect men in situations in which they are excluded, or where their needs are not tended to quickly and sufficiently.

One example that expresses gender inequality for men is when, in their condition as workers, they do not have the access to day-care services unless they are widowers or single fathers with custody of their children, because it is assumed that, being men, they have no need of these services. It is not conceived that they would have child-rearing and -care responsibilities, because it is generally assumed that this is the “exclusive” duty of women. Another form of gender inequality that affects men, in the health sector, is the excessive risk of traffic accidents and social violence events that their male role induces them to face.

In this context, as seen from public policy design, differentiated attention to the specific needs of different social groups implies the development of concrete actions and strategies directed towards closing the gaps of inequality, with the corresponding resource assignment to achieve it.

In this Guide, we present a proposal for the formulation of public programs and budgets from the gender equality perspective.

From what has been said so far, it is easy to understand that a public budget focused on gender equality or using a gender equality perspective (or gender sensitive budget, as they are sometimes called) is one in which necessary and sufficient funds are considered to put into effect specific actions to eliminate gaps of inequality between the genders through attentions to the differentiated needs of diverse groups of men and women.

Gender sensitive budget initiatives require two steps: first, analysis of the situation and then budget formulation.

Analysis of public budgets from a gender equality perspective stems from recognition of the basic fact that the assignment and use of public resources does not have a neutral effect or, in consequence, the same impact on different social groups. When the distribution of said resources has been decided without analyzing unequal relationships between the genders, the result usually creates or reaffirms culturally established inequality conditions and unbalance in power relations between different social groups.

On the other hand, gender focused public budget analysis allows the neutrality of impact on men and women to be questioned, from the design of the programs to the exercise of public funds, by understanding that proper social role assignment between people comes with unequal power distribution among them, and that this is reflected in the effects of public policy.

In effect, this type of analysis allows visualization of how women's work makes an important contribution to the operation of some public programs, health programs among these, as is the case of the Increased Cover Program and now, the Equal Start in Life Program, which represents a heavier workload for women⁶.

Although there are other types of inequalities, gender focused public budget analysis specifically attends those that are gender related, and its methodology seeks to make them evident in the process of public funds assignment.

Formulation of budgets using a gender perspective consists of the incorporation of a gender equality perspective into Budget Projects (*Proyectos de Presupuesto*) (once called Annual Operative Programs -- *Programas Operativos Anuales* or *POA*). This is to say that the three fundamental aspects must be kept in mind when formulating a budget: 1) unequal power distribution between men and women; 2) value of housework, generally done by women; and 3) the differentiated impact of public spending on both. The goal is to take into account and satisfy the specific needs of the population equally. By doing this, greater levels of efficiency and transparency in public funds management can be reached.

It is important to point out that gender focused budgets are not budgets that have been made separately, nor are they budgets made exclusively for women. What they are is budgets, formulated in a different way and with a new presentation, that reflect the inclusion of the gender equality concept as well as the differentiated needs and interests of the beneficiary population based on sex, age and/or condition when it comes to access to public health services.

In the next chapter, the way this process is put into action is explained.

⁶ PÉREZ F., Lucía C., and MARTÍNEZ, M., M^a Concepción (2004).

2. How Budgets Using a Gender Perspective are Elaborated

The formulation of gender sensitive public budgets implies, as a previous step, the design of public policy with the same concept of gender equality. In order to achieve this, we explain how to include this perspective both in the programming phase and in the budgeting phase in this chapter.

This Guide has been developed to help conduct the inclusion of gender equality perspective in the programming and budgeting processes of the Ministry of Health and State Health Services. The formulation of gender sensitive budgets has the goal of achieving a more efficient resource management that can bring about more effective results in tending to the health needs of diverse population groups.

Thus, the Guide constitutes a tool for those responsible of different health programs to include the goals and resources necessary to reduce gender inequalities into methodologies and procedures already in use.

In all programming process, a diagnosis is the start point, which is why the Guide establishes as its first step a revision of the diagnosis on which the system is based, this time including gender perspective. It is precisely in this phase where gender inequality problems should be detected and, based on this information, definitions, objectives, criteria, priorities strategies and courses of action for public policy established.

For this reason, gender equality criteria must be included in the first stage, so that they are later reflected in all the components of the program, meaning the objectives, strategies and actions that are designed to tend to the specific needs of the benefiting population.

Subsequently, the assignment of resources using criteria of this nature derives from what is established in corresponding programs and policy, because of which the budgeting phase must reflect, in any way necessary, the incorporation of gender equality perspective.

The development of the guide and its design are based on the programming and budgeting processes that are now used in the Ministry of Health, as well as the formats used for the integration of respective Budget Projects, so that they will be applied together with the current programming and budgeting procedures.

THE GUIDE

In order to make the instrumentation of the Guide easier, three moments or phases have been identified: diagnosis, programming and budgeting. Each one of these phases is associated to the realization of two steps or activities that must be

developed as part of the phase. Thus, this Guide consists of six steps that follow a sequential and cyclical order, depending on their corresponding phases. The steps are as follows:

DIAGNOSIS

1. Revision and analysis of the diagnosis using a gender equality perspective.
2. Analysis of gender inequalities.

PROGRAMMING

3. Determination of components and actions.
4. Definition of priorities.

BUDGETING

5. Assignment of resources for the correction of gender inequalities.
6. Indicator design.

The diagram on the **next** page shows the way these steps are organized and sequenced. Because their development is cyclic, and depends on the previous activities, application of the Guide can be started at the corresponding step. We assume that, given the determination expressed by the Ministry of Health to include gender equality perspective in its programs, some general direction or management units have probably already taken some actions towards achieving our goal. Because of this, there is the possibility of beginning the process at any step, and not only the first.

For example, if there is already a diagnosis and a course of action has been defined, in both cases taking into account gender equality perspective, the process can be started at step 3.

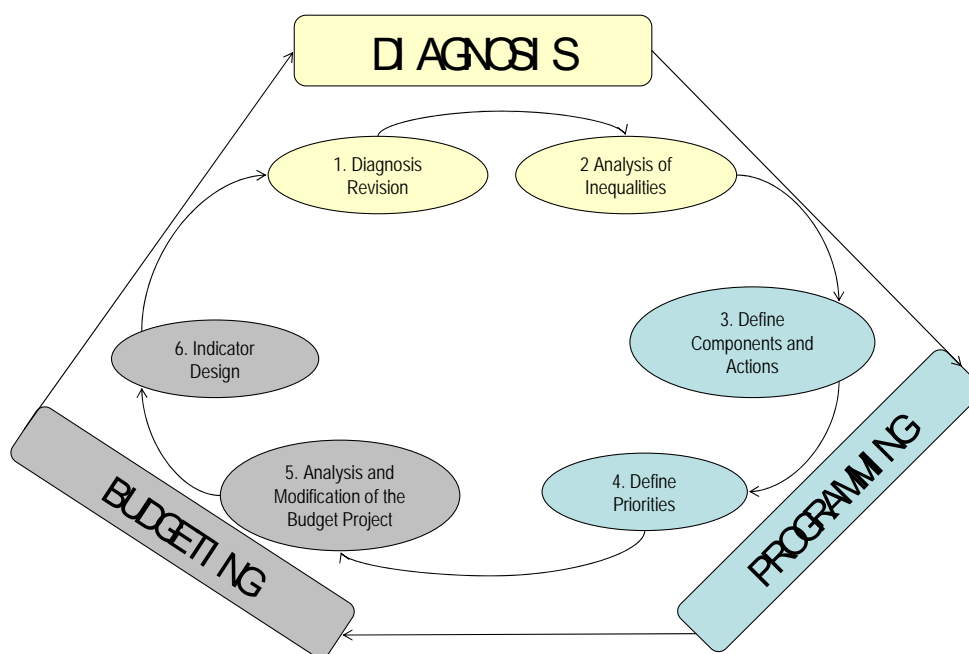
Who is in Charge of Putting this Guide into Effect?

The administration of the process must be taken on by those responsible for the technical areas of the program, which are capable of making decisions about the inclusion of criteria that reflect gender perspective. Besides, it is necessary to name a person responsible of the corresponding information area.

At least one of the people who are technically responsible for the program must have received gender perspective sensitivity training. If no one in the department

has received this training, the Ministry's Centre for Gender Equality can provide counselling on the subject.

STEPS FOR THE FORMULATION OF GENDER SENSITIVE BUDGETS



Development of the Steps in the Guide

The main steps for developing the process are as follows:

1. Revision and analysis of the diagnosis from the gender equality perspective.

Every program –in principle– bases its actions on a diagnosis of the problem it intends to solve, so the first step of this Guide consists in analyzing said diagnosis with the following in mind: a) the different roles that society deems as worthy for men and women, and b) the way in which differentiation between what is male and what is female affects or may affect the problem referred to, in order to review if both elements have been considered in the program.

The specific objective of this step is to have a diagnosis that includes gender inequality criteria, and in the case that it does not, to point out the measures to be taken for it to include this criteria.

It is understood that a diagnosis has been made considering gender perspective when it allows one to know the specific situation by groups of beneficiaries, from this particular point on view.

A diagnosis of this nature requires disintegrated information of all the different beneficiary groups of the program, by sex, age and relevant socio-demographic and epidemiological characteristics, from the point of view of attention to specific problems.

To know if the diagnosis incorporates gender differences and allows identification of the existing inequalities, we suggest starting the reflection process with the following questions:

- ✓ Did the diagnosis of specific health needs take into account different focus groups or was it made in a general fashion for all of the affected population in conjunction?
- ✓ Is the information in the diagnosis disintegrated by sex, age, epidemiological condition and specific access and use of healthcare services characteristics?
- ✓ Does it take into account the differentiated impact that disease, or health attention, has on the groups of people involved?

2. Analysis of gender inequalities.

Development of this step should allow identification of unequal conditions in: a) risk of becoming ill, b) perception of the health-illness condition, c) demand of attention and d) access and use of healthcare services, derived from the influence of gender differentiation. It should also show how different forms of social relationships between men and women determine certain unequal conditions, discrimination or lack of attention to their healthcare needs, and/or those of different beneficiary groups of the program.

To perform this analysis, we propose, once again, a series of guide questions:

- ✓ Does the diagnosis provide enough elements to know how gender inequality affects a person's possibility of being at risk for health problems?

- ✓ Does it determine risk condition for illnesses by gender and differentiated groups, as well as possible causes?
- ✓ What are men's and women's particular problems or difficulties in accessing health services?
- ✓ Can inequalities in attention to specific healthcare needs be seen?
- ✓ Were asymmetries in quality of attention for different parts of the objective population detected?
- ✓ Are funds assigned to determine which groups are most affected by health problems and to seek the possible relationship between this fact and gender condition?
- ✓ Do the programs' goals reflect concern for equality between women and men, and for the avoidance of discrimination in attention and access to healthcare services?

Once the questions above have been answered there will be advances in the construction of a diagnosis using gender perspective. In consequence, the factors or elements that are incorporated (or identified to be incorporated) to the diagnosis in order to reflect a more equal treatment for different population should be taken into account in the following programming stage processes.

3. Determination of components and actions.

The specific goal of this step is to establish strategic courses of action, or adapt the existing ones, to correct discrimination in attention to healthcare needs or problems, as well as those problems that arise during treatment or access to corresponding services.

To achieve it, we must ask ourselves if the strategies and components of the program already include actions directed towards reducing inequalities. If they do not, the diagnosis will serve as the basis to determine the pertinent strategic actions in order to correct the asymmetries identified.

The suggested way to determine said actions is to answer the following questions:

- ✓ In each of the components of the program, what are the priority actions and who is the beneficiary population?
- ✓ In what way are the different needs of men and women taken care of?
- ✓ Are specific actions taken and funds assigned for the most vulnerable groups, or for those most affected by a particular healthcare problem?

- ✓ Starting with the current budget, what type of components are assigned the most funds?
- ✓ Does this fund assignment have any effect on or diminish unequal attention to groups that require healthcare services?
- ✓ What type of actions would it be necessary to add to the program and consider in the budget to achieve greater equality and efficiency in the attention of the healthcare needs of affected groups?

4. Definition of priorities.

The specific objective of this step is to define the order of and set priorities for the proposed courses of action, as well as those already in existence. It is important to choose the strategies and actions with the most impact on gender equality and those that could make the greatest contributions towards closing the existing gaps.

Thus, this step consists in analyzing if the established hierarchy in the program corresponds with the objectives of correcting inequalities, or if it is necessary to determine a different order of priorities with the defined courses of action.

Once the actions and strategies that must be put into effect to cover healthcare needs in an equal way among the different groups of the objective population have been identified and determined, it is necessary to establish the correct order of priorities for such actions.

To define the priority level of each action, the following elements are proposed as a guide for discussion:

- ✓ Based on the program's objectives and the gender focused diagnosis, how would you re-order the actions?
- ✓ Do you consider the components, actions and strategies implemented by the program enough to battle gender impact?
- ✓ What actions and strategies would it be necessary to redesign or reformulate to make the program more equal? Should new actions and strategies be added in order to achieve this goal?
- ✓ Can these actions and strategies be assimilated –with some adjustments– to those that already exist?
- ✓ How could the objectives and goals on the program be reformulated to consider gender equality priorities?

The priorities established must contribute to define those actions that, depending on available resources, are feasible, without forgetting that it is desirable that all of the actions included in the program should seek to contribute, in one way or another, to achieve gender equality in attention to groups.

Execution of this step provides the opportunity to reformulate, at least partially, through the annual realization of the Budget Project, some of the elements of the program in which gender perspective can begin to be incorporated.

The reflection brought about by the questions included in each of the steps of this Guide seeks to provide a **gender focused programming**. Since what has been investigated up to this point can be systematized and integrated into the corresponding program as new criteria for resource assignment, this is precisely the phase previous to the elaboration of a budget that includes gender perspective.

This is not, at least in the beginning, about rewriting or completely substituting the existing programs, but incorporating gender equality criteria little by little, so that they can become the basis for inclusion in the next step of government programming.

The objective is to include a vision of gender equality in the frame that defines health program public policy, in order to translate it into part of their objectives and actions.

The above intends to establish, as part of the objectives and the priority of the actions defined to reach them, the objective of greater equality in the attention given to healthcare needs among the population that benefits from the programs.

When a program has been built using gender perspective, a budgeting process with the same perspective is logically and almost automatically derived from this.

The very program defines, in itself, the budget assignment criteria for the strategies chosen, depending on the set priorities, all of which is reflected in Budget Projects.

5. Assignment of resources for the correction of gender inequalities.

Determination of objectives and corresponding actions, as well as the established components and priorities, must bring about the assignment of the necessary funds to place them into action, which consequently, implies including them in the Budget Project structure.

In order to do this, it is important, first off, to review and analyze them, to be able to identify the part of the existing program structure in which the funds can be assigned, of if it is necessary to include other headings in the current structure.

The following questions can guide this analysis:

- ✓ In which of the existing headings could the necessary funds for the actions directed towards achieving gender equality be included?, and/or in which of the components that have already been established can new headings be included for resource assignment with this purpose?
- ✓ Is it necessary to invest resources to document, with hard data (through operative investigation or changes to the existing information systems), the possible gender inequalities that affect health, in the aspects that the program in question covers?
- ✓ Would resources tagged for differentiated groups be necessary due to their condition facing a certain problem and in function of their needs?
- ✓ What specific actions would have tagged resources?
- ✓ How would the reformulation of actions and strategies, and resources tagged for specific actions, be expressed in the outline of the Budget Project?
- ✓ Is it necessary to assign, in the training heading, specific resources for the gender equality issue, both for the officials who design the programs or are involved in their development and for the personnel who operates them?

Formulated in this way, gender sensitive budgets must be the foundation for further actions in the inclusion of gender perspective in later programming processes and the definition of public policy.

It is understood that it is desirable to employ, as much as possible, the same structure and formats for Budget Projects (previously *POAs*) that are currently used in administrative procedures. Nonetheless, if it is necessary, these may be modified to include the concepts that refer to the objective of achieving gender equality in the demand, access and use of healthcare services as well as the attention provided.

6. Indicator design.

The last step corresponds to indicator design, which must reflect the program's impact and the effect of the corresponding resource assignment, in terms of achieving greater gender equality.

The specific goal of this step is to provide evaluation parameters to measure the result of actions and their corresponding budget assignments, through which we

seek to reduce gender and inequality gaps. This evaluation, of course, will be the basis for the establishment of criteria, as well as the preparation and development of the next project.

The design of said indicators should be oriented towards evaluating the complete project in a comprehensive manner. In the short run, it should include process and result indicators, and impact indicators should be added in the long run.

Development of the steps described will lead to the inclusion of gender equality perspective in subsequent programming and budgeting processes.

3. An Applied Example: The COESIDA Budget Project in Michoacán

Introduction

In this chapter we present an example of the Guide's application in the formulation of gender sensitive budgets.

With the objective of putting the present Guide in practice, it was decided to work with a dependency of the Ministry of Health in charge of coordinating the actions of a program of national reach and that had a permanent relationship with the development of programs and budgets at a state level. The National Centre for the Control and Prevention of HIV/Aids (*Centro Nacional para la Prevención y Control del VIH/Sida --CENSIDA*) was selected.

CENSIDA personnel provided both the basis and the necessary information to obtain a diagnosis on the HIV/Aids issue, as well as the data necessary to adapt the Guide to all the aspects and problems linked with HIV/Aids.

In order to achieve the practical exercise that comes with the application of this Guide, four state healthcare services that face different issues related to the HIV/Aids epidemic were invited: Chihuahua, Michoacán, Mexico State and Morelos.

The Second Gender Sensitive Budgets Seminar-Workshop took place from June 2nd to June 4th of 2003, with the participation of the Women and Health Program Coordination, now the National Centre of Gender Equality and Reproductive Health (*Centro Nacional de Equidad de Género y Salud Reproductiva*), CENSIDA, the heads of the state programs mentioned above, FUNDAR Centre for Research and Analysis (*FUNDAR, Centro de Análisis e Investigación A. C.*), and Gender Equality: Citizenship, Work and Family (*Equidad de Género: Ciudadanía, Trabajo y Familia A. C.*).

During the Workshop, state teams made up of directive personnel from each state worked together with one person from each of the participation institutions.

As an example of use of the Guide for the Formulation of Gender Sensitive Budgets, the results obtained by the group from Michoacán were selected, not only because of these results but because the state has a well defined program that is already in execution, in which only a few changes had to be made.

What follows is a summary of the work done to rewrite COESIDA Michoacán's 2004 Project Budget.

Before beginning the exercise in the Workshop, personnel from all four state COESIDAs were asked to present the following information:

- State Program
- Epidemiological Diagnosis
- Information disintegrated by age and by sex

Besides this, a working document was written up: **Gender, Budgets and HIV/Aids** (*Género, Presupuestos y VIH/Sida*), containing a brief introduction to the subjects that were to be worked on in the Seminar, where a common work basis was established and terms like gender and gender sensitive budget were defined. This document, which proved very useful, can be consulted in Attachment 1.

Attachment 2 contains the list of questions used to lead the activities shown in the Guide, and that were adapted for the case of the HIV/Aids epidemic. To complement these two attachments, Attachment 3 includes the results of the same exercise for the other three participating states.

DEVELOPMENT OF THE GUIDE'S STEPS

STEP 1

Revision and Analysis of the Diagnosis from the Gender Equality Perspective

According to what has been established in the Guide, *a gender focused diagnosis requires disintegrated information for different groups of beneficiaries by sex, age and relevant socio-demographic and epidemiological characteristics, to provide attention for specific problems.*

The diagnosis that COESIDA Michoacán has made, on the whole, taking into account these criteria, because the information is separated under different socio-demographic criteria, with added information that refers to different risk practices in vulnerable groups, and includes relevant information from the point of view of the different epidemiological profiles of each group.

The discussion at Michoacán's work table and the information the heads of the state's program provided lead to the establishment of the following results when answering the questions contained in step 1.

1. COESIDA Michoacán's epidemiological diagnosis presents an advance in the inclusion of gender equality perspective. Their diagnosis is very detailed and provides all information separated by age and sex. It also includes data

about marital status, occupation, studies, sexual practices and transmission category, by area and risk group, besides other details, obtained by “Centinela” surveys and from their administrative records. This information constitutes a foundation of great importance for integration of a diagnosis based on gender perspective.

Nevertheless, the diagnosis can be enriched with relative information about the age at which patients become sexually active, and the incidence of HIV/Aids among different ethnic groups. It would also be convenient to divide the information about means of sexual transmission of the infection by sex, and to divide the total data by year, because if it provides only accumulated figures, you cannot observe de dynamics the disease has followed in the state.

- ☞ The State of Michoacán presented its first HIV cases in 1985; its tendency was initially rural, due to the fact that migrating population (mostly male) was the main carrier of the disease, but this has changed with time.
- ☞ Today the epidemic is urban for the most part, and sexual transmission is the first cause of infection.
- ☞ In the specific case of women, the source of transmission in 100% of reported cases is sexual.
- ☞ Of all the registered HIV cases, 81% are in men, while infected women make up only the remaining 19%.
- ☞ Approximately 30% of registered cases of infection are men who have sexual encounters with other men.
- ☞ In 2002, the total number if HIV/Aids deaths was 72.
- ☞ Cases detected in women have been on the rise ever since the disease was first found in Michoacán. In the 80’s, the man-woman ratio was 13:1, now it is 4:1, above the national average (6:1).

2. COESIDA Michoacán’s diagnosis clearly establishes the specific risk position for women and their condition facing the disease, particularly the group of women that are fulltime housewives, which it defines as one of the groups most vulnerable to sexually transmitted diseases (STD), including HIV/Aids.

In virtue of all we have shown, we can only add how cultural gender aspects may be affecting this risk position. For example, prejudice can prevent

women from getting tested for HIV when they suspect possible infection, especially in the case of women whose partner is a migrant, which is a relevant aspect; given that Michoacán is a state with very high migration.

In addition, and taking advantage of the information that is already divided by sex, even within the risk groups, some man/woman ratio for different variables could be calculated, such as: HIV carriers, detection and medical treatment demand, number of detections per group and per risky practices. This would allow a comprehensive analysis of the state of infection between men and women, as well as the prevailing of HIV in both, and in each group.

3. To summarize, the workgroup concluded that by adding this information to the diagnosis, the way the disease affects men and women grouped under different vulnerability criteria in different ways can be seen.

STEP 2

Analysis of Gender Inequalities

As it has been already pointed out, a diagnosis based on gender perspective allows knowledge of the specific situation by beneficiary groups, identifies unequal conditions in access to, attention and use of healthcare services, and evaluates differentiated impact based on sex, age and/or gender condition facing health problems, in the application of programs.

When answering the questions corresponding to this step, the following results were found:

1. COESIDA Michoacán's diagnosis already signals out, appropriately, fear of discrimination as a source of inequality in the program application, and that becomes an obstacle both for the demand and the access to healthcare services.

The diagnosis clearly shows that women are one of the groups most vulnerable to STDs, and particularly to HIV. In the discussion pertaining to identification of inequalities, the group determined that the risk of exposure is greater for full time housewives, especially partners or wives of migrants, because they consider their sexual relations safe and secure, even though that may not be the case.

Women's risk of exposure was analyzed in terms of the subordinated condition in power relationships between men and women that is imposed upon them, which is why women don't have, in many cases, negotiation capacity in relation to condom use, or, any possibility to guarantee safe sexual relations; the very mention of the subject turns them into "suspects",

instead of them being seen as human beings who demand the right to protect themselves from any possible risk.

Thus, this gender inequality affects not only the cultural concepts linked to different sexual practices, but women's risk condition in exposure to HIV by sexual contact. As we have mentioned before, sexual contact is the main form of infection.

Frequently, infected women remain ignorant of their condition because their partners don't warn them of the risk. This is even more common among married women.

☞ Most of the women who get tested for HIV are pregnant women (perinatal transmission group), who are regularly and persistently offered the test since 2003. Up until May of the same year, there had only been one case detected.

☞ Out of 29,143 pregnant women en 2002, 2,077 were tested for HIV, 7% had a record of previous STD or knew that their mates were positive or migrants who had had tuberculosis.

2. It is well known that men who have sexual relations with other men (MSM) are the group most affected by the infection and that, like women, fear of discrimination and stigma is an important obstacle preventing their access to healthcare services.

In fact, there is a strong stigmatization component related to HIV/Aids for all the groups at risk, including Injectable Drugs Users (IDU) and Commercial Sex Workers (CSW), which does not depend on their sexual preferences.

3. In Michoacán's case, it is assumed at many health centres that people who go to get tested can lie about their sexual practices, because of fear of being stigmatized. This can happen especially with MSM, who register as heterosexuals.

According to the program leaders in Michoacán, in general, the discrimination factor is much higher with second level medical attention than at the first level.

- ☞ The program itself has been careful to avoid unequal or discriminatory treatment of any of the risk groups; in the epidemiological watch that has been in effect since 2001, there has even been an effort to increase the sample groups to include migrants, taxi drivers, truck drivers (especially during harvest season), and prison inmates.
- ☞ The epidemiological watch includes the gathering of 25,000 samples among the identified risk groups.

4. The information above can be included in the goals of the state program's components, with the purpose of taking into account gender inequalities that stem from the cultural aspects that have been already discussed in order to attain equal treatment and attention for different risk groups, and thus eliminate discriminatory practices derived from prejudice about different sexual practices.
5. Another element that creates inequalities is what the Program authorities call "echo issues", that refer to immediate disclosure of events or news, given the small localities the happen in and the fact that in many cases, healthcare workers are fiends or relatives of the people seeking to be tested for HIV or medical attention.
6. Because Michoacán's Program has identified the groups most at risk, and the transmission category as the most important element of the epidemiological profile in attending the disease, some actions have been established specifically directed towards high risk groups, as in the case of MSM.

Lastly, it is important to point out in this step that the inequalities detected in attention to the illness and access to healthcare services do not stem from the program itself but, in some cases, from discriminating and stigmatizing attitudes of healthcare service providers. These can be partly attributed to a lack of training in patient and service beneficiary handling.

Once the sources of inequality have been identified, and with them, the activities corresponding to the diagnosis phase, we must proceed to those that refer to the programming phase.

STEP 3

Determination of Specific Components and Actions for Reducing Inequalities

Development of this step is based on the revision of the components and actions that Michoacán State's program already considers, in order to determine which of these would have to be rewritten or established to achieve greater equality in the program's application. Currently, it is made up of five components that are the same ones that were established for the whole country:

1. Sexual prevention
2. Perinatal prevention
3. Blood transmission prevention
4. Complete attention for women infected with HIV/Aids or STDs
5. Damage control

In function of the result of the diagnosis, the program's actions seek to include strategies directed more and more towards high risk groups. This is the case of MSM, full time "housewives", CSW men and Injectable Drug Using Women (IDUW).

The analysis of the program's components and actions lead to the following results.

1. The components, actions and strategies established in the program correspond to what has been established in the diagnosis of the epidemiological situation.

- ☞ 92% of the program's budget is destined towards care of ill patients, and the remaining 8% to prevention and epidemiological watch.
- ☞ Epidemiological watch is based on the gathering of "Centinela" surveys in different geographical areas, especially those that have been identified as most at risk, as are the migrant zones, those where truck drivers lie overnight (Zamora and La Piedad), and those with a high concentration of homosexual men (Lázaro Cárdenas and the area surrounding Morelia). It is also gathered in schools with population that is over 18.

- ☞ In the "Centinela" survey, there are three types of format used to gather information, directed towards different population: women, men and pregnant women.

2. In the prevention component, the priority group is made up of the whole young adult population, which would make it convenient to design and implement actions using the gender perspective for men and women.
3. It is important to mention that COESIDA Michoacán has instrumented actions directed at the group most at risk, which is MSM. In relation to their diagnosis, a distinctive action has been established for this group: condom distribution in their favoured spaces of concentration, such as public baths and bars, as well as strip bars.

☞ Due to the fact that MSM is one of the main risk groups, Michoacán's Program already considers designing an outreach strategy for these groups, which are difficult to identify. To facilitate this, program leaders plan to hire a person to take on this specific responsibility. The strategy contemplates the hiring of a person convinced of taking preventive measures, and with the capacity for dialogue, and influence in the community, which will make communication with these groups easier.

4. COESIDA is conscious of the need to instrument a greater number of prevention actions by risk groups, especially for "housewives" and youth, notwithstanding the fact that budget restrictions limit their execution.

The workgroup agreed that it would be convenient to develop prevention campaigns for risk groups, accompanied by specific pamphlets, posters and talks for each of the groups at risk.

In the same manner, it is necessary to create actions directed towards groups for women, in which migrant's partners must be included. It would be especially convenient to establish empowerment strategies for all of them, especially some containing information about their sexuality, emphasizing methods of sexual negotiation with their partners and the risk of contracting HIV/Aids that they face.

Authorities of Michoacán's Program are already incorporating actions that reflect the gender equality perspective, and especially taking on actions destined towards "housewives" and MSM.

The workgroup concluded, as a result of this step, that achieving greater gender equality in the program's execution requires:

- ☞ Developing new strategies for male and female condom distribution.
- ☞ Including training actions in handling HIV, gender and human rights for healthcare workers.
- ☞ Providing psychological attention for men and women (counselling and guidance).
- ☞ Adding to HIV prevention and detection efforts in groups of women through empowerment oriented goals.
- ☞ Developing strategies and actions as part of the components directed at prevention in different groups of women and youth.

Thus, once some actions and components it is necessary to include in the program to achieve greater gender equality in the its application have been identified, priorities must be defined both for new and existing actions.

STEP 4

Definition of Priorities

Analysis of the program allowed the group to conclude that, although the components, strategies and actions constructed have advanced in their incorporation of a gender equality perspective, it would be convenient to include further actions, strategies and components to ensure that the program be even more equal in attending risk groups, and to assign a different rank to those actions that are not considered priorities.

From the data above, it was found necessary to:

1. Reformulate the program's objectives by vulnerable groups, using gender perspective, to include goals differentiated by risk groups and disintegrated by sex.
2. Establish actions for those groups identified as most vulnerable and at risk, in the first place MSM, as well as "Housewives" and migrants' partners.
3. Define as a priority training and sensibilization of all healthcare personnel, because even though they may understand the HIV issue, they do not

necessarily have a precise comprehension about gender equality and the negative effects that discrimination can have on different vulnerable groups.

4. Include as priorities, from the gender category, preventive actions directed towards “housewives”. Even when the hierarchy established for the components seems to be adequate, we must insist on the urgency of giving more importance to prevention efforts.
5. Guarantee the supply of formula for the babies of HIV carrying or infected women.
6. Keep and reinforce actions dedicated to the prevention and detection of perinatal transmission of HIV/Aids and STDs.
7. Implement some specific actions for the issue of damage control, such as:
 - ✓ Massive campaigns against stigmatization of HIV positive people (posters, adds in the media, workshops).
 - ✓ Empowering vulnerable social groups that are affected (in coordination with non profit organizations).

In the Guide, this phase (programming) has the purpose of incorporating a gender equity perspective into the frame that defines public policy, which implies translating it in a specific and disintegrated manner as part of the objectives and actions in the programs, in order to obtain greater gender equality in the attention of the beneficiary population’s healthcare needs.

STEP 5

Budgeting (Budget Projects)

Revision of the Budget Project formats according to the analysis that has just been made resulted in the need to make some changes and add a few elements in order to assign specific resources for the correction of gender inequalities. Said changes are shown within the formats.

Where any changes or the addition of concepts are proposed, they are shown in shaded fields, and in some cases, there are notes at the end of the tables.

ACTION PROGRAMME FOR THE PREVENTION AND CONTROL OF HIV/AIDS AND STDs
ANNUAL OPERATIVE PROGRAMME 2004

COMPONENT OF THE ACTION PROGRAMME: SEXUAL PREVENTION	
HEALTHCARE SERVICES CATALOGUE	
FUNCTION:	PUBLIC HEALTH
ACTIVITY:	EPIDEMIOLOGICAL WATCH

HIV DETECTION IN GROUPS WITH RISKY PRACTICES AND GREATER VULNERABILITY

STATE OR ENTITY:

Michoacán

TABLE 1

Group	Surveys to be applied	HIV Detection (First ELISA)	HIV Detection (Second ELISA)	Sum of First and Second ELISA	+ 20%	Total HIV Detections (First and Second ELISA)	W.B.
MSM		0	0	0	0	0	0
CSW MEN		0	0	0	0	0	0
CSW WOMEN		0	0	0	0	0	0
UDU MEN		0	0	0	0	0	0
IDU WOMEN							
PREGNANT		0	0	0	0	0	0
TOTAL	0	0	0	0	0	0	0

Groups	Rates
MSM	0.15
CSWM	0.122
CSWW	0.0035
MIDU	0.06
WIDU	
Pregnant	0.0009

☞ Incorporate into the epidemiological watch actions a specific field for the case of Women Users of Injectable Drugs (WUID).

ACTION PROGRAM FOR THE PREVENTION AND CONTROL OF HIV/AIDS AND STDs
ANNUAL OPERATIVE PROGRAM 2004

<p>COMPONENT ACTION PROGRAM: SEXUAL PREVENTION HEALTHCARE SERVICES CATALOGUE FUNCTION: PUBLIC HEALTH ACTIVITY: INFORMATION, EDUCATION AND COMMUNICATION (IEC) FOR SPECIFIC POPULATIONS</p>
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TABLE 3

INFORMATIVE MATERIAL				
PAMPHLETS				
Population	Estimated Group Population	Copies Required	Unit Cost	Total Cost
MSM		0	\$0.00	\$0.00
Migrants (M & W)				
Women				
Men				
IDU (M & W)		0	\$0.00	\$0.00
Women				
Men				
CSW (M & W)		0	\$2.00	\$0.00
Women				
Men				
Women at Risk				
Posters				
Population	Estimated Number of Sites	Copies Required	Unit Cost	Total Cost
MSM		0	\$4.00	\$0.00
Migrants (M & W)				
Women				
Men				
IDU (M & W)				
Women				
Men				
CSW (M & W)				
Women				
Men				
		0	\$4.00	\$0.00
Total		0	\$4.00	\$0.00

☞ In the Information, Education and Communication actions format, where men and women are totalled in every field (M & W), it is necessary to disintegrate the information and provide the specific data for each sex.

**ACTION PROGRAM FOR THE PREVENTION AND CONTROL OF HIV/AIDS AND STDs
ANNUAL OPERATIVE PROGRAM 2004**

COMPONENTS OF THE ACTION PROGRAM: SEXUAL PREVENTION HEALTHCARE SERVICES CATALOGUE FUNCTION: PUBLIC HEALTH ACTIVITY: INFORMATION, EDUCATION Y COMUNICACION (IEC) FOR SPECIFIC POPULATIONS

TABLE 3

TRAINING AND EDUCATION					
Type of	Number of	Number of Personnel to Train per Jurisdiction	Number of Workshop	Cost per	Sub-total
Symptom			0	\$0.00	\$0.00
Sensibilization			0	\$0.00	\$0.00
Sensibilization on Gender Issues (HIV and Human Rights)					
Promoter Training			0	\$0.00	\$0.00
			TOTAL		\$0.00

☞ Given the magnitude of the sensibilization issue, this concept can be incorporated into de Training and Education Format, to make sure that the importance of sensibilizing operative and program personnel is understood.

ACTION PROGRAM FO THE PREVENTION AND CONTROL OF HIV/AIDS AND STDs
ANNUAL OPERATIVE PROGRAM 2004

COMPONENT OF THE ACTION PROGRAM: PERINATAL PREVENTION
HEALTHCARE SERVICES
FUNCTION: PUBLISHED
ACTIVITY: PERINATAL

HIV DETECTION IN PREGNANT WOMEN

TABLE 13

Total Reaginic Tests on Pregnant Women in 2003	VDRL Rate	HIV Tests on Pregnant Women (First ELISA)	HIV Tests on Pregnant Women (Second ELISA)	Total of ELISA Tests for Pregnant Women	WB	Centrifugal Tests for the Detection of HIV in Marginal Communities
0		0	0	0	0	

☞ They added, in the format for Perinatal Activity, HIV detection for pregnant women, the Centrifugal Testing column.

ACTION PROGRAM FOR THE PREVENTION AND CONTROL OF HIV/AIDS AND STDs
ANNUAL OPERATIVE PROGRAM 2004

**COMPONENT OF THE ACTION PROGRAM: PERINATAL PREVENTION, BLOOD TRANSMISSION
 PREVENTION, INTEGRAL ATTENTION TO PEOPLE WITH HIV/AIDS AND STDs
 HEALTHCARE SERVICES
 INSTITUTIONAL STRENGTHENING (MEMORANDUM ITEMS)
 ACTIVITY: TRAINING**

STATE TO JURISDICTIONAL LEVEL TRAINING BUDGET

STATE OR ENTITY:

TABLE 21

Sanitary Jurisdiction	Day s	Travelling Allowance	Expenses	Fares	Total Expense
Training in HIV/Aids and Gender Issues for Healthcare Workers					0
NOM (Official Mexican Name) HIV Training Information Systems					0
					0
					0
TOTAL	0	0	0	0	0

☞ Incorporation of the Training in HIV/Aids and Gender Issues for Healthcare Workers row into the Institutional Strengthening Format.

STEP 6

Indicator Design

Some of the indicators designed in the Workshop, in different workgroups, can be found in the table found on the following pages.

The indicators respond to the changes suggested for the Annual Operative Program (POA), now Budget Project, 2004 and have been linked to a series of recommendations, in terms of objectives and strategies, which stem from what was analyzed in the previous steps, and that we assume must be incorporated into the program.

☞ In addition, an important element that must be considered in the new programming is the disintegration of objectives, goals and indicators by gender.

IMPLICATIONS TO POLICY: SPECIFIC STRATEGIES, GOALS AND INDICATORS

The goals and strategies are summarized in the following table:

STRATEGIES BY RISK GROUP

RISK GROUP	OBJECTIVES AND GOALS	STRATEGIES
MSM	To detect, by 2004, 50 men who have sex with other men (MSM)	<ul style="list-style-type: none">• Hire a promoter that belongs to the group and can function as a link between it and the HIV/Aids program.• Evaluate the impact related to investigation and condom distribution.
Women: housewives and migrants' wives	To detect 2,114 women at risk	<ul style="list-style-type: none">• Hire nine promoters to contact this group (one for each jurisdiction).• Distribute condoms (male and female).• Host women's empowerment introduction talks.• Provide informative material focused on women.• Work in coordination with government and non profit institutions focused on this group.

Perinatal	To diminish syphilis cases in this group, especially in women from remote communities	<ul style="list-style-type: none"> • Extend access to RPR testing (syphilis detection tests). • Train doctors in remote communities.
MCSW (Men)	<p>1) To detect a greater number of commercial sex workers that practice risky behaviour.</p> <p>2) To design specific policy for this group.</p>	<ul style="list-style-type: none"> • Introduce this category into the Project Budget.
WCSW (Women)	To reduce incidence	<ul style="list-style-type: none"> • Distribute condoms • Induce empowerment

OTHER TRAINING AND PROVISIONING STRATEGIES		
CONCEPT	OBJECTIVES AND GOALS	STRATEGIES
Healthcare Personnel	Sensibilize a greater percentage of public healthcare providers to gender perspective.	<ol style="list-style-type: none"> 1. Focus efforts on the three most affected jurisdictions. 2. Sensibilize first level hospital staff.
Baby Formula	Insist on the acquisition of at least 48 thousand litres of baby formula.	<ol style="list-style-type: none"> 3. Work in coordination and cooperation with the Equal Start in Life Program.

Aside from this, the following indicators were defined. They can be used to evaluate the program's impact in achieving its goal of closing gender inequality gaps.

INDICATORS
<ol style="list-style-type: none"> 1) Nine detected cases in the MSM group. 2) Detected MSM/ MSM who use condoms.
<ol style="list-style-type: none"> 3) Number of coordination instances. 4) Number of cases detected in women*. <p>*This requires desegregation of different groups of women: housewives, migrants' partners and migrant women.</p>
5) Sensibilized healthcare personnel/ total healthcare personnel involved in the program in the three jurisdictions.
6) Percentage of needs covered.
7) Number of syphilis cases detected.
8) CSW men sensibilized/ total CSW men.

9) CSW women sensibilized/ total CSW women

In addition to the above, other workgroups proposed the following indicators:

Concept	Indicator
Sexual Prevention	1) Number of pamphlets distributed per group. 2) Percentage of coverage of the objective population. 3) Number of condoms distributed per gender. 4) Number of young women who accept the condom. 5) Number of schools visited/ total schools of each level of education.
Damage Control	1) Number of annual complaints. 2) Number of healthcare workers trained/ total healthcare workers in the area. 3) Number of complaints per services in the area.
Blood Transmission Prevention	1) Number of new cases per gender. 2) Number of sanitary equipments distributed per non profit organization.
Perinatal Prevention	1) Number of positive pregnant women detected in rural communities.
Institutional Strengthening	1) Percentage of correct records. 2) Number of returned formats in the area.

These indicators are only an example of those that could be developed.

4. Necessary Factors for Gender Perspective Programming

Considering that the development of activities proposed in this Guide leads, on a certain level, to the inclusion of a gender equality perspective in programming processes and the formulation of public budgets, it is necessary to point out and accept that full application of this perspective demands the development of other activities and involves other factors, even in some areas and scopes that are out of the Ministry of Health's control.

The additional activities and factors that we are referring to, and that should be taken into account for the conclusion of this process, are the following:

1. To push for changes in the General Planning Law, in order to ensure that, from this legislative frame, gender perspective can start to be inserted in the design and development of public policy.
2. To promote the deployment or the adaptation of information systems, so that their organization, structure and integration reconcile with the demands of gender perspective for disintegration of data by sex, age and relevant socio-demographic characteristics.
3. To integrate a gender equality perspective from the budget elaboration process, as it is determined by the Ministry of Finance and Public Credit and its equivalents at a state level, to the programming structure development process, so that its inclusion may be translated into and consolidated in the formats established by these authorities for the formulation of public budgets.
4. To seek a widening of the program's parameters that makes it possible to include a gender equality perspective in the different areas that operate the Ministry of Health's programs leading to greater equality, efficiency and transparency.

The factors enumerated above must be taken into account, because the application of a gender perspective should be a transversal process, including the application of gender equality concepts from the very definition of public policy to the programs' operation, including programming and budgeting processes.

Gender equality perspective seeks to contribute to the full establishment of democracy in the country, which implies providing equal development possibilities to the whole of society. Nevertheless, this means, first of all, that we must accept that there are existing inequalities between men and women, and that these must be overcome before the instrumentation of public policy has a real impact on the welfare level of society as a whole.

In brief, programming with a gender equality perspective requires the express purpose of providing equal development possibilities to men and women, as well as the diverse groups of society in general, stemming from the will to eliminate prevailing unequal conditions among them.

V. RECOMMENDATIONS

In order to support the inclusion process of gender equality into the units and departments of the healthcare sector and in the elaboration of their Budget Projects, the following recommendations are issued:

1. Seek support and counselling from the Ministry of Health's National Centre for Gender Equality and Reproductive Health.
2. Opportunely and clearly define the formation of the program's team, which must include an area technician, a director capable of making decisions, and a person in charge of the information systems area.

The idea of forming a definite workgroup has the intention of giving the greatest possible continuity and coherence to the process.

3. Anticipate the organization of a gender issues and public budgets with gender equality perspective sensibilization and training workshop.
4. Take into account that it is not imperative that this process begin parallel to the formulation and presentation of the corresponding Budget Project. Although the ideal procedure would be to form the group and start training before the elaboration of the budget for the next cycle, if this proves impossible, it is not necessary to wait, the process can be started at any point in the cycle.
5. It is plausible to include a gender equality perspective in the programs even before the formal Budget Program elaboration begins, because the steps corresponding to the revision of the diagnosis and adaptation of the general questionnaire proposed in the Guide can be carried out before any formal steps of the process have begun.

ATTACHMENTS

ATTACHMENT 1

SUMMARY OF HIV/AIDS AND ITS CURRENT SITUATION IN MEXICO

1. Gender and HIV/AIDS

HIV/AIDS

AIDS (Acquired Immune Deficiency Syndrome) is a disease caused by a type of retrovirus called Human Immunodeficiency Virus (HIV), which causes the destruction of the ill person's immunological system. The main function of said system is to defend the organism through different immunological mechanisms, from the aggressions caused by different types of micro organisms. HIV infects mainly a subgroup of immune system cells that possess a molecule called CD4+, essential to immune response.

Nowadays, it has been proven that there are three forms or ways of HIV transmission: sexual (heterosexual, homosexual and bisexual), by blood (transfusion, use of contaminated needles, sharing of contaminated needles by injectable drug users, occupational risk) and perinatal (trans-placenta to children of infected mothers during birth or through breast milk). Despite the fact that HIV has been detected in different body fluids such as saliva, tears and urine, there is no proof that kissing or sharing household utensils with an infected person can transmit the AIDS virus.

From the moment that HIV enters the organism, it begins to proliferate continuously. The destruction of CD4 lymphocytes produces severe suppression of the immune system, which favours the appearance of opportunistic infections and neoplasias that are characteristic of AIDS. In general, at least three evolutionary phases of the infection can be identified: initial phase of primary or acute infection, chronic phase and final phase. Survival prognosis is variable. The virus strain and subtype, the general state of the person's health and their access to healthcare services for the medical treatment of opportunistic diseases seem to affect their survival. Treatment with anti-retrovirals has greatly increased both life expectancy and quality of life.

Gender and Sexuality

Gender is not a synonym for sex. Gender refers to the existing norms and expectations within a society about what constitutes "normal" or "appropriate" male or female behaviour. Even though gender roles may vary from one culture to another, a common characteristic is the differentiation between men and women in

respect to the adequate roles for each of them, their access to productive resources and decision making. Thus, in most societies, women have a disadvantaged position with respect to men.

Despite the importance of gender in the structuring of social life, there are other determining social constructions, one of which is sexuality. Sexuality can be defined as the social construction of a biological urge (see Gupta, 2000). Individual sexuality is determined by a series of aspects such as: who a person has sex with, in what way, why, in what circumstances and with what results. The rules (both implicit and explicit) imposed by society and defined by sex, gender, age, ethnic group and social class affect individual sexuality, and a key aspect of the dynamic created between gender and sexuality is power distribution. For example, unequal power relationships between men and women often translate into an unequal balance of power in (heterosexual) sexual relations.

Thus, gender is also intersected by other forms of inequality that can be more or less relevant depending on the context, and that can increase or diminish the negative aspects of gender relations. In the issue we are concerned with, HIV/AIDS, the sexuality axis is fundamental for the understanding of the epidemic's dynamic and for the designing of courses of action that allow a reduction in the terrible impact of the disease.

Said actions should be designed keeping a gender perspective in mind. This implies analyzing, with critical eyes, differentiation, domination and subordination processes between men and women; in other words, social relations between the sexes. It is a tool intended to integrate men and women's worries and experiences in the formation, instrumentation and evaluation of programs and policy, so that both social groups are equally benefited and the perpetuation of inequalities is avoided.

In consequence, the objective of putting a gender perspective based program into effect is to reach equality between men and women (and the different groups they make up), which presupposes recognizing their different needs and interests, and calls for an evaluation of all government actions depending on their differentiated impact on both sexes and the orientation of actions towards a redistribution of power and resources.

Gender and HIV/AIDS

Considering health from a gender perspective supposes, besides examining men and women's different needs in regard to this issue, observing the differences in risk factors and determiners (both social and biological), severity and duration of illnesses, and differences in perception of illnesses, in access and use of public healthcare services and in the general health of different groups of men and women. It is important to accept that the heaviest health problem burden falls upon those who suffer the greatest wants from an economic and capabilities (analphabeticism, discrimination and lack of information, for example) point of view.

Social groups with less economical, political and social power will thus be more vulnerable to diseases.

The relationship between HIV/AIDS and gender was established in the UN General Assembly Special Session on HIV/AIDS, which took place in July 2001, where it was recognized that gender issues and unequal power relationships derived from them increased both the risk and the possibility of AIDS transmission. Gender inequality increases women's and stigmatized groups' vulnerability to the epidemic and, in the case of women, an increase in workload when the disease enters their homes or communities. On the other hand, it was also argued that girls and women have less access the information necessary to avoid the disease, and to prevention, treatment, healthcare and other services. It is because of this that countries should create and accelerate the execution of national strategies that promote women's progress and their rights, encourage shared responsibility with men to ensure safe sexual practices, confer power to women so that they may decide freely about their sexuality, and increase their ability to protect themselves from HIV/AIDS infection.

The goal is that by the year 2005, all countries will have put into effect measures to elevate women's and teenage girl's ability to protect themselves from risk of infection, mainly through the provision of healthcare services, including those for sexual and reproductive health, and through education for prevention that favours gender equality within a frame sensible to gender and cultural differences.

This frame must not only include a cultural construction of female and male roles and identities perspective, but also a perspective of the social construction of sexuality and of what is perceived as "correct" or "normal" sexuality in a given context. As we shall examine below, in most countries, people with different sexual practices face discriminatory and lack of power situations that have made them particularly vulnerable to the virus.

Different Vulnerabilities to HIV/AIDS

Certain aspects of the female physiology make women more susceptible to HIV. For example, they have a greater part of mucous surface area exposed to abrasion during heterosexual intercourse and semen has a higher HIV concentration than vaginal fluids do. Girls and teenagers, in whom the vaginal mucous area is not fully developed, are particularly vulnerable in cultures that favour marriage at an early age.

Besides biological susceptibility, women face increased vulnerability due to socio-cultural factors. First of all, the silence taboo that surrounds sex and that dictates that "good" women should stay ignorant and passive regarding the issue. Secondly, the norm of female virginity, that prevents women who wish to obtain information about sex from doing so because they fear being considered sexually active, and, thus, stigmatized. In the third place, the cultural value of maternity prevents women from using barrier methods, such as condoms, that reduce the

risk of contracting HIV/AIDS. The fourth factor is the economic dependency of women, which also increases their disadvantage; for example, they may be forced to exchange sex for money or food. Finally, violence against women also increases their vulnerability to the disease.

About this last point, it has been argued that HIV prevention efforts should include the prescription of anti-retrovirals to rape victims. Facing this, social norms that have denied women the right to make decisions concerning their sexuality are of particular importance for the HIV/AIDS problem.

Male vulnerability to the disease is related to, in the first place, social norms of masculinity, in function of which it is expected that men “know” about sex and have plenty of experience. This prevents men, especially young men, from acquiring information about the issue, and of course, from accepting their ignorance about it. Secondly, it is thought that having multiple partners is part of male nature, which multiplies possibilities of transmission. Third and lastly, the notions of masculinity that emphasize sexual domination of women as their defining characteristic contribute to homophobia and the stigmatization of men who have sex with other men, which is the group most at greatest risk in our country.

Thus, HIV/AIDS prevention and treatment programs must take into account people’s sexual rights, and the right to not be discriminated for “different” sexual practices, because men who have intercourse with other men suffer double the discrimination: for exercising a “different” sexuality and for being carriers of the virus. Due to this, it is essential to develop courses of action focused on tending to the specific needs for men who have sex with men.

This group is particularly vulnerable to the infection both for biological and social factors. In regard to biological factors, intercourse with anal penetration is common in the sexual relations of men who have sex with other men. This practice implies an elevated risk for HIV transmission when one of the men carries the virus and they do not use a condom, because the rectum’s mucous is very delicate and can easily tear, and even the smallest lesions are enough to allow the virus to enter the system. It is also known that rectal mucous cells have much less immunity to resist HIV than vaginal mucous cells. On the other hand, risk for the receiving member of the couple in unprotected anal sex (five to 30 cases for every 1,000 exposures) is higher than the risk for a woman having unprotected vaginal sex with an infected man (one to two cases for every 1,000 exposures).

Besides this biological vulnerability, the absence of concrete numbers and investigations of this social group is noticeable. In some countries, the lack of epidemiological data about the incidence of the virus in men who have sex with other men is an important obstacle for prevention efforts. There are even cases in which surveys do not include a field for “men who have sex with other men”. This is, without a doubt, due to the social context of rejection that this group suffers. It is a fact that sexual relationships between men happen in most societies. Nevertheless, their existence, as well as the importance of recognizing them for the

prevention of the disease, is frequently denied. This type of relationship is still commonly stigmatized and condemned, and those who openly practice them still face discrimination.

It is because of this that most sexual relationships between men are kept hidden or in secret. For example, many men who have intercourse with other men do not consider themselves homosexual or bisexual; they are often married or have sexual relationships with women. This is especially common in places where marriage is still a prerequisite to wholly “fit in” to society. Among the men who have sex with other men group, commercial sexual workers are a particularly difficult group to reach because, unlike their female counterparts, they are not usually organized or structured.

Derived from all this, we can say that men who have sex with other men are often dishonest when questioned about their sexuality, so they may not always report probable symptoms of HIV or other sexually transmitted diseases, or decide not to go to a health clinic to be tested for HIV for fear of the results and of the rejection and stigmatization that they would eventually be exposed to. In addition to this situation, many HIV/AIDS prevention programs do not include adequate provisions for men who have sex with other men. For example, educational material made for men who identify themselves as homosexuals may be considered too “explicit” by those who do not consider themselves homosexuals, but have sexual relationships with other men.

2. The HIV/AIDS Situation in Mexico

Mexico can be considered a country with a “concentrated” AIDS epidemic, meaning that there is a prevalence of HIV infection that has spread rapidly in a subgroup of the population and that has, as of yet, not extended significantly into the general population. The rate of HIV infection in the 15 to 49 year old population is 0.3%; this number has been stable for the past twelve years. Among pregnant women in urban areas, the rate of infection is 0.1%. According to the *National Register of AIDS Cases*, there is a 15% prevalence of AIDS infection among men who have sex with other men (MSM), 12.2% among men who are commercial sexual workers (MCSW), 6% among injectable drug users (IDU), 2.1% among tuberculosis patients and 1.6% among prison inmates. Among women, the most affected groups are those of prison inmates (1.4%) and sexual workers (0.3%). Infection rate for pregnant women is 0.09%.

In regard to the main causes of HIV transmission, sexual transmission has been the most substantial, with 86.6% of all registered cases. It has been noted, within this form of transmission, that men who have sex with men are the most affected subgroup, making up 62.2% of the cases. Nonetheless, the proportion of heterosexual transmission has grown considerably in the last few years, and now represents (at the date the *Register* was compiled) 37.8% of all cases.

The second most important cause of HIV transmission is by blood; 10.8% of all cases are attributed to this form of transmission. Of this 10.8 %, 72.5% of the cases are due to blood transfusions, and 8.3% are associated with IDU.

Finally, although perinatal transmission is only the cause in 1.9% of the cases, this is the main form of transmission among the population under 15 years of age. These three causes of HIV transmission account for almost 100% of all cases.

Of the accumulated total of cases of people with HIV/AIDS, most are men, making up 85.4%, while 14.6% are women, which translates into a 6:1 ratio, or six men with HIV/AIDS for every woman. Most are at a reproductive age, between 15 and 44 years of age, although the most affected population within this age group is that of young adults, 25 to 34 years old. The states with the highest accumulation of AIDS cases are the Federal District (Mexico City), Jalisco and Baja California, while the ones with the least amount of cases are Chiapas, Zacatecas and Tabasco.

Up to September 2002, there were 57,640 registered AIDS cases. Nevertheless, there is a margin of error due to sub-register, caused not only by a delay in notification of the disease, but also by a delay in discovery of the disease, given the time that elapses between infection, diagnosis and notification. For this reason, 35% is added to the last cipher in the report, to account for notification delay, and 18.5% to account for sub-register of cases. In this way, the accumulated cases calculated for this year were really 64,000. In the same manner, it is estimated that there are between 116,000 and 177,000 people infected, a mean of 150,000.

We can come to the conclusion that in our country, the disease is concentrated in men, meaning that this is an illness that, up until now, affects them more than it does women, despite the biological and social vulnerability that women face. The proportion of AIDS cases diagnosed in 2002 was 16.5% women and 83.5% men. Among men, the group with the highest exposure to infection was that of men who have sex with other men. Besides this, it is important to mention that, when analyzing year by year case diagnosis, a progressive increase of cases in women can be seen, as well as a tendency of growth in the history of the epidemic.

3. Gender Sensitive Budgets

Public budgets, being the most important public policy tools in government, reflect the government's vision of social and economic development, and, in more general terms, a society's values and priorities, as well as their underlying power relationships. It is not a coincidence that marginal sectors of society are usually the ones most affected by budgets, and those with the least opportunities to politically influence them. Because of this, public spending has the highest potential to diminish existing gaps between men and women (and different groups of men and women) only if gender oriented courses of action, programs and policy are formally expressed in the budgets. Thus, gender sensitive budgets arise as an answer to

the need to instrument effective strategies to monitor and push for social and economic equality.

If we begin by considering that women and men have different lives due to the structuring of gender roles, and that because of this they face different restrictions, responsibilities and choices, we can also say that men and women will not respond to budget policy in the same way. Nonetheless, public policy (and consequently, budgets) is designed uniformly, to tend to what is assumed are the needs of all the population. Its architects do not take into consideration the socially construed roles, capabilities and responsibilities for different groups of men and women. In addition, it is not even a question if, due to this situation, policy and the programs derived from it have a differentiated impact on different vulnerable or at risk groups.

On top of this, the fact that budgets are presented without the slightest mention of women (or men, for that matter), creates the impression that they are only a technical instrument with similar effects on all the beneficiaries. Not knowing budgets' differentiated impact on men and women, however, does not mean that budgets are neutral regarding gender; more likely, they are blind to gender: a budget that ignores inequalities between men and women, and different gender constructions in society, will replicate or maintain existing gender relations without change, and will make any positive impact on economic growth and human development more difficult.

It is important to emphasize that gender sensitive budgets are not budgets made for the exclusive benefit of women, rather, they refer, first of all, to the desegregated analysis, by sex, of budgets using a gender perspective, and secondly, to the very formulation of the budgets, valuing their impact on the lives of men and women and taking into account the inequalities and differences that occur within different groups of men and women. Thus, their objective is to introduce gender perspective along all the stages of government programs, projects and strategies (conceptualization, design, budgeting, instrumentation and evaluation), making sure that the interests, needs and priorities of men and women, boys and girls (and different groups of men, women, boys and girls) are really included in the budget.

Understanding gender sensitive budgets as exclusively for women would imply designating them as an interest group that competes with others for the scant resources the government can spare. This vision assumes, on the one hand, that all women (and all men) want or need the same things, and, on the other, that the goal of gender sensitive budgets is reduced to having a greater portion of government funds assigned to programs or actions exclusively focused on women. In contrast with this idea, designers of public policy and budgets should recognize existing inequalities between different groups of men and women, especially in relation to age, ethnic group, social class, geographic localization and, specifically for the subject we are working on, sexual orientation, given that policy against HIV/AIDS that benefits a certain group of men or women does not necessarily benefit a different group (and may even have an adverse effect).

In this manner, one of the objectives of including gender equality perspective in CENSIDA's budget would be to transform the prevailing pattern of power inequality between men, women and stigmatized groups (for example, men who have sex with other men, or commercial sexual workers) through programd actions for fighting HIV/AIDS, which should create a context in which both the needs of different groups of women and men and the different social obstacles they face according to their gender and sexuality are valued and taken into account. Thus, the different needs of the population would be reflected in specific actions and services that would diminish the vulnerability of the groups that, in our country, are most affected by the epidemic.

ATTACHMENT 2

QUESTIONS APPLIED TO THE MICHOACÁN COESIDA CASE

STEP 1

Diagnosis

- *What is the general interpretation of the diagnosis of the HIV/AIDS situation from which the state program stems?*

Take into account the following factors:

- What information was used to make the diagnosis on the HIV/AIDS situation in the state (epidemiological situation, start of active sex life, migration, ethnic groups, frontier zone situation, tourist area, etc.)?
- Was the information desegregated by sex, age and risky practices (transmission by use of injectable drugs, men who have sex with men, male and female sexual workers)?
- Does the program include information about:
 - The man/woman ratio in the medical treatment field
 - The man/woman ratio of HIV carriers in the state
 - The man/woman detection demand
 - The number of detections per vulnerable and risk practices groups
 - Who the educational material and campaigns about HIV/AIDS are directed at (objective audience group: men, women, risk groups, ages, etc.)
 - Who attend the planned educational sessions (men, women)
 - Civil society organizations (CSO) that work on the HIV/AIDS issue in the state and who their actions are directed at?
- Are different efforts made to determine the impact of the disease on different vulnerable populations and risk groups?

STEP 2

Analysis of Inequalities

- *What could the impact of gender inequality and different sexual practices be on the possibility of contracting HIV, depending on each of the three main forms of transmission of the virus (sexual, blood, perinatal)?*

Take into account the following factors:

- What part do inequality and fear of discrimination play, for different sexual practices, in the demand and use of the healthcare services granted by the program?
- What are men and women's particular difficulties and problems in accessing healthcare services?
- Are any resources destined to epidemiological watch for determining who make up the groups most affected by HIV/AIDS in the state?
- Under what criteria is the watch designed? Using what procedures? How periodically are samples taken? What size is the sample of each group tested?
- Do the goals of the state program reflect concern about equality between men and women, and about avoiding discrimination for different sexual practices?

STEP 3

Program Components and Specific Actions

- *Are the components, actions and strategies that the program implements based on the diagnosis of the situation of the epidemic in the state?*

Take into account the following factors:

- Considering the resources programd for 2003, what type of components obtained the most resources in the program (sexual prevention, perinatal prevention, blood transmission prevention, integral attention to people with HIV/AIDS and STDs, damage control)?
- Within each of the components, what are the highest priority actions and who is the benefiting population?
- Are the strategies implemented related to the needs of the groups most at risk of contracting the disease in the state? For example, in what way are the different needs of MSM, sexual workers and IDU tended to in the actions derived of these components?

- Are specific actions planned and resources assigned for the most vulnerable groups, or for those groups most affected by HIV/AIDS in the state (for example, are specific actions dedicated to prevention among sexual workers)?
- Are the specific needs of different groups of men and women (MSM, CSW, IDU and other vulnerable groups) tended to?
- Is there any prevention action that includes house calls to the patients and/or provides attention to the orphans of the epidemic?

STEP 4

Prioritization

- *Do you consider that the components, actions and strategies implemented by the state program are enough to counteract the impact of gender on the disease? From a gender perspective, what actions and strategies should be designed, reformulated or added to make the program more equal?*

Take into account the following factors:

- In what order of priority would the program's components, actions and strategies be placed in order for them to reflect concern for gender equality?
- How would the program's objectives and goals be rewritten considering said priorities?

STEP 5

Budgeting

- *What requirements (in terms of budget, human resources and abilities) would be necessary to put the reformulation of strategies and actions into effect?*

Take into account the following factors:

- Would it be necessary to tag resources for men and women and/or vulnerable or at risk groups? What specific actions should be tagged?
- How would the reformulation of actions and strategies and the tagging of specific actions be reflected in the Budget Project's guidelines?

STEP 6

Indicators

- *What would be the indicators necessary to follow up and evaluate the new actions and their budget requirements?*

For the construction of indicators, the results expected of the suggested actions and strategies to reduce inequalities should be taken into account.

ATTACHMENT 3

Examples from Different States

The results that the different workgroups from Mexico State, Morelos and Chihuahua reached are now presented.

The results show different degrees of advance in the process, depending on the previous information base, knowledge of gender analysis and/or sensibilization of those involved in the process.

In the case of the State of Mexico, the exercise advanced all the way to step five, where they even made an approximate calculation of the resources necessary to put the proposed actions for gender inequality corrections into effect.

The state of Morelos, for their part, finished the exercise up to step four, yet they added some elements and spending areas that may be included to contribute to the formulation of a budget with a gender equality perspective.

Finally, the case of the state of Chihuahua clearly shows how the lack of information and a precise diagnosis can limit the development of the methodology. With all this, the group made a significant effort in the application of the method and even managed to propose a series of indicators to evaluate the way that some modifications made to the program, based on a gender equality perspective, might help achieve an advance in the program, towards the correction or reduction of gender inequalities.

All in all, they provide a panoramic vision of what the inclusion of gender equality perspective in healthcare programs implies, and equally reveal how the methodology can begin to be applied, depending on the prevailing conditions in responsible administration units in terms of information bases, training and sensibilization about the subject.

STATE OF MEXICO

STEP 1

Revision of the Diagnosis Using a Gender Equality Perspective

In the case of the State of Mexico, all the information needed by the HIV/AIDS Program was available, and, besides this, they had the collaboration of a representative from a non profit organization, *Casa Toluca* (Toluca House) dedicated to help people with HIV/AIDS, which added a different perspective to the discussion. The results they reached are the following:

1. As is the case in other states, there is a sub-register of cases equivalent to 18%, and a notification delay of 35%. Nevertheless, there is a historical record of cases dating from 1985 to April 2003 available, with 7,599 cases recorded, of which 5,461 are deaths and the remaining 2,138 are people living with the virus.
2. The most affected jurisdictions are Nezahualcoyotl, Ecatepec, Naucalpan, Tlalnepantla, Cuautitlán and the state capital, Toluca, although there might be a sub-register problem in other jurisdictions that has kept them off this list. The epidemic, as we can see, is concentrated in cities and suburban areas, as well as marginal areas and areas with the highest poverty index.
3. Another problem identified was that of migrants who become infected in the United States and upon returning home, pass the virus on to their partners, some of which, in the case of women, even become pregnant.
4. Starting in 2003, all data collected has been separated by jurisdiction. The information available per age group shows that the group with the most cases of infection (AIDS cases) is of young adults 25 to 34, where 3,106 cases have been reported, adults from 35 to 44 are the second most at risk group. So, at productive and reproductive ages is where there is the most incidence of the disease. There are 1,247 infected women in the state, and 6,352 men, meaning five men for each woman. In the child group, there are 111 cases registered in children under five (perinatal AIDS transmission). In the five to 14 years of age group, there are some cases of infection due to sexual abuse.
5. There are 52 rural women and 67 urban women receiving attention, and approximately 170 men. More than 200 people with the disease in the State of Mexico receive care and medication in Mexico City (Federal District).

6. By risk group, the following information about infection percentage was found: MSM, 29.36%; Bisexuals, 18.52%; Heterosexuals, 35.37%; CSW, 1.79%, IDU, 0.64%, Former Remunerated Blood Donors 2.81%, Perinatal, 2.46%, Blood Transfusion, 7.8%, Haemophiliacs, 1.15%, Occupational Exposure, 0.1%. In addition to these ciphers, death certificates testify to 3,661 cases in which the risk group or means of transmission was unknown.

- ☞ Desegregated information by sex and age is available.
- ☞ This is a male epidemic, originated by transfusions in Nezahualcoyotl (a jurisdiction close to Mexico City) and has now become hetero-bisexual with a large incidence on migrants.
- ☞ It is considered a stable and concentrated epidemic.
- ☞ The information available is for AIDS cases, not HIV carriers.
- ☞ There is no coordinated work with the Reproductive Health unit, according to those responsible for the program.
- ☞ The most vulnerable population groups are male and female CSW and partners of migrants.

STEP 2

Analysis of Inequalities

Turning our attention to gender inequalities, it was found that awareness campaigns could have been inaccurately directed, focusing on some groups and neglecting information important to others. The program has paid less attention to migrants, indigenous ethnic groups, MSM, CSW and IDU than it should have. Printed pamphlets are mostly directed at young adults, women, MSM, parents, teachers and healthcare workers. Currently, the program faces a problem: posters directed at MSM are not authorized, although they were used before with the States multi-organization HIV/AIDS Program logo, but without the State of Mexico Ministry of Health.

Women attend more open population educational sessions, while non profit organizations direct their attention to youth, MSM, CSW, people in correctional facilities, minors in juvenile correction facilities and children.

Starting with the information previously obtained in the diagnosis, a first analysis was made using a gender equality perspective, and it was found that pregnant women were usually offered testing and counselling. Nonetheless, women generally find out they carry the disease only when their husband or partner dies from it, or when their child is diagnosed.

Paradoxically, the state program's actions have a positive effect mostly on women, for a great number of these actions take place during healthcare fairs that are

organized, and usually attended by, women. Nevertheless, on analysis, it seems that many of the strategies used to attract women to these fairs are not very effective, because for every voucher they show as evidence of their attendance to an educational talk or an examination or test (Pap smear, dental examination, etc.), they are given a “motivational prize”. Apart from this, there is a social morale that directs all campaigns towards a “politically non-conflictive” population, which is not necessarily the population where the major risk groups can be found.

The program identifies and works with groups characterized by their risk practices, yet not defined as risk groups, such as: migrants, native ethnic groups, youth, women at a reproductive age, users of injectable drugs and MSM.

The woman in charge of the state program says that, in her opinion, they do work with a gender perspective in mind. In particular, she emphasized that sensibilization workshops have been very effective in tending to the needs of vulnerable population.

It was pointed out that there are more MSM who request testing, or, in the case of those already infected, medication, but that the group does not request any other healthcare services. More men than women are treated for sexually transmitted diseases (STDs). Women do not seek detection services, because they do not have a clear perception of their risk, or the sufficient information about the disease, and because they feel safe when they have only one sexual partner. Because they do not feel ill, they do not seek healthcare services. It follows that it is less likely that women get tested for HIV, considering that they do not even request the tests they should have on a regular basis, such as the Pap smear.

The funds destined towards epidemiological watch are scant, and used to identify those groups most affected by HIV/AIDS. The state used the “Centinela” surveys, as well as notification of AIDS cases and HIV positive detections. A sample size for each group has not been defined.

There is concern for equality, but this does not carry through to the practical application of the program. Additionally, the program seeks the support of non profit organizations, which are supplied with condoms for their work with vulnerable groups.

Gender inequality does not seem to affect MSM in the aspect of discrimination in services, but rather because they are forced to hide their identity in the face of the cultural concepts imperative in society today. Thus, the stigmatization MSM face imposes obstacles in their use of healthcare services.

One effect of gender inequality on women, that not only occurs in the HIV/AIDS scenario, is that which refers to their condition as the caretakers of family health, of their husband, their children, their elder family members, etcetera, while they do not have a specific person assigned to support them in the care of their own health,

except for other women in their family (their mother, aunt, daughter, or a close friend).

On a different note, there are no indicators or data that show the impact of the damage control component of the program in the objective population, or by risk group.

One priority in gender issues is the MSM group. Within this group, those who do not consider themselves gay or bisexual present a greater difficulty for establishing contact. One way to reach these MSM is working with male CSW.

Besides all this, sensibilization is required for healthcare workers. Full identification of inequalities demands a diagnosis of the different conditions and ways in which men and women face, and live with, risk and infection.

- ☞ Many campaigns are directed at women, but these campaigns are not as effective as was hoped.
- ☞ There is plenty of knowledge about the disease in the state.
- ☞ Campaigns directed specifically towards MSM are necessary.
- ☞ Sensibilization of healthcare workers has been an important and effective step forward.
- ☞ The most stigmatized group is that of MSM.
- ☞ Women do not seek testing because they do not feel they are at risk.

STEP 3

Determination of Specific Components and Actions for the Reduction of Inequalities

The components of the state's program are:

1. Sexual Prevention
2. Perinatal Prevention
3. Blood Transmission Prevention
4. Integral Attention to people infected with HIV/AIDS and STDs
5. Damage Control

Most of the resources are destined to HIV/AIDS attention and not sexually transmitted diseases in general, although the funds assigned to prevention also

helps prevent other STDs, given that the handing out of condoms is one of the prevailing actions. The same goes for blood transmission prevention. There is, nevertheless, a considerable amount of funds directed towards partial attention of the infection, through the supply of anti-retroviral (ARV) medication.

The prevention component, which is based overall on the distribution of condoms and pamphlets to the general population, should include actions segmented by risk group, because at this time, the most benefited population is 15 to 49 year old men.

The main action for the attention component of the program is medical coverage, as well as medication supply. In this case, men are once again the main beneficiaries, which is why the workgroup saw the need to plan actions that include other groups without lessening the attention for those who already receive it, considering that MSM are the group most at risk.

Due to the fact that most of the prevention and attention strategies are not related to the needs of the groups most at risk, it is imperative to include actions that are segmented and oriented at each one of the risk groups: migrants, their female partners, and IDU men and women, among others. This way, actions can be integrated and specific resources assigned to attend not only the MSM group, but also other high risk groups, among which orphans of HIV/AIDS infected parents are also important.

- ☞ More resources must be assigned to prevention efforts, to attend the specific needs of the most vulnerable groups.
- ☞ There must be more efforts towards providing patients with attention for their psychological needs, and not only supplying medication.
- ☞ Actions must be incorporated and put into effect by risk group: women, male and female users of injectable drugs, youth, migrants' female partners, urban and rural women, among the most important groups.

STEP 4

Definition of Priorities

Based on the inequalities detected in the former step, it was decided that there should be specific awareness campaigns for the women of each group (girls, married and single women, urban and rural women, women with sexually active lives, and young women and teenagers). Also, priority must be given to sexual prevention efforts for teenage urban, rural and semi-rural women, and gender focused actions must be directed at teenage males, in order to build in them a correct idea of masculinity before they migrate.

By component, the priorities would be established as follows:

1) *Sexual Prevention*

- ◆ Prevention campaigns for young women.
- ◆ Training of healthcare personnel.
- ◆ Sensibilization of young men about gender issues, before they emigrate.

2) *Blood Transmission Prevention*

- ◆ Detection and elaboration of a state IDU diagnosis, in combination with the sexual prevention strategy. Male and female users of injectable drugs are difficult populations to locate, which is why this first step is a priority. Action based on a pilot program is suggested.
- ◆ Reinforcement of the sanitary watch of all transfusions.

3) *Perinatal Prevention*

- ◆ Strengthening of healthcare workers' training so that they offer testing to pregnant women.
- ◆ Having resources available for detection equipment and reactive chemicals.

In general, prevention priorities were set as follows:

1. Gender and HIV/AIDS/STDs training and sensibilization for healthcare workers.
2. Prevention strategies with a gender perspective directed at MSM, youth, women (urban zones, marginal areas, semi-rural and rural), native ethnic groups and migrating population.
3. Differentiated prevention strategies for CSW men and women.
4. Diagnosis and design of prevention strategies for IDU and their sexual partners.
5. Timely detection (in pregnant women and vulnerable groups).
6. Reinforcing actions in order to obtain safe blood.
7. Design, after conducting an investigation, of prevention models and strategies with a gender perspective.
8. Consolidation of efforts and cooperation with non profit organizations, including budget support for them.

Attention priorities are the following:

1. To provide integral attention to people living with HIV.
2. To provide differentiated emotional support for men and women (individual or group counselling).
3. To offer specialized consults.
4. To provide anti-retroviral medication.

5. To provide medication for opportunistic infections.
6. To provide follow-up laboratory services (viral load, CD4 and clinical tests).

The goals and strategies are summarized in the following table:

Focus Group	Objectives and Goals	Strategies
CSW (Men)	Training in sexual transmission and prevention issues.	Design a prevention campaign directed at CSW that has repercussions on their clients, their sexual partners and their families.
Healthcare Personnel	Expand the testing offer to pregnant women	Sensibilization in gender issues and HIV/AIDS/STDs
Pregnant Women	Get more pregnant women tested.	Elaborate, with the Reproductive Health Board, a pamphlet about the benefits of being tested for HIV/AIDS, directed at pregnant women.
Men and Women Living with HIV/AIDS	Know the following variables: quality of attention, therapeutic adherence, time elapsed between the diagnosis and beginning of treatment, social impact of their condition, psychological impact and survival rate (in years).	Carry out a comparative diagnosis for both sexes, with a sample of 50 urban women and 50 rural women, 50 urban men and 50 rural men, all of them living with HIV/AIDS and currently undergoing treatment at the specialized services attention units in the State of Mexico.

STEP 5

Budgeting

The workgroup from the State of Mexico tried to quantify the cost of the new strategies that were considered a priority, but did not elaborate the correspondence between this and the Budget Project tables for 2004. We present the estimated costs the team elaborated:

1. For the prevention strategy for CSW men: Estimations were made for the design and elaboration of printed material, the making of a topic guide, formation of a focus group, group sessions, condom distributions and in-depth interviews:

- Material: \$150,000 pesos[∇]
- Equipment and Recording Material: \$30,000 pesos
- Human Resources:
 - Recruiter: \$12,000 pesos
 - Interviewer (psychologist): \$40,000 pesos
 - Transcriber: \$16,000 pesos
 - Doctor: \$40,000 pesos
 - Anthropologist: (2 months): \$20,000 pesos
 - Five Workshop Leaders (10 months): \$250,000 pesos
- Travelling Allowances: \$50,000 pesos
- Total Cost for the Strategy: \$700,000 pesos

The need was also foreseen to budget funds for six months of training to be replicated in the different jurisdictions, Nezahualcoyotl, Ecatepec, Naucalpan, Tlalnepantla, Toluca and Cuautitlán, in order to prepare participants in the following topics: condom use, negotiation with customers, male identity, self-esteem and value of their role in HIV/AIDS prevention as health promoters.

2. For the healthcare personnel sensibilization strategy: The goal is to train personnel in 310 healthcare units, giving priority to 36 general hospitals.

- This will take up \$600,000 pesos for the trainer training strategy.

3. For the strategy directed at prevention in pregnant women:

- \$100,000 pesos for the elaboration of printed material.

4. For the gender inequalities diagnosis strategy:

- \$200,000 pesos for the comparative diagnosis.

STEP 6

Indicators

Indicators
Continued use of condom.
Healthcare services quality.
Increase in detection of HIV in pregnant women.

[∇] Translator's note: In August 2005, the approximate exchange rate for the Mexican peso is: \$11 pesos per American dollar, \$15 pesos per Euro, \$28 pesos per pound.

The first indicator can be obtained through surveys of sexual practices accustomed by CSW and clients, while the others can be obtained through surveys of healthcare services users, considering gender perspective.

MORELOS

STEP 1

Revision of the Diagnosis from a Gender Equality Perspective

The state has its own epidemiological information, which it gets through the IMSS, the ISSTE[∇] and other healthcare and welfare institutions. In addition to this, they consider information from clinical labs, which hand in a weekly report of positive and negative cases from the testing they perform. This data is corroborated before providing epidemiological watch.

The diagnosis also includes information from surveys on sexual behaviour and practices taken among teenagers, CSW women and migrants, and the information provided by the “Centinela” surveys (2002) taken of teenagers and young adults 15 to 24 years old.

Part of the information is desegregated by sex. This desegregation is obtained from the survey sheets, in which some risk practices have been identified: in IDU, for example, the information is desegregated by sex and efforts are made in conjunction with rehabilitation centres (positive results from thyzo blood tests, like ELISA, are sent to the Ministry of Health). In the case of CSW, they only work with women. For the MSM group, information is gathered in collaboration with a non profit organization called CD4, and so far, they have only performed sexual behaviour survey.

For the period between 2000 and 2003, in Morelos, 114 people were undergoing anti-retroviral (ARV) treatment. 67 of these were men and 47 women, including some minors. Of the registered HIV carriers in the state, 140 are men and 57 women.

[∇] Translator’s Note: IMSS, *Instituto Mexicano del Servicio Social*, is a government run, national institution that provides welfare (including pensions, healthcare and other services) for the working population. ISSSTE, *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*, also government run, provides the same services for government employees.

In the year 2002, 238 tests were requested, 122 by men and 116 by women. Between January and May 2003, 107 tests were requested, 56 by women and 51 by men.

In 2001, a second generation behaviour watch was performed within specific groups.

In coordination with the state's "Jornaleros" Program (which organizes legal, temporary migration) and the "Leave Healthy, Return Healthy" Program, a survey was performed including 717 interviews to migrants. In addition 770 questionnaires were collected among female CSW and 1,508 to young adults and teenagers (half of them in schools and half of them in textile factories).

Besides this, educational material was printed out for a permanent program directed at teenagers in middle and higher education (equivalent to 12-14 year olds and 15-18 year olds respectively), consisting of three booklets that provide the following: a) basic information, b) information about safe sex, and c) information about protected sex. There are also workshops for parents, where they are given the material and explained all the elements of sexual education, encouraging communication. This material is mainly focused on urban population.

For MSM, CENSIDA material is printed out, and CD4, the non profit organization, is in charge of distribution. The material was adapted for the group, especially the language. There are no special materials for female CSW, because they work directly with municipal authorities.

The HIV/AIDS program is in constant communication with different non profit organizations to reinforce their work, among them: **CD4**, whose work focuses on prevention among MSM; **Cadena contra el Sida** (Chain Against Aids) offers food baskets to infected people; **Vida de Morelos** (Morelos Life) provides social assistance and in some cases, helps find temporary shelter for people living with AIDS; and **CIDHAL**, an organization that develops actions directed at women. The program also keeps close ties with the state funded organization *Causa Joven* (Young Cause or Youth Cause).

The diagnosis stems from the fact that that profile of the epidemic is heterosexual and is mostly focused on teens. In this aspect, there is no distinction made between male and female teenagers, or vulnerable or specific group. Nevertheless, by 2002, the HIV/AIDS population was as follows:

- o IDU: 2%.
- o Heterosexuals: 32%.
- o Perinatal: 2%.
- o Prostitution Sex: 16%.
- o Bisexuals: 22%.
- o Homosexuals: 14%.

- No Documentation: 3%.
- Prostitution Sex AIDS: 9%.

By age group, the state follows the national tendency in the 15 to 44 year old group.

- ☞ In Morelos, the man/woman ratio for detected cases is one of the lowest in the country.
- ☞ There is no information about male CSW.
- ☞ The epidemic is preponderantly heterosexual, and the main cause is sexual transmission.

STEP 2

Inequality Analysis

Inequality plays a major part in terms of discrimination. Socially, there is greater sensibility towards the subject, for although the stigmas and discrimination persist, the demand for information has steadily increased. Prison inmates, for example, have been given talks and workshops on the subject. There is also a higher demand for work proposals (teenager awareness program) in private schools. This shows that fear and stigma have been slowly declining.

Nonetheless, many myths and taboos about different sexual practices and the exercise of teenage sexuality still exist, and this cancels out the effect of information campaigns about safe sex. In rural areas and small communities, people's access to healthcare services is limited by the strong possibility that the healthcare worker knows the person seeking service. There is fear of identification and discrimination, which makes people more prone to incur in risk practices.

On occasion, confidentiality is not respected among healthcare workers, especially in rural areas, which makes people more reluctant to approach them and demand service. The lack of resources for personnel training prevents change in this situation. In fact, only jurisdictional chiefs receive training, and they must replicate and multiply what they have learned, which opens many possibilities for non-compliance. As if this were not enough, the infrastructure is inadequate and there is no incentive system in place. One of the groups most affected by this situation is women, as well as male CSW.

Apparently, everyone has access to healthcare services. In the case of MSM, for example, they are using these services more and more thanks to the help of the non profit organization, CD4. It is not clear if they face discriminatory barriers in their access to healthcare, because they receive all their information, material,

condoms, etc. through CD4. It must be acknowledged that, among discriminated groups, CSW men are at the top of the list, and they are, therefore, not easy to identify. CSW women are a different case, because municipal authorities usually keep records of CSW women in their jurisdiction.

It is important to point out that resources are appointed, in the state, to epidemiological watch, because the head of the HIV/AIDS program is also responsible for all epidemiological watch in Morelos, but those resources are channelled for the general population and not by risk group. Besides, there is an external factor that provides support for all efforts in the state, improving results: the National Public Health Institute (*Instituto Nacional de Salud Pública*) is based in Cuernavaca, the state capital.

The criteria that define the epidemiological watch are: disease load and some incipient gender criteria (especially those that refer to equal watch over men and women, independent of their sexual practices), that are in accordance to Official Mexican Norms NOM 010 and NOM 017 for epidemiological watch.

With people who have tested positive, the periodical watch is done once a year, if they have developed AIDS, twice a year. “Centinela” and sexual behaviour surveys are taken each year, with a variable sample size.

The goals of the program are not desegregated by sex, except those that are related to pregnant women. Due to this, there is no data on how much is spent on each man and each woman. The vulnerable population is not clearly identified in terms of goals. Although there are some previsions for the following years in terms of gender issues, there is no data, and no specific yearly goals have been made.

- ☞ There is greater stigmatization in rural and small urban areas, which makes people’s access to healthcare services more difficult; inequalities are especially high for women who live in rural areas.
- ☞ In the case of MSM, the most direct link to the group is a non profit organization (CD4), and the organization is in charge of developing campaigns and distributing condoms; which makes it impossible to know for certain if they face discriminatory barriers or not. Even so, it is assumed that they do.

STEP 3

Determination of Specific Components and Actions for the Reduction of Inequalities

The program's components are: sexual prevention, blood transmission prevention, perinatal prevention, attention and damage control.

According to the information provided, resource assignment had the following structure: prevention, 86.1%; attention, 12.7%; and institutional strengthening (education and communication), 1.2%. Damage control was not included in this year's Annual Operative Program (POA 2004). The budget calculated the need for 10 million Mexican pesos, yet they were only assigned four million pesos. It would seem that Morelos spends more on prevention than on treatment, which is rare for any state in Mexico, but the figures did not include cost of the treatment, because Morelos has consolidated purchasing for this type of medication.

Priority Actions and Benefiting Population for each Component

Component	Actions/Beneficiaries
Sexual Prevention	Awareness campaigns for the general population.
	Education programs about healthy sexual behaviour for vulnerable groups: MSM, Women CSW, teenagers (15-24), migrants, pregnant women.
	Promotion and distribution of condoms to the general population, especially to groups with risk practices (MSM and Male CSW).
Perinatal Prevention	Information and counselling for women with STDs, or who are HIV positive.
	Detection of syphilis and HIV in pregnant women (goal: 100%).
	Prophylactic treatment for HIV positive women.
Blood Transmission Prevention	Campaigns about safe blood transfusions and transplants for the general population.
	Hepatitis B vaccination campaigns for donors, healthcare personnel and risk groups.
	Training for legal area and healthcare personnel of CONADIC who work with IDU.
	Training in the correct following of universal precautions for healthcare personnel.
Integral Attention	Detection and treatment of HIV/AIDS and STDs for any person who requests it.
	Strengthening of counselling, attention and treatment services, directed at healthcare personnel.
	Actions to ensure the medication supply, directed at healthcare personnel.
	Improvement of the epidemiological watch.

	Improvement in service quality, directed at healthcare personnel.
Damage Control (Not in Budget)	Workshops about stigma and discrimination, directed at non profit organizations.
	Inter-institutional coordination to offer different services to the community (shelters, orphanages, food baskets, identification of adoption families).
	Actualization of networking, institutional services and community support directories.
	Encouragement of the denouncement of human rights problems and support for the defence of human rights cases.
	Revision of state legislation to favour respect of human rights and to avoid discrimination.

Campaigns and actions are focused on the general population. There are no resources, campaigns or posters directed at specific populations, with specific messages. Nonetheless, the Program supplies paper to different non profit organizations for this effect, for example, to CD4, which makes and distributes their own awareness posters.

STEP 4

Definition of Priorities

Actions that should be added in order to make the program more gender sensitive:

Sexual Prevention:

- ✓ Specific campaigns for specific groups, particularly women, male and female CSW and migrants.
- ✓ Identification of male CSW groups, because female CSW have already been identified by municipal authorities, and there has even been a census taken.
- ✓ Monitoring of pregnant women, through an increase in testing, which is now very low.
- ✓ Distribution of condoms in schools, because the current distribution channels are not efficient, and this makes distribution to youth very difficult. This type of action would have to be performed at a national level, with a multi-sector

focus as well as a gender focus, in order to ensure equal distribution to men and women, particularly young men and women.

- ✓ Increase in collaboration between CENSIDA and the Reproductive Health Administration.
- ✓ Training and sensibilizing within the health sector, so that teenagers may be given the information, attention and contraceptive material they need, while respecting their right to confidentiality, and without discrimination.
- ✓ Differentiated information about STDs, because men request check-ups less frequently than women, partly because some diseases may be asymptomatic in their case.

Perinatal Prevention:

- ✓ Given that the actions performed seem to be adequate, there are no new priorities established for this component.

Integral Attention:

- ✓ For counselling: training and sensibilization of personnel in issues like confidentiality, gender perspective, sexuality, HIV/AIDS and STDs. This is already done in second level attention areas, but training is also required for first level attention personnel, as well as permanent actualization for everyone about new treatments, human rights, etc.
- ✓ Improvement of epidemiological watch: timely notification, correct filling in of all formats and sheets. The problem is already diminishing, because information is monitored and corroborated, but it persists and it must become a priority to correct it.

Damage Control:

- ✓ Organize workshops against stigmatization and discrimination through non profit organizations, so that they can replicate them. There has already been some work with personnel from different jurisdictions. Stigmatization and discrimination issues should be handled in conjunction with informative material for youth.

STEP 5

Budgeting

Even considering that the corresponding revision of the 2004 Budget Project was not performed, some elements that could be included in the structuring of the new budget projects were identified.

- Resources for the design, printing and distribution of material for a sexual prevention campaign are fundamental.
- These resources can be tagged, in order to ensure that they are used for campaigns, posters, etc., directed at specific groups.
- Resources are needed for training and sensibilization of personnel on issues like gender, discrimination, human rights and HIV/AIDS. This is even more important for those working with youth, MSM and CSW.
- Budgeting for follow-up and evaluation actions.

CHIHUAHUA

STEP 1

Revision of the Diagnosis from a Gender Perspective

The only source of information that the Program has are the data collected on a central level by CENSIDA, which are only partially desegregated by sex.

There are no “Centinela” or any other type of survey taken in the state, making the first limit of the diagnosis the fact that vulnerable groups have not been identified. Diverse sexual practices are also mostly unidentified, and there is no desegregation by sex or by age.

The information that is available shows the following:

- The first HIV/AIDS cases in the state presented around 1984. There have been no substantial advances in the information generated since that date.
- It is known that the epidemic is mostly heterosexual.
- The most vulnerable group is MSM.
- Despite Program authorities' acceptance of the fact that there is a large number of people in the IDU group, this is not considered an important factor for blood transmission, because it is not registered as a risk group for HIV/AIDS transmission.

- ☞ Information about HIV/AIDS in the state is scant and incomplete, because of the lack of “Centinela” surveys (which give more complete information). This is due, on the most part, to:
- ☞ The existence of a conservative society, in which stigmatization occurs very frequently.
- ☞ The lack of recognition of diverse sexualities and risk practices.
- ☞ The fluctuation of population that migrates from other states in the country, and its possible influence on the epidemic, are not taken into account.
- ☞ The little information that is available shows that the epidemic is essentially heterosexual and that there is greater incidence in men.
- ☞ Even when there are many IDU, they are not considered a focus of infection in terms of blood transmission because this practice is not officially recognized.
- ☞ The geographical and socio-cultural situation of the state has a negative influence on the complexity of information collection and clear strategy design for fighting the epidemic.

STEP 2

Analysis of Inequalities

The lack of information pointed out in the previous step is a major obstacle for the clear observation of how gender inequalities influence the incidence of HIV/AIDS in the state.

According to the civil society organizations that participated in the workshop, as well as one of the people responsible for the Program in the state, the sub-register and lack of truthfulness in the information is due essentially to the extremely conservative society that prevails in Chihuahua. The stigmatization that exists in connection to the virus causes many people to lie about their risk practices and their sexuality.

The lack of disposition and sensibilization on the part of healthcare workers is likely to be one of the causes that make acquiring data about both male and female patients very difficult. It also keeps many patients from deciding to get necessary and relevant testing.

In Chihuahua, women do not often attend healthcare services for HIV testing (it seems to us that saying “what this implies at a socio-cultural level” is too ambiguous; gender perspective, in fact, is also a factor and has many implications on the socio-cultural plane, which shows that this is not a clear explanation of why women do not get tested). When they do request a test or treatment, it is because their partners have been infected with the disease, making them aware that they are very much at risk.⁷

⁷ The epidemic in Chihuahua has followed the national tendency, with a man/woman ratio of 6:1.

Lack of information makes it difficult to trace goals that really diminish gender inequalities. In Chihuahua, they stem from the fact that there is no self-care culture in the population, and that there is discrimination of certain groups (CSW, IDU and MSM) within the healthcare services units.⁸

Even with the issue so stigmatized and information so scarce and unreliable, general consensus is that the most affected group is MSM, who in most cases are also CSW and/or IDU, but there are no specific strategies directed at them.

The HIV/AIDS problem has not been analyzed in terms of gender, although the heads of the Program admit to having found that one group that should be focused on is that of young women, who, in places like Ciudad Juárez (the state capital), are an important risk group.

The problem, once again, is that there is no diagnosis that shows vulnerable groups and different risk practices. Nevertheless, there is evidence of gender inequalities that, in this case, affect women, for example: women are discriminated when under treatment for IDU, and on many occasions, their children are taken from them.

In some jurisdictions of Chihuahua, the existence of male and female CSW is denied completely (the same goes for IDU), which is also a factor for sub-registration. Despite the fact that one of the main public health problems in the state is that of teenage pregnancies and perinatal death, data about sexual habits is not taken into account for the diagnosis.

- ☞ The major inequality lies on the simple fact that there is no information desegregated by sex or by risk group, not even at a state-wide level.
- ☞ Inequalities because of sex and different sexual practices are an important factor for infection of HIV/AIDS.
- ☞ The most vulnerable group is MSM; nevertheless, stigmatization prevents most from accepting their own sexual preferences, and specific strategies from being directed at them.
- ☞ Chihuahua does not have the minimum gender focus, and there is absolutely no gender perspective on their treatment of this epidemic.

STEP 3

⁸ Program authorities do not have hard facts about the proportion of men and women who seek testing and/or treatment for the virus, they only know that it varies in different healthcare facilities (but there is no record showing which cities or jurisdictions vary).

Determination of Specific Components and Actions for the Reduction of Inequalities

Considering that the diagnosis does not show substantial data about the epidemiological situation and vulnerable groups, it is difficult to direct components of the program specifically towards these groups.

Within the Annual Operative Program (POA) for 2004, the Treatment component takes up most of the resources, followed by Sexual Prevention and Blood Transmission Prevention, which consist of quick testing for syphilis. There are 90 men and 31 women currently in treatment.

There are no resources included for IDU in the blood transmission prevention budget, but a diagnosis survey has been performed for this population. IDU and youth are the most defined focus populations, although there are no articulated strategies designed for them.

Sexual prevention actions consist in the distribution of pamphlets and awareness campaigns among youth. The content is the same for both sexes. Condom distribution resulted in 39,868 condoms handed out to men, and 28,585 handed out to women.

Detection has a separate budget, with which 3,961 tests were done on the general population. This area does have information desegregated by sex. The test was practiced on 2,410 women and 1,551 men, in 610 populations with risk practices.

In the case of Perinatal Prevention, a pamphlet was designed for women. Some detection tests were done on pregnant women, but these have a cost, which keeps many people from requesting them.

There are resources assigned to institutional strengthening programs and strategies (that can be helpful in training and sensibilizing personnel at an operative and supervision level, on gender perspective).

It is important to mention that within the 2004 Annual Operative Program, the purchase of baby formula and follow-up on potentially infected children is considered. For all of these cases, and as is common with many state budgets, there are no funds assigned for damage control.

☞ Summing up: there are no differentiated attention strategies for different groups. No home visits, or strategies for attending orphans are considered either. In general, incorporation of actions based on a gender equality perspective is recommended for all the Program's components.

STEP 4

Definition of Priorities

The work team came to the conclusion that in order to have a set of priorities different to the ones currently in place, more resources would be necessary for the sexual prevention, damage control, blood transmission prevention and perinatal prevention components. The treatment component is unavoidable, and it is also the one using up most of the funds available. The recommendations are the following:

- 1) Incorporate a gender equality perspective in the Program's objectives and actions, with special attention for IDU's partners, work with young women and the design of specific actions for MSM.
- 2) Reformulate objective by vulnerable groups, considering a gender perspective.
- 3) Identify specific areas where risk groups concentrate (such as gay bars).
- 4) Incorporate new risk groups that are characteristic of this state, such as women who work in factories.
- 5) Identify the female sexual partners of people who belong to vulnerable groups, in order to provide them with objective information, so that they will have decision parameters and negotiation guidelines, for example, when to request that their partner use a condom.

In terms of the budget, it is necessary to consider assigning funds to the damage control component, which currently, has none. It is also necessary to include the salaries for one or two people from non profit organizations, who can work with IDU and MSM "pairs".

Due to the lack of information the program suffers from, indicators for Chihuahua are designed using basic national information. The following table orders them according to the priorities established:

Priorities were established according to general guidelines, as follows:

COMPONENT	STRATEGY	INDICATOR
Sexual Prevention	<ul style="list-style-type: none">• Information for specific groups (pamphlets and fliers):	<ol style="list-style-type: none">1) Number of pamphlets handed out for each group.2) Coverage percentage of the objective population.

	<ul style="list-style-type: none"> - IDU and their partners - IDU women - Young women - Female factory workers - MSM - Female and male prison interns - Migrants (families on border and transit areas). 	<ol style="list-style-type: none"> 3) Number of condoms handed out for each sex. 4) Number of young women who accept a condom. 5) Ratio of total schools visited/total number of schools, for each level of education.
Damage Control	<ul style="list-style-type: none"> • Massive campaigns against stigmatization of people with the disease (posters, advertisements in the media, workshops). • Empowerment of affected social groups (which will be done in cooperation with non profit organizations). • Human rights handout sheets including data about how to enter a complaint against healthcare authorities that practice discrimination. • Training for healthcare workers in HIV, gender and human rights issues. 	<ol style="list-style-type: none"> 1) Total number of reports per year. 2) Number of workers trained/total number of workers in the area. 3) Number of complaints about service in the area.
Blood Transmission Prevention	<ul style="list-style-type: none"> • Continued detection of IDU in men and women. • Distribution of syringes and hygiene equipment (water, chlorine and cotton) through non profit organizations, to diminish risk for IDU. 	<ol style="list-style-type: none"> 1) Number of new cases, male and female. 2) Quantity of equipment distributed per non profit organization.
Perinatal Prevention	<ul style="list-style-type: none"> • Purchase of small (six tube) centrifugal detection equipment for detection in pregnant women in rural communities. • Purchase of reactive chemicals, syringes and needles. • Detection and attraction of pregnant women to 	<ol style="list-style-type: none"> 1) Number of HIV positive pregnant women detected in rural communities.

	include them in the timely HIV and syphilis detection system through community promoters.	
Institutional Strengthening	<ul style="list-style-type: none"> • Training in the correct filling of forms. • Training on official norms for healthcare workers and laboratories, as well as private doctors and hospitals. 	<ol style="list-style-type: none"> 1) Percentage of correctly filled forms. 2) Number of returned forms.

Steps 5 and 6 were not concluded, and in the case of the indicators suggested, these were added to the ones in Michoacán's example.

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