Gender mainstreaming in WHO: where are we now?

REPORT OF THE BASELINE ASSESSMENT OF THE WHO GENDER STRATEGY

World Health Organization

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Abbreviations

AFR	WHO African Region
AFRO	WHO Regional Office for Africa
AMR	WHO Region of the Americas
AMRO/PAHO	WHO Regional Office for the Americas/Pan American Health Organization
CO	Country office
CCS	Country cooperation strategy
EMR	WHO Eastern Mediterranean Region
EMRO	WHO Regional Office for the Eastern Mediterranean
EUR	WHO European Region
EURO	WHO Regional Office for Europe
GWH	Department of Gender, Women and Health
GWHN	Gender, Women and Health Network
OSER	Office-specific expected results
RO	Regional office
SD	Strategic direction
SEAR	WHO South-East Asia Region
SEARO	WHO Regional Office for South-East Asia
UG	Ungraded (post)
WPR	WHO Western Pacific Region
WPRO	WHO Regional Office for the Western Pacific

Executive summary

In May 2007, the World Health Assembly (WHA) approved resolution WHA60.25 on the *Strategy for integrating gender analysis and actions into the work of the World Health Organization* (WHO Gender Strategy) and asked the Director-General to report on progress made in implementing the resolution every two years.

This report presents the synthesis findings of a baseline assessment that was conducted in all six WHO regions and at headquarters in 2008 to determine the current status of gender integration in WHO and to identify gaps and actions to implement the WHO Gender Strategy. The WHO Gender Strategy is being implemented through four strategic directions (SD):

SD1: Building WHO capacity for gender analysis and planning;
SD2: Bringing gender into the mainstream of WHO's management;
SD3: Promoting use of sex-disaggregated data and gender analysis;
SD4: Establishing accountability.

For the first strategic direction (SD1), the baseline examined institution-wide capacity for gender analysis and actions through an all-staff online survey in which 2160 WHO staff participated. For the second strategic direction (SD2), 131 planning officers were interviewed to examine the extent to which gender was integrated into WHO's operational planning and programme cycle. Human resources data from 2007 were analysed to examine WHO's proximity to achieving sex parity in staffing, and a content review of documents was conducted to assess whether country cooperation strategies (CCS) and country workplans integrate gender adequately. The third strategic direction (SD3) was measured through a content review of key WHO publications that assessed the extent to which they promote and use sex-disaggregated data (SDD) and gender analysis. The last strategic direction (SD4), measuring senior management accountability for gender equality, was assessed through a content review of their speeches.

The results corresponding to strategic direction 1 (SD1) highlight that a majority of WHO staff who participated have a basic understanding of gender and health. The online survey shows that nearly four out of five staff are aware of the WHO gender policy and/or the WHO Gender Strategy, and nearly three out of five staff have a good knowledge of basic gender concepts. A majority of staff (60% or more) report that gender is relevant either to their own work or to the work of their units. In contrast, a smaller proportion of staff (one third) are at least moderately applying gender analysis and actions to their work and, similarly, only one third report receiving institutional support for integrating gender into their work. Staff in the Region of the Americas (AMR) consistently do well on basic understanding of gender and health, application of gender analysis to their work and institutional support for gender mainstreaming, whereas headquarters (HQ), the South-East Asia Region (SEAR) and the Eastern Mediterranean Region (EMR) lag behind on these indicators. Staff report a need for more knowledge and skills related to gender analysis, tools and evidence, as well as technical support from gender units or focal points in order to be able to integrate gender into their work.

The findings related to strategic direction 2 (SD2) reveal that there is a strong level of gender integration in the operational planning process, but very few units integrate gender during the implementation and monitoring and evaluation stages. Collaboration with gender focal points or units is a key factor encouraging the integration of gender into operational planning. Furthermore, very few country cooperation strategies (three out of nine sampled) have integrated gender, despite the existence of an institutional framework requiring country cooperation strategies to integrate gender. Only five out of 14 sampled country workplans integrate gender. With respect to sex parity in staffing, women are underrepresented, particularly at the higher professional

grade levels (P4 and above), at all levels of the Organization. For example, no more than one quarter of all senior management (i.e. grades D and UG) are women.

The baseline status of strategic direction 3 (SD3) highlights this to be another area where WHO needs to improve. For example, less than one quarter of the sampled WHO publications promote or use sex-disaggregated data and roughly half of them promote or use gender analysis.

Lastly, with respect to strategic direction 4 (SD4), which measures institutional accountability related to gender, only a third of the public speeches (14 out of the 40 sampled) made by senior management (Regional Directors and Director-General) include any reference to gender, whereas the findings of the online survey and planning-officer interviews highlight that senior management commitment is essential for encouraging WHO staff to integrate gender into their work.

In conclusion, WHO is doing well in terms of staff's awareness of gender and health concepts. It is also doing modestly well in integrating gender into the operational planning process. However, much more work needs to be done to build capacity and create an enabling institutional environment for staff to apply gender analysis skills to their work and to support the integration of gender into the implementation and monitoring and evaluation stages of the programme cycle. There is also a need to support ministries of health in order to reflect gender in country cooperation strategies and country workplans and to generate and use sex-disaggregated data. Advocacy is required to encourage WHO technical units to promote and use sex-disaggregated data and gender analysis in their publications. Advocacy is also required to increase senior management commitment to gender equality, not just through public speeches, but also through other accountability measures (performance reviews, tracking resource allocations, etc.). Tools, capacity-strengthening, evidence generation and advocacy are needed to support integration of gender into WHO's work.

1. Introduction

In response to the Beijing Platform for Action,[1] the Executive Board, at its 116th session, requested the Director-General to prepare a draft strategy and plan for bringing gender into the mainstream of WHO's work.[2] Responding to this request, in May 2007, the Secretariat submitted a draft *Strategy for integrating gender analysis and actions into the work of the World Health Organization* (WHO Gender Strategy) to the Sixtieth World Health Assembly for its consideration. The World Health Assembly adopted resolution WHA60.25 and asked the Director-General to report on progress made in implementing the resolution every two years. A draft plan of action (PoA) was also prepared to support the implementation of the WHO Gender Strategy.

The WHO Gender Strategy is being implemented through four strategic directions:

SD1: Building WHO capacity for gender analysis and planning;
SD2: Bringing gender into the mainstream of WHO's management;
SD3: Promoting use of sex-disaggregated data and gender analysis;
SD4: Establishing accountability.

The entire WHO Secretariat, including headquarters, regional offices and country offices, is responsible for implementing the WHO Gender Strategy. The Gender, Women and Health Network (GWHN)[3] plays a catalytic role by providing technical support for the implementation of the Strategy. In 2007, the Network developed a monitoring and evaluation framework to support the implementation of the Strategy (see **FIGURE 1**). The monitoring and evaluation framework was built on actions and indicators identified in the draft plan of action. The first step in the monitoring and evaluation framework was to conduct a baseline assessment. This report presents the synthesis of the results of the baseline assessment conducted in all six WHO regions and headquarters.[4]

FIGURE 1 The WHO Gender Strategy monitoring and evaluation framework

[1] United Nations. Beijing Declaration and Platform for Action. In: *Report of the Fourth World Conference on Women (Beijing, 4–15 September 1995)* (United Nations Document A/CONF.177/20/Rev.1). New York, United Nations, 1996.

[2] See document EB116/2005/REC/1, summary record of the second meeting.

[3] The Gender, Women and Health Network (GWHN) includes the Department of Gender, Women and Health at headquarters, the gender regional advisers and/or gender units in the regional offices and the gender focal points in country offices.

[4] Regional reports are available for the following WHO regions: Western Pacific (WPR), Europe (EUR), Eastern Mediterranean (EMR), Americas (Pan American Health Organization – AMR/PAHO) and Africa (AFR). The findings from headquarters (HQ) are included in this synthesis report, not reported separately.

1.1 Purpose

The purpose of the baseline assessment is twofold: to determine the current status of gender integration in WHO in relation to the four strategic directions of the WHO Gender Strategy and to identify gaps and actions to implement them.

The baseline values reported here supported the Director General in her first progress report on resolution WHA60.25 to the World Health Assembly in 2009, and will provide the benchmarks against which progress in the implementation of the WHO Gender Strategy will be monitored in the future.

1.2 Objectives

The specific objectives of the baseline assessment are to assess:

- institution-wide capacity for gender analysis and actions (SD1);
- the extent to which WHO management has integrated gender (SD2) by:
  - examining WHO's proximity to achieving sex parity in staffing in 2007
  - measuring the extent to which WHO's operational planning and programme cycle integrates gender and
  - assessing whether Country Cooperation Strategy documents and country workplans address gender;
- the extent to which key WHO publications promote and use sex-disaggregated data and gender analysis (SD3);
- commitment of senior management (e.g. Director-General, Regional Directors) to gender equality (SD4).

2. Methods

The method for the baseline assessment involved defining and developing indicators to measure each of the four strategic directions (see **TABLES 2.1 TO 2.4**). The assessment used a mixed-method approach for collecting qualitative and quantitative data.[1] A team of consultants collected data between February and September 2008.

2.1 Strategic Direction 1: Building WHO capacity for gender analysis and planning

An online anonymous survey (see **ANNEX 1**) was conducted to assess awareness of institutional gender equality policies/strategy, knowledge of gender concepts, application of gender analysis skills and level of institutional support received by staff for integrating gender into their work. All WHO staff were emailed a link to the online survey and encouraged by senior management in their respective offices (i.e. Assistant Directors-General, Regional Directors and Directors) to complete the questionnaire. The survey data were subjected to data compilation and statistical analysis to calculate the baseline values for the indicators (see **TABLE 2.1**).

TABLE 2.1 Measures of staff capacity for gender analysis and planning

	INDICATORS	DEFINITIONS
1	Overall: Percentage of all WHO staff (by sex, WHO category, WHO level and WHO region[a] who have a basic understanding of gender and health	
1.1	Percentage of all WHO staff with awareness of at least one WHO gender policy or strategy	Awareness of at least one of the four WHO gender policies or strategies
1.2	Percentage of all WHO staff with a good knowledge of gender concepts	Knowledge of gender concepts classified as none, some or good, based on four knowledge questions. Answering at least 3 out of 4 questions correctly was categorized as having good knowledge
1.3	Percentage of all WHO staff who say Yes, gender is relevant to the work of unit	Relevance of gender to their own work and to the work of their unit categorized as yes, no or don't know in response to two questions in the online survey
1.4	Percentage of all WHO staff who say Yes, gender is relevant to their own work	
2	Percentage of all WHO staff who are at least moderately applying gender analysis and actions in their work (disaggregated by sex, WHO category, WHO level and WHO region)	Measured on a scale of not applying, some, moderate, or strong application. These are based on 11 questions with scores ranging from 0 to 11. Those who score 6-11 points are classified as at least moderately applying gender analysis
3	Percentage of WHO staff who report at least some institutional support for integrating gender issues into their work (disaggregated by sex, WHO category, WHO level and WHO region)	Measured on a scale of none, some, or strong support. It is based on four questions. Those who reported at least one form of institutional support are categorized as receiving at least some institutional support

[a] The term "WHO category" refers to professional (P), administrative (G) and director-level (D) staff. The term "WHO level" refers to headquarters (HQ), regional offices (RO) and country offices (CO).

[1] Data-collection tools were pretested at AMRO/PAHO and refined thereafter.

A total of 2160 out of 8560 staff (25%) responded to the online staff survey.[1] This is within the expected range of response rates for self-administered online surveys,[2] which face self-selection bias – in this case, WHO staff with a knowledge of or interest in gender.

2.2 Strategic Direction 2: Bringing gender into the mainstream of WHO's management

Data for this strategic direction were collected to measure i) the extent to which gender was integrated into the programme cycle; ii) the extent to which country cooperation strategies and country workplans integrate gender; and iii) the extent to which there is sex parity in WHO staffing (see **TABLE 2.2**).

TABLE 2.2 Measures of integration of gender in WHO's management

	INDICATORS	DEFINITIONS
4.1	Percentage of planning focal points whose responses reflect "strong" integration of gender during the **operational planning process** for the 2008–2009 biennium (by sex, WHO category, WHO level and by collaboration with the Gender, Women and Health Network)	Integration of gender into **operational planning** is classified as weak, moderate or strong. These categories are based on questions 11–18 of the questionnaire (Annex 2), with scores ranging from 0 to 8 points. Those who score 7 or 8 are classified as strongly integrating gender
4.2	Percentage of planning focal points whose responses reflect "strong" integration of gender during **programme implementation** for the 2006–2007 biennium (by sex, WHO category, WHO level and by collaboration with the Gender, Women and Health Network)	Integration of gender into the **programme implementation** is classified as weak, moderate or strong. These categories are based on questions 21–25 of the questionnaire (Annex 2), with scores from 0 to 12. Those who score 10–12 are classified as "strongly integrating gender"
4.3	Percentage of planning focal points whose responses reflect "strong" integration of gender issues during **programme monitoring and evaluation** for the 2006–2007 biennium (by sex, WHO category, WHO level and by collaboration with the Gender, Women and Health Network)	Integration of gender into **programme monitoring and evaluation** is classified as weak, moderate or strong. These categories are based on questions 28–33 of the questionnaire (Annex 2), with scores ranging from 0 to 25. Those who score 19–25 are classified as "strongly integrating gender"
5.1	Number of post-2005 country cooperation strategies, of those sampled, that strongly integrate gender	In the content review of the country cooperation strategy documents, a series of criteria are applied. For each criterion that is met, the document is given a score of 1. Scores range from 0–9. The number of country cooperation strategies that score at least 7 is totalled to arrive at this indicator value
5.2	Number of 2006–2007 biennial country workplans, of those sampled, that strongly integrate gender	In the content review of the country workplans, a series of criteria are applied. For each criterion that is met, the country workplan is given a score of 1. Scores range from 0 to 6. The number of country workplans that score at least 5 is totalled to arrive at this indicator value
6.1	Percentage of all professional and administrative long-term and temporary posts by sex and grade level (cumulative) until 31 December 2007	"Long-term" posts or appointments refer to positions lasting longer than 12 months "Temporary" posts or appointments refer to positions lasting 12 months or less
6.2	Percentage of all long-term and temporary new appointments in 2007 by sex and WHO category (Professional, National Professional Officer and General Service)	Grade levels are Professional (P1-P6, D1, D2, UG); National Professional Officer (A, B, C and D); and General Service (G1-G7)

[1] This percentage was calculated using the total long-term and temporary staff figures published in the *Human resources: annual report*, 10 April 2008, p. 5.

[2] Hamilton MB (2003). *Online survey response rates and times: background and guidance for industry*. Cambridge, MA, Tercent Inc. (http://www.supersurvey.com/papers/supersurvey_white_paper_response_rates.pdf, accessed 26 April 2010).

To measure the integration of gender into the operational planning and programme cycle, face-to-face and phone interviews were conducted with 131 planning focal points[1] who were involved in operational planning in 2007. The interviewers used a structured and open-ended questionnaire (see **ANNEX 2**). It focused on three things: how gender issues were incorporated into operational planning for the Medium-Term Strategic Plan (2008–2013), how the 2006–2007 programme implementation incorporated gender, and how programme monitoring and evaluation activities for 2006–2007 integrated gender.

Integration of gender into country cooperation strategy and country workplans was assessed through content analysis of country cooperation strategy documents prepared after 2005 and the 2006–2007 biennial country workplans. A total of nine country cooperation strategy and 14 country workplans were sampled across the six WHO regions. The content analysis of the country cooperation strategies focused on whether the document:

- explicitly mentioned promotion of gender equality;
- consulted with women's groups and/or involved the Ministry of Women's Affairs;
- promoted sex-disaggregated data;
- analysed/interpreted the different outcomes for women and men;
- specified actions to address gender inequalities.

Similarly, the content analysis of the country workplans focused on whether they:

- included a statement on gender equality or equity;
- specified an action, product or services for collaboration with women's groups;
- specified a product, action or services for using or promoting sex-disaggregated data;
- included at least one office-specific expected result, or product or activity or service that specifically mentioned addressing gender.

Information on sex parity was compiled from data reported in the *Human resources: annual report* for 2008 and supplemented by human resources data, including data on temporary staff, provided by the relevant units in the Regional Offices for the Americas and the Western Pacific.[2]

2.3 **Strategic Direction 3:** Promoting use of sex-disaggregated data and gender analysis

This strategic direction is measured by the extent to which WHO publications from 2007 promote or use sex-disaggregated data and by the extent to which they promote or use gender analysis in health (see **TABLE 2.3**).

A total of 28 publications from across six WHO regions and headquarters were randomly selected from the 2007 publications list, covering four broad categories: i) seminal institution-wide documents (e.g. *World health report*); ii) policy/governing body documents; iii) evidence-type documents; and iv) tools/normative guidelines. The content review focused on whether the documents promoted and/or used sex-disaggregated data and gender analysis (see **ANNEX 3**).

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[1] Planning focal points are defined as those individuals who were involved in strategic and operational planning in 2007 (typically directors of departments or divisions and/or coordinators of units or teams).

[2] The overall staff numbers for the Regional Office for the Western Pacific provided by the Regional Office human resources unit and those reflected in *Human resources: annual report for 2007* are not very different, except that the former provided sex-disaggregated data for temporary appointments. In the Regional Office for the Americas (AMRO/PAHO), the number of staff reported in *Human resources: annual report for 2007* is only one quarter of the total number of staff that is reported by that Regional Office's human resources unit. This is because *Human resources: annual report for 2007* includes only AMRO/PAHO staff funded by WHO, whereas AMRO/PAHO receives separate contributions from its Member States that fund many more staff, which is not reflected in the WHO database.

TABLE 2.3 Measures on promoting and using sex-disaggregated data and gender analysis

	INDICATORS	DEFINITION
7	Number of new WHO publications, of those sampled, that promote and/or use sex-disaggregated data	Publications that promote and/or use sex-disaggregated data are scored on the basis of a Yes or No response. If the publication scores either 1 or 2, then it is considered as promoting or using sex-disaggregated data. If it scores 0, then it does not promote or use sex-disaggregated data. The number of publications that score a 1 or 2 is totalled to arrive at this indicator value
8	Number of new WHO publications, of those sampled, that strongly promote and/or use gender analysis in health	Publications that promote or use gender analysis in health are compiled from a series of criteria (see Annex 3). The scores range from 0 to 7. Documents that score between 5 and 7 are classified as publications that strongly promote or use gender analysis. Documents that score 2–4 promote or use gender analysis somewhat and those that score 0–1 do not promote or use gender analysis in health. The number of publications with scores of at least 5 is totalled to arrive at this indicator value

2.4 **Strategic Direction 4:** Establishing accountability

This strategic direction was assessed by examining the extent to which senior management are publicly committed to gender equality. It was measured by a content analysis (see **ANNEX 4**) of 40 speeches by the Director-General and Regional Directors (see **TABLE 2.4**).

TABLE 2.4 Measure of institutional accountability for integration of gender into WHO's work

	INDICATORS	DEFINITION
9	Number of speeches by the Director-General and Regional Directors, of those sampled, which include at least one reference to gender	Speeches by the Director-General and Regional Directors in which there is at least one reference to gender, using a word search for 13 words or phrases related to gender (see Annex 4) are totalled

2.5 Ethical considerations

Ethical concerns of maintaining the anonymity of respondents, respect for privacy, confidentiality and ensuring the security of the survey and interview responses were given careful consideration. All respondents to the online survey and the planning officer interviews were given clear information about the purpose of the baseline, the use of the data and how it would be reported. The online staff survey was anonymous and the database was accessible only to the project administrator. Planning officer interviews were conducted in privacy and the officers were asked for their consent to be interviewed and for the use of the information for this report.


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3. Findings

3.1 **Strategic Direction 1:** Building WHO capacity for gender analysis and planning

The findings for the first strategic direction describe: i) the extent to which WHO staff have a basic understanding of gender and health; ii) the extent to which staff are applying gender analysis skills to their work; iii) the level of institutional support for integrating gender into staff's work; and iv) the factors that facilitate or inhibit the integration of gender into WHO's work.

3.1.1 Level of basic understanding of gender and health

Firstly, a high proportion (four out of five) staff are aware of at least one WHO gender policy or strategy (see **TABLE 3.1**). When the overall percentage is disaggregated by sex, the results indicate that more male than female respondents are aware of at least one WHO gender policy or strategy. When disaggregated by staff category, nearly four out of five professionals (P) and three out of four general service (G) staff are aware of a WHO gender policy or strategy.

TABLE 3.1 Percentage by sex and category of respondents who report awareness of at least one WHO gender policy or strategy in WHO regions and HQ

REGIONS AND HQ	BY SEX		BY CATEGORY			OVERALL
	% MALE	% FEMALE	% D[a]	% P	% G[b]	
HQ	83	75[b]	100	77	78	78
WPR	80	80[b]	100	84	75[b]	80
SEAR	84	65[b]	100	79	67[b]	75
EMR	72	69[b]	80	85	52[b]	71
AFR	74	68[b]	78	76	64[b]	71
EUR	83	76[b]	–	86	78[b]	78
AMR	93	93	100	94	88[b]	93
Other[c]	76	69	100	85	56	72
Total	**81**	**77[b]**	**94**	**83**	**71[b]**	**79**

[a] A total of 51 Directors (D) participated across the six regions and HQ. Therefore, the sample size for some response categories is too small to draw meaningful conclusions.
[b] Denotes that the difference in percentage values is statistically significant at $p<0.05$.
[c] "Other" means intercountry support teams, special programmes, Global Fund staff and the Global Service Centre Staff.
– No staff participated in the survey in this category.

Secondly, a moderately high proportion of staff (three out of five) have a "good" knowledge of gender concepts (see **TABLE 3.2**). More men report good knowledge than women. More professional (P and D) staff report good knowledge of gender concepts than general service (G) staff.[1] Between half and two thirds of staff across the six regions and headquarters report "good" knowledge of gender concepts.

[1] This comparison needs to be interpreted carefully, as G staff are not required to have knowledge of gender concepts as part of their terms of reference. Therefore, questions about knowledge of gender issues may not be applicable to them.

TABLE 3.2 Percentage by sex and category of respondents who had a good knowledge of gender concepts in WHO regions and HQ

REGIONS AND HQ	BY SEX		BY CATEGORY			OVERALL
	% MALE	% FEMALE	% D	% P	% G	
HQ	58	58	93	62	45[a]	58
WPR	62	53	100	68	41[a]	56
SEAR	54	47	100	63	42[a]	51
EMR	62	56	60	71	42[a]	59
AFR	59	57	78	64	49	58
EUR	70	63	–	74	54[a]	65
AMR	65	63	50	68	54[a]	63
Other	48	55	50	65	40	52
Total	**61**	**58**	**78**	**66**	**46**[a]	**59**

[a] Denotes that the difference in percentage values is statistically significant at p<0.05.
– No staff participated in the survey in this category.

Furthermore, three out five staff consider gender to be relevant to their own work (see **TABLE 3.3**). This includes approximately two thirds of the male respondents and a little over half of the female respondents.

TABLE 3.3 Percentage by sex and category of respondents within WHO regions and HQ who reported gender being relevant to their work

REGIONS AND HQ	BY SEX		BY CATEGORY[a]		OVERALL
	% MALE	% FEMALE	% D	% P	
HQ	59	51	100	66	54
WPR	76	57[b]	–	81	64
SEAR	61	63	–	74	62
EMR	62	49	–	78	55
AFR	72	59[b]	78	78	66
EUR	67	48[b]	–	73	54
AMR	75	58[b]	90	77	65
Other	52	55[b]	–	73	54
Total	**68**	**54**[b]	**86**	**74**	**60**

[a] Results for G staff are not reported, as working on gender does not form part of their terms of reference.
[b] Denotes that the difference in percentage values is statistically significant at p<0.05.
– No staff participated in the survey in this category

3.1.2 Extent of staff application of gender analysis skills

In contrast to their level of knowledge, only one third of staff are at least moderately applying gender analysis skills to their work (see **TABLE 3.4**). More male respondents (44%) report at least moderately applying gender analysis skills to their work compared with female respondents (25%). The South-East Asia Region and the Region of the Americas had the highest percentages of staff reporting at least moderately applying gender analysis skills to their work compared to the other regions and headquarters.

TABLE 3.4 Percentage of respondents by sex and WHO staff category who are at least moderately applying gender analysis skills to their work in WHO regions and HQ

REGIONS AND HQ	BY SEX		BY CATEGORY		OVERALL
	% MALE	% FEMALE	% D	% P	
HQ	39	20	88	30	26
WPR	51	24	75	55	34
SEAR	41	41	40	53	41
EMR	33	24	80	53	33
AFR	36	28	63	43	36
EUR	25	19	–	38	25
AMR	42	34	80	52	42
Other	32	28	–	46	32
Total	**44**	**25**[a]	**74**	**43**[a]	**33**

[a] Denotes that the difference in percentage values is statistically significant at $p<0.05$.
– No staff participated in the survey in this category

3.1.3 Level of institutional support for integrating gender into staff's work

Overall, only one third of the staff report at least some institutional support for integrating gender into their work (see **TABLE 3.5**). The South-East Asia Region and the Region of the Americas had the highest percentages of staff reporting at least some institutional support for integrating gender into their work.

TABLE 3.5 Percentage by sex and category of respondents who report at least some institutional support for integrating gender in WHO regions and HQ

REGIONS AND HQ	BY SEX		BY CATEGORY		OVERALL
	% MALE	% FEMALE	% D	% P	
HQ	31	26	50	35	27
WPR	34	28	75	40	31
SEAR	41	37	–	53	39
EMR	40	31	80	48	35
AFR	36	23	38	35	30
EUR	24	23	–	33	23
AMR	52	26	70	51	43
Other	36	31	–	46	33
Total	**37**	**28**	**54**	**40**	**32**

– No staff participated in the survey in this category.

3.1.4 Factors that facilitate or inhibit integration of gender into staff's work

In order to better understand the information on knowledge of gender concepts and application of gender analysis skills to their work, respondents were also asked to describe factors that facilitated or inhibited integration of gender into their work. The four most frequently identified facilitating factors are (**BOX 1**):

BOX 1

- information-sharing about gender issues in your area of work (29%);
- colleagues with gender expertise to collaborate with (28%);
- discussions on gender issues in your area of work in department/unit staff meetings (26%); and
- a designated gender focal point (22%).

The four most frequently identified inhibiting factors are (**BOX 2**):

BOX 2

- insufficient knowledge or skills on gender to apply them to my work (29%);
- lack of appropriate tools to help me address gender in my work (25%);
- lack of appropriate data/evidence on gender in my area of work (24%);
- no budgetary resources available to work on gender (17%).

Lastly, staff also expressed a need for institutional support to integrate gender into their work in the form of (**BOX 3**):

BOX 3

- opportunities to learn or further develop skills in gender (52%);
- data/evidence on gender issues in my area of work (37%);
- resource materials (35%); and
- technical support from gender focal points or units (35%)

3.2 **Strategic Direction 2:** Bringing gender into the mainstream of WHO's management

The findings for this strategic direction describe: i) the extent to which gender is integrated into the operational planning and programme cycle; ii) the extent to which gender is integrated into country cooperation strategies and country workplans; and iii) the extent to which there is sex parity in staffing.

3.2.1 Integration of gender into the WHO operational planning and programme cycle

Around 37% of the 131 planning officers interviewed "strongly" integrate gender into their operational planning (see **TABLE 3.6**). This drops to less than 10% for programme implementation and less than 5% in the monitoring and evaluation phases.

More female planning officers (44%) than male (34%) report a "strong" level of gender integration in their operational planning. More directors (D) than other professional staff (P) report a "strong" level of gender integration (48% vs. 33%). Collaboration with the Gender, Women and Health Network makes a difference, with a higher proportion (48%) of those who collaborate reporting

strong gender integration in operational planning compared with those who do not collaborate (26%). The Western Pacific Region has the highest percentage (56%) of planning focal points reporting a "strong" level of gender integration in operational planning, and the African Region (30%) and headquarters (32%) have the lowest proportions of planning focal points reporting a strong level of gender integration in operational planning.[1]

TABLE 3.6 Percentage by sex, category of respondents and collaboration with GWHN reporting a strong level of gender integration in the operational planning and programme cycle in WHO regions and headquarters

	% STRONG GENDER INTEGRATION IN OPERATIONAL PLANNING	% STRONG GENDER INTEGRATION IN PROGRAMME IMPLEMENTATION	% STRONG GENDER INTEGRATION IN PROGRAMME MONITORING
Overall	37	6	2
By sex			
Male	34	5	2
Female	44	7	0
By Category			
D	48	10	0
P	33	3	2
Collaboration with GWHN			
Yes	48	11	3
No/Don't know	33	0	0
Regions/HQ			
HQ	32	10	0
WPR	56	0	6
SEAR	25	0	0
EMR	36	8	7
AFR	30	5	0
EUR	27	7	0
AMR	39	0	0

While very few planning focal points report a "strong" level of gender integration, many more focal points report a "moderate" level of gender integration in operational planning, programme implementation and monitoring and evaluation (see **TABLE 3.7**). For example, nearly three in five planning focal points report a "moderate" level of gender integration in programme implementation, with headquarters and the Western Pacific Region having the highest percentages compared with the other regions. Nearly one third of the planning focal points report "moderate" gender integration in the programme monitoring and evaluation stages – with the Western Pacific Region doing best compared with other regions.

Planning focal points were asked to identify factors that facilitated or inhibited the integration of gender issues in operational planning, programme implementation and monitoring and evaluation. Many respondents across the regions stated that commitment shown by senior management (e.g. Director-General, Regional Directors, senior managers) was an important facilitating factor. Others frequently reported that support from the Gender, Women and Health Network was helpful in obtaining technical and financial support, as illustrated by the following quote:

[1] The percentage figures and the sample size for a strong level of gender integration in programme implementation and monitoring and evaluation are very small, and therefore the disaggregations by sex, staff category and regions are not discussed further.

TABLE 3.7 Percentage reporting moderate level of gender integration in the operational planning and programme cycle in WHO regions and headquarters

REGIONS AND HQ	% MODERATE GENDER INTEGRATION IN OPERATIONAL PLANNING	% MODERATE GENDER INTEGRATION IN PROGRAMME IMPLEMENTATION	% MODERATE GENDER INTEGRATION IN PROGRAMME MONITORING
Overall	28	58	30
HQ	36	71	33
WPR	39	88	61
SEAR	0	25	0
EMR	50	31	29
AFR	10	40	26
EUR	20	53	20
AMR	39	65	19

> *"Having a gender focal point helps staff to build their capacity to integrate gender into their work. This is a critical factor in mainstreaming the issue".*

Planning focal points also identified availability of funds, greater awareness of gender equality and its importance as one of the six cross-cutting themes of WHO's work as being important enabling factors for integrating gender into operational planning and programme implementation. This is illustrated by the following quote:

> *"Having clarity regarding what is possible to accomplish; knowing that gender-sensitive actions can make a difference is a motivation, an incentive for action that is supported by collaboration with the GEH unit".*

Respondents identified a number of factors that inhibited or posed a challenge to integrating gender into operational planning, programme implementation and monitoring and evaluation. These are summarized as follows:

- a refusal to consider gender and other cross-cutting issues, such as equity and human rights, as a priority;
- a lack of human and financial resources devoted to addressing gender issues in all phases of the programme cycle;
- inadequate sex-disaggregated data and evidence to ensure integration of gender issues during all aspects of the programme cycle;
- no clear operational/institutional mechanisms (i.e. policy frameworks, guidelines and directives) to facilitate the integration of gender issues in all phases of the programme cycle;
- insufficient time and political commitment from senior management in terms of budgetary allocations;
- lack of priority given to gender at the country level, which affects integration of gender issues in country and regional workplans;
- lack of appropriate tools including gender-sensitive indicators that are tailored for specific health issues;
- lack of awareness of gender among programme staff and cultural attitudes and barriers towards addressing gender;
- gender blindness – assuming that programmes will benefit men, women and children equally.

For example, illustrating the first bullet point, one respondent explained:

> *"Still this issue is not recognized and because of the amount of work and the amount of other priorities, its importance in planning strategic objectives and activities is underestimated".*

Illustrating another bullet point about the lack of capacity and availability of sex-disaggregated data, one planning focal point remarked:

> *"The level of capacity one would require in order to collect sex-disaggregated data in some remote areas of Africa is at a much higher calibre than what is realistically possible at the field level, where often a "clinic" is simply a hut that is only occupied a few short hours a week. We simply are not working at that level of capacity in these areas".*

3.2.2 Integration of gender into country cooperation strategies and country workplans

The findings on the extent to which gender is integrated into country cooperation strategies and country workplans are summarized by the following indicators (**BOX 4**):

BOX 4

- number of post-2005 CCS that "strongly" integrate gender; 1/9
- number of post-2005 CCS that "moderately" integrate gender: 3/9
- number of country workplans (2006/2007) that "strongly" integrate gender: 0/14
- number of country work plans (2006/2007) that "moderately" integrate gender:5/14

Only one country cooperation strategy (China) is classified as "strongly" integrating gender. However, three additional country cooperation strategies (India, Honduras and Trinidad & Tobago) are classified as "moderately" integrating gender. These four strategies were produced in country offices that collaborated with the Gender, Women and Health Network, highlighting the facilitating role that the Network plays in helping countries to integrate gender into country cooperation strategies. While none of the country workplans could be classified as "strongly" integrating gender, five countries (two each from the Western Pacific Region and the Region of the Americas and one from the Eastern Mediterranean Region) are classified as "moderately" integrating gender.[1]

3.2.3 Sex parity in staffing

The findings on sex parity in WHO staffing assess how well WHO is doing in recruitment and retention of women, particularly at higher levels where they can influence organizational policies and decision-making. The data describe the proportion of women in the professional, general service and national professional officer categories, representation of women in the higher-level professional categories (i.e. P4-P6/D1, D2 and UG) and new recruitments of women in the professional categories in order to reach sex parity targets.

Overall, women comprise nearly 48% of all WHO long-term posts.[2] However, when this overall figure is disaggregated by staff category, women are concentrated in general service (G) categories (61%), followed by national professional categories (NPO), and hold approximately one third of all professional (P) posts (see **FIGURE 2**).

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[1] Because of the small sample sizes of the CCS and country workplans, it is difficult to draw conclusions about the observed findings or explain why some CCS and country workplans are more successful at integrating gender than others.

[2] *Human resources: annual report for 2008*, dated 10 April 2008, p. 6.

FIGURE 2 **Long term and temporary posts by sex and staff category (professional, national professional officers and general service), 2007**

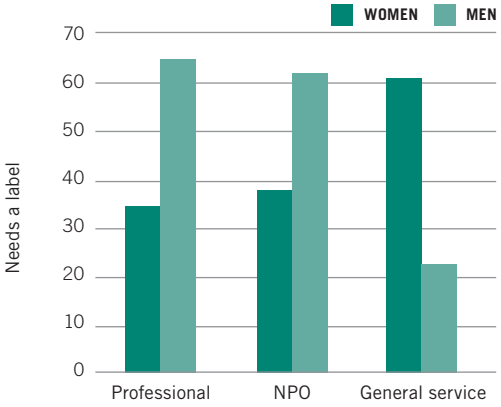
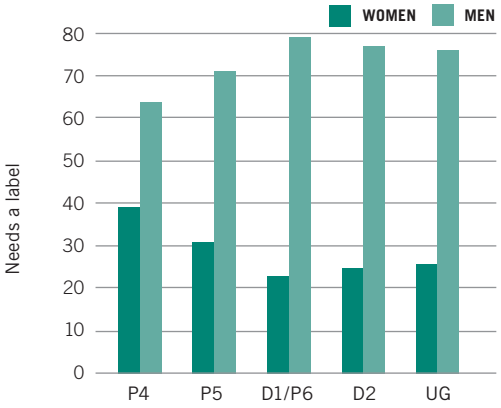


FIGURE 3 **Long-term and temporary posts disaggregated by sex and grade-level (P4-D1/P6, D2 and Ungraded)**



Overall, women comprise 37% of P4 staff (see **FIGURE 3**). This figure drops to 22% at the D1/P6 grade level and only a quarter of the highest level (i.e. UG) posts are held by women. The decrease in the percentage of women in the higher professional grades is consistent in all regions, with the exception of the Region of the Americas, where there is an increase in the percentage of women from P4 (34%) to P6/D1 (39%) grades. Headquarters has 18 ungraded posts, but only five of them are held by women[1] (see **ANNEX 5**).

In 2007, women comprised 44% of all long-term new appointments. This proportion remained more or less steady across the three WHO staff categories (i.e. P, NGO and G). In the regions and headquarters, women comprise approximately half of all new professional long-term appointments. These findings suggest that, at least in new appointments, there is a concerted effort to increase the representation of women, especially in the professional (P) category. However, since data are not available for the proportion of women by grade-level, it is difficult to assess whether sex parity, through increased representation of women at higher grades (i.e. P4-P6/D1, D2 and UG) will be achieved in the near future.

3.3 Strategic Direction 3: Promoting use of sex-disaggregated data and gender analysis

The baseline values for this strategic direction are summarized by two indicators (**BOX 5**):

BOX 5

- number of new WHO publications that promote or use sex-disaggregated data: 6/28
- number of new WHO publications that "strongly" promote and/or use gender analysis in health: 13/28.

Of the six WHO publications that promoted or used sex-disaggregated data, two each were from the African Region and the Region of the Americas and the remaining two were one each from the European and Western Pacific Regions. The consultants also noted in their content analysis the missed opportunities where sex-disaggregated data could have been recommended or used:

[1] *Human resources: annual report for 2007*, dated 10 April 2008, p. 7.

> *"The document recommends the development of situation analyses and diagnostics, but no explicit mention/recommendation is made to do any type of data disaggregation by sex".*

Of the 13 publications (i.e. nearly half of those sampled) that "strongly" promoted or used gender analysis in health, four (all) were from the Western Pacific Region. The African, European and Eastern Mediterranean Regions and the Region of the Americas each had two publications that "strongly" promoted or used gender analysis in health. Headquarters had one and the Regional Office for South-East Asia none.

3.4 **Strategic Direction 4:** Establishing accountability

The baseline value for this strategic direction is summarized as one indicator as follows (**BOX 6**):

BOX 6

- number of speeches by the Director-General and the Regional Directors, of those sampled, which include at least one reference to gender: 14/40.

Approximately one third (14 out of 40) of the public speeches by senior management contains at least one reference to gender. The Region of the Americas had the most number of speeches that referenced gender (eight out of nine), followed by headquarters (three out of four) compared with the other regions that had less than half or none. Speeches that were broader in scope (e.g. improving health in the Americas) included more frequent references to gender, whereas issue-specific speeches (e.g. those focused on HIV or healthy environments) had fewer references to gender.

There were many "missed opportunities" in the speeches to highlight the importance of gender. For example places where references to the importance of sex-disaggregated data and empowering women could have been made.

While this indicator does not adequately capture institutional accountability, it was the only feasible one at the time of the baseline.[1] Nonetheless, the results clearly highlight a need for greater commitment at the senior level to integrate gender into WHO's work, starting with explicit references to gender and women's empowerment in public speeches and directives to staff from WHO senior management.

[1] The suggestion to analyse speeches was made by the Director General's Office, which suggested that speeches could be taken as a baseline for accountability. Going forward, additional measures for tracking institutional accountability for gender mainstreaming will be developed. These may include measures related to tracking resource allocation and staff performance on gender. The feasibility of collecting data on such measures needs to be explored further.

4. Limitations of the assessment

One limitation of the findings of the online survey is the low response rate (25% overall). The findings are thus limited by a self-selection bias – i.e. those who participated in the survey may have been more interested in gender and hence, more likely to have good knowledge of gender and report its relevance and application to their work. The actual overall levels of knowledge about gender may potentially be lower than those reported in the baseline. Despite the low response rate, the overall sample size of 2160 respondents is quite robust for statistical analysis, and the findings are remarkably consistent across regions.

For the planning focal point interviews, the sampling frame of potential respondents from headquarters and regional offices is quite small. Moreover, there were not enough human or financial resources to conduct interviews with planning focal points from more than a few country offices. Limitations were set on the number of WHO documents reviewed, owing to the labour and time-intensive nature of document reviews coupled with the limited human and financial resources available for the baseline. A more robust sample size would improve the reliability of the findings.

Two areas could not be adequately addressed in the baseline assessment. Firstly, the number of WHO office-specific expected results (OSERs)[1] and products that address gender[2] could not be measured owing to WHO's transition to the new Oracle-based administrative system. Secondly, as described earlier, the indicator to capture institutional accountability is not adequate and additional measures need to be developed.

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[1] Office-specific expected results: overall expected result statements for each budget centre (e.g. department or unit) at various levels of the Organization.

[2] Products: deliverables that contribute to the office-specific expected results (publications, activities, etc).

5. Conclusions

To what extent do WHO staff have knowledge of and are applying gender analysis and planning in their work (SD1)?

Despite the high proportion of WHO staff with good knowledge of gender and who recognize its relevance to their work, staff are not able to translate this into application of gender analysis skills to their work (i.e. there is a "know-do" gap). This applies to all regions and to headquarters. One possible explanation for the "know-do" gap is that information on gender concepts can be self-learned or obtained through training, but application of gender analysis skills requires technical, financial and institutional support (e.g. collaboration with gender experts, skills training, evidence and political and financial support from management). The low level of institutional support for integrating gender reported by staff therefore, may partly explain the "know-do" gap. The low level of institutional support is reflected as factors that inhibit WHO staff from integrating gender into their work – specifically issues of lack of appropriate tools, data/evidence and budgetary resources for gender are identified. These factors also explain the "know-do" gap. Additional reasons for this may need to be further investigated. This represents a key area for developing action to implement the WHO Gender Strategy with respect to Strategic Direction 1. The Region of the Americas has among the highest proportion of staff who are aware and have knowledge of gender concepts, which may be attributed to the presence of institutional mechanisms such as the PAHO gender equality policy and the high level of senior management support for gender issues.

To facilitate integration of gender into WHO's work and hence, address the "know-do" gap, the findings suggest a need for a systematic capacity-building strategy for WHO staff. Such a strategy needs to include the development of gender analysis tools adapted to the specific needs of different technical programmes; generation of evidence on the role of gender in specific health issues; financial and human resources allocated to gender; and strengthening the technical support provided by the gender focal points/units.

To what extent is gender integrated into WHO's management (SD2)?

There is a sharp decrease in the reporting of "strong" levels of gender integration between the operational planning phase and the programme implementation and monitoring and evaluation phases ("planning-implementation" gap). These results are contrary to the expectation that, if gender is integrated into planning, it would be reflected in the implementation and monitoring phases. The "planning-implementation" gap may, in part, be explained by a number of factors inhibiting gender integration described by the respondents. These include:

- lack of prioritization of gender relative to specific health issues;
- lack of evidence on gender and health, e.g. through availability of sex-disaggregated data;
- lack of adequate financial and human resources allocated to gender;
- lack of tools on gender and health tailored to specific technical areas; and
- inadequate commitment and support from senior management.

The challenges to integrating gender in the operational planning and programme cycle are consistent with those identified by the online survey on staff capacity. Therefore, taken together with the results of Strategic Direction 1, they make a strong case for developing institutional support mechanisms to facilitate gender integration into WHO's work. The planning focal point

interviews also suggest that collaboration with the Gender, Women and Health Network is positively associated with strong integration of gender in the programme cycle. This is also corroborated by the qualitative findings, in which several respondents articulate the importance of receiving technical support from gender focal points as a facilitating factor.

The review of country cooperation strategies and country workplans shows that hardly any (only one out of nine country cooperation strategies and none of the 14 country workplans) strongly integrate gender. A few more integrate gender moderately. The poor reflection of gender in WHO's work at the country level needs to be explored further. Triangulating the country cooperation strategy and country workplan review with planning focal point interviews, one finds that the Western Pacific Region and the Region of the Americas have the highest proportion of planning focal points reporting strong gender integration in operational planning. These are also the two regions whose country cooperation strategies and country workplans integrate gender. Interviews with country planning focal points indicate that support from the WHO Representative (WR) and advocacy with the Ministry of Health plays an important enabling role to integrate gender in country cooperation strategies or country workplans. This is because country cooperation strategies and country workplans have to be agreed with Ministries of Health. Given the small sample size of the country cooperation strategies and country workplans and the limited interviews with country-level planning focal points, in the mid-term review it will be necessary to expand the sample sizes in order to allow for more generalizable conclusions. Additional qualitative questions related to barriers in reflecting gender in country cooperation strategies and country workplans will also provide a better understanding of the challenges to integrating gender in WHO's work at the country level.

Analysis of the sex parity data shows that women are underrepresented, particularly at the higher professional grades (P4 and higher). It remains unclear whether women are being recruited to long-term appointments at a pace that will fill this gap in the near future, particularly at the higher grade-levels. Any future actions to address this need should be considered in light of World Health Assembly resolution WHA56.17 of 2003, which reaffirms a target of achieving 50% appointments of women in the professional and higher grade levels.

To what extent is WHO promoting or using sex-disaggregated data and gender analysis (SD3)?

Less than one quarter of the sampled WHO publications promote or use sex-disaggregated data. Triangulating with the planning focal point interviews for strategic direction 2, one possible explanation for this finding is that many countries collect sex-disaggregated data at the facility level, but aggregate them as they are reported upwards (i.e. to district, subregional, regional and national level). As a result, the sex-disaggregated data may not be available at the national level. Planning focal points also note that in some countries, there is inadequate capacity in terms of human resources and infrastructure for collecting and reporting sex-disaggregated data.

Less than half the sampled WHO publications promote or use gender analysis to understand how social, cultural and economic determinants could affect men's and women's health differently. Moreover, sampled publications vary in how they include gender analysis. For example, some conduct an analysis of women-specific issues only, others analyse the differences between women and men. Several publications that conducted gender analysis did not do so systematically, resulting in missed opportunities that could have enhanced the understanding of the particular health problem or issue under consideration. For the mid-term review and final evaluation of the WHO Gender Strategy, the criteria for scoring WHO publications will need to be refined in terms of what is considered as gender analysis of a particular health problem or issue.

To what extent is there accountability for integrating gender into WHO's work (SD4)?

Only one third of the sampled public speeches by senior management (Director-General and Regional Directors) include any explicit references to gender or related terms. On the other hand, the findings of the online staff survey and planning focal point interviews suggest that senior management commitment is important for encouraging WHO staff and managers to integrate gender into their work. Similarly, lack of institutional support has already been identified as a challenge to this undertaking. Therefore, there is a need for advocacy targeted at senior management to increase their commitment to gender integration in WHO's work. While this is an essential first step for establishing institutional accountability mechanisms, additional actions are also needed to advance this strategic direction.

The overall results of the four strategic directions are remarkably consistent across the six WHO regions and headquarters, and provide a compelling picture of how WHO is doing in integrating gender into its work. They also provide insights into the practical actions needed to implement the strategy. Such actions include the need to strengthen institutional support for integrating gender, both within WHO and in work with Member States, and work concertedly with human rights and equity in order to prioritize the reflection of these cross-cutting issues in WHO's programme cycle. Policy changes in WHO that can facilitate actions to integrate gender into its work include the issuance of new country cooperation strategy guidelines that are more explicit in their requirements to address gender; new business rules that explicitly require the integration of gender into the planning and implementation phases of the programme cycle; and a clear statement in the Medium-Term Strategic Plan guidelines on the need to improve capacity to collect and use sex-disaggregated data. These new rules provide a reference for monitoring whether gender is being effectively integrated in country cooperation strategies and the programme cycle.

6. Recommendations for implementing the WHO Gender Strategy

The following broad areas for action emerge from the findings of this assessment (see **BOX 7**). Examples are provided for each area of action to illustrate the kind of specific steps that could be taken to implement the WHO Gender Strategy. For each area, concrete recommendations need to be further developed in consultation with the appropriate units in WHO. While the Gender, Women and Health Network plays a role in catalysing the implementation of the WHO Gender Strategy, the primary responsibility lies with many other parts of the Organization.

BOX 7

1. Strengthen capacity and institutional support for WHO staff to apply gender analysis skills and gender-responsive actions in their planning, programme and technical work. This could include the following actions.
   a. Support WHO staff in participating in learning activities on gender and health.
   b. Facilitate collaboration with gender focal points/units.
   c. Allocate human and financial resources to work on gender.
   d. Support development of evidence and tools on gender and health.
   e. Conduct a needs assessment to better understand the gaps in knowledge and skills related to gender and health by various staff (e.g. P, G, D grades) and technical programmes.
2. Identify mechanisms for integrating gender during the operational planning period and programme implementation stage (e.g. mid-biennium reviews). This could include the following actions:
   a. Conduct training for all programme managers in preparation for operational planning.
   b. Develop job aids and strengthen capacity of WHO managers to integrate gender into biennial operational workplans (e.g. a classifier on gender in the Global Management System, a checklist for managers to assess whether their workplans have integrated gender).
3. Strengthen institutional efforts to integrate gender into country cooperation strategies and country workplans. This could include the following actions:
   a. Strengthen the role and capacities of country offices, including gender focal points to conduct advocacy with Ministries of Health to integrate gender into the coountry health planning process.
   b. Build partnerships with women's organizations and Ministries of Women's Affairs (or equivalent).
   c. Ensure regional support to country offices for gender work at country level.
4. Identify barriers/challenges to achieving sex parity and increasing representation of women at the higher professional grades, and strengthen actions to implement the WHO resolutions on sex parity. This could include the following actions:
   a. Special emphasis on recruitment, staff development and promotion of women at the P4 grade level, as this is the main level for women to enter the higher professional grades.
   b. Enhance leadership skills of female staff.
5. Strengthen the capacities of WHO technical units to promote and use sex-disaggregated data and gender analysis systematically in all health planning, guidelines, tools, monitoring and evaluation and programme implementation documents/ publications. This could include the following actions.
   a. Identify barriers to collection, promotion, analysis and use of sex-disaggregated data in WHO's technical programmes as well as in countries.
   b. Strengthen the country offices to work with Ministries of Health and other national partners to generate, compile and analyse sex-disaggregated health data.
6. Advocate with senior management to enhance their commitment and accountability to mainstreaming gender in WHO's work. This could include the following actions:
   a. Disseminate the baseline assessment to senior management across the Organization.
   b. Encourage senior management to include references to gender and women's empowerment systematically in all public speeches and explicitly encourage their staff to do the same in their technical work.
   c. Establish mechanisms and guidelines to improve resource allocations for work on gender.
   d. Establish gender competencies for staff performance in job descriptions, performance management and development, etc.

Annexes

Annex 1

Online all-staff questionnaire: Survey of WHO capacity for gender analysis and planning (Strategic Direction 1)

Introduction

This online survey is part of a baseline assessment to monitor and evaluate the implementation of the WHO strategy to integrate gender analysis and actions into the Organization's work. An exploratory baseline assessment is under way to understand the extent to which WHO is currently addressing gender in its work. The online survey aims to identify current staff capacity at WHO to integrate gender into their work.

Your responses to this survey will support the implementation of the strategy by providing vital information on capacity constraints in addressing gender in your work. The assessment is coordinated by the Department of Gender, Women and Health at headquarters and the gender focal points in each of the six regional offices.

The survey is for all WHO staff at all levels of the Organization. It is divided into four sections:

- general demographic questions;
- basic understanding of gender and health;
- acquisition and application of knowledge on gender to your work at WHO; and
- institutional support received for addressing gender in your work.

Thank you in advance for your participation in this survey. The survey is anonymous and you will not be asked to identify your name. The responses you provide will **not be** used to judge your individual work performance.

The responses will be compiled to assess institutional level needs and gaps in efforts to build the capacity of WHO staff to integrate gender into their work. The key findings will be shared with WHO staff in the near future.

Section 1: General demographic questions

Kindly click onto the correct demographic information that describes you:

1a At what level of the Organization are you working?

Headquarters	If you ticked this option, go to question 3a
Regional office	If you ticked this option, go to question 2a
Country office	If you ticked this option, go to question 2b
Other	

1b If other, please specify .....

2a If you work for a Regional Office please select from the following list:

Regional office	AMRO/PAHO
	WPRO
	SEARO
	AFRO
	EMRO
	EURO

2b If you work for a Country Office, please select the country from the list:

3a Headquarters staff, please select the department you work for from the list:

3b If regional or country office, please specify the name of the department/division/unit you work for .....

4a What is your designated grade?

UG	
D	
P	
G	

4b Specify the level (i.e. 1, 2, 3, 4, 5, 6 or 7):

5 Are you:

Female	1
Male	2

6 How long have you been employed by WHO?

< 1 year	1
Between 1 and 5 years	2
> 5 years	3

7a What is the highest level of education you have attained?

High School	1
Graduate (e.g. some college or a bachelor's degree or a medical degree)	2
Post-graduate degree (e.g. masters, PhD, other)	3
Other	4

7b

Other, please specify	

Section 2: Assessing knowledge/understanding on gender and health of all staff

The questions in this section are aimed at assessing the current understanding of gender and its relationship to health.

8 Are you aware whether there is a (please select all that apply):

- ☐ WHO gender policy
- ☐ PAHO gender equality policy
- ☐ Other gender policy specific to your regional office
- ☐ WHO strategy for integrating gender analysis and actions into its work
- ☐ Don't know

9 How would you define the term "sex"? (please select only one option)

- ☐ Biological and physiological characteristics of men and women
- ☐ Male and female differences
- ☐ A way to separate men and women in studies/A demographic variable)
- ☐ All of the above
- ☐ None of the above
- ☐ Don't know

10 How would you define the term "gender"? (please select only one option)

- ☐ Male and female differences
- ☐ Politically correct way to say "sex"
- ☐ Social process that shapes men and women's life conditions and opportunities through the establishment of different roles, norms and relations
- ☐ Working on women's issues
- ☐ All of the above
- ☐ None of the above
- ☐ Don't know

11 How would you define the term "gender mainstreaming"? (please select only one option)

- ☐ Consulting women before finalizing a health programme or policy
- ☐ Developing projects for women
- ☐ Consideration of women and men's needs in all aspects of programme design to benefit them equitably
- ☐ All of the above
- ☐ None of the above
- ☐ Don't know

12 The main objective of the WHO strategy for integrating gender analysis and actions into its work is: (please select only one option)

- ☐ To end discrimination against women in the world
- ☐ To empower female staff at WHO to make better decisions about their health
- ☐ To expand WHO's capacity to analyse and address the role of gender and sex in health
- ☐ All of the above
- ☐ None of the above
- ☐ Don't know

13 Is gender relevant to the work of your unit?

No	
Yes	
Don't Know	

14 Is gender relevant to your own work?

No	
Yes	
Don't Know	

Section 3: Acquisition of knowledge and application of skills in gender analysis and responsive actions

The purpose of this section is to:

- identify how many staff have undergone any type of learning on gender and health;
- what you learned in this process; and
- how you are applying the skills learned in this process to your work.

It will give some insights into the gaps between knowledge of gender and its application, and which tools have been found to be most useful and why. The WHO strategy on integrating gender analysis and actions (and regional policies such as the PAHO gender equality policy) respond to the fact that all levels of the Organization have a responsibility in addressing gender in health. Therefore, this section is to be completed by all staff regardless of your functions.

15 Have you ever received or sought any information on gender?

Yes	If you ticked this option go to the next question
No	If you ticked this option, go to question 21

16 How was this information about gender received?

Through training	If you ticked this option, go to question 18a
Formal education	If you ticked this option, go to question 18a
Self learned	If you ticked this option, go to next question

17a Was the self-learned knowledge on gender gained through? (Please select all that apply)

Job experience	
Distance learning	
E learning	
Internet searches	
Other	

17b If other please specify .....

18a Was gender discussed as part of training or formal education on the following issues (please select all that apply)?

- ☐ Gender and Health
- ☐ Social Determinants of Health
- ☐ Human Rights
- ☐ Equity or Poverty Reduction
- ☐ Sexual and Reproductive Health
- ☐ Other

18b If other, please specify .....

19 What was the duration of the training or formal education on gender?

< 3 days	
3–7 days	
> 1 week	

20a What issues or topics were covered in your training or self learning or formal education on gender? (Please select all that apply)

- ☐ Basic concepts of gender
- ☐ Principles of gender analysis
- ☐ Application of gender analysis in a health context
- ☐ How to select or construct indicators that reflect gender inequalities in health
- ☐ Relevance and use of sex-disaggregated data
- ☐ Health-sector planning that addresses gender inequalities
- ☐ Gender mainstreaming
- ☐ All of the above
- ☐ Other

20b If other, please specify .....

21 The following questions ask you how you address gender in your work at WHO.

If your current responsibilities do not include any of the following functions at WHO, then you can use the third response option.

	NO	YES	THIS FUNCTION IS NOT PART OF MY CURRENT JOB RESPONSIBILITIES AT WHO
a. Include analysis of women and men's different needs, life conditions and opportunities in determining the problems to be addressed			
b. Develop explicit objectives to promote equality between women and men in projects/ publications/programmes			
c. Use indicators that assess progress made in reducing inequalities between women and men			
d. Analyse differential impact of interventions on women and men			
e. Collect or compile or use or promote sex-disaggregated data			

	NO	YES	THIS FUNCTION IS NOT PART OF MY CURRENT JOB RESPONSIBILITIES AT WHO
f. Allocate resources (human and financial) to address women and men's different life conditions and opportunities in relation to their health			
g. Include both men and women in the decision-making process			
h. Ensure equitable distribution of resources and benefits for women and men of different groups			
i. Apply principles of gender equality to recruitment and management of human resources			
j. Include principles of gender equality when developing terms of reference for staff or collaborators			
k. Ensure inclusive non-sexist language in documents			

22a What prevents you from addressing gender in your work? (Please select all that apply)

- ☐ Insufficient knowledge or skills on gender to apply it to my work
- ☐ Work schedule is too busy to accommodate work on gender
- ☐ No interest in gender/not relevant to my work/not a priority
- ☐ Lack of appropriate data/evidence on gender in my area of work
- ☐ Lack of appropriate tools to help me address gender in my work
- ☐ No budgetary resources available for work on gender
- ☐ No human resources available for work on gender
- ☐ Insufficient technical follow-up after training to address gender in my work
- ☐ None
- ☐ Don't know
- ☐ Other

22b If other, please specify .....

Section 4: Institutional support to staff for addressing gender

This section aims to assess the level of institutional support received by staff for addressing gender in their work. The purpose is to identify what institutional measures exist and what are the gaps in creating an enabling environment for staff to learn about gender and apply the skills to their work.

23 Have you received support from your supervisor to address gender in your work as follows)

	NO	YES	THIS PARTICULAR FUNCTION IS NOT PART OF MY CURRENT RESPONSIBILITIES AT WHO
a. Opportunities to learn or further develop skills in addressing women and men's different needs, life conditions, opportunities in relation to health			
b. Discussions with your supervisor on how to address women and men's different needs, life conditions and opportunities in relation to health as part of your or your department/unit's work?			
c. Funds have been allocated from your department/unit's budget for work to address women and men's different needs, life conditions and opportunities in relation to health?			
d. Asked to report back on how women and men's different needs, life conditions and needs in relation to health have been addressed in your or your department/unit's work?			

24a What are the existing facilitating factors or opportunities that support your ability to address gender in your work? (Please select all that apply).

- ☐ A designated gender focal point
- ☐ Linkages with country/ regional / HQ gender focal points/units
- ☐ Discussions on gender in your area of work in department/unit staff meetings
- ☐ Colleagues with gender expertise to collaborate with
- ☐ Information sharing on gender in your area of work
- ☐ Information sharing on gender training opportunities
- ☐ Information sharing on upcoming seminars / meetings on gender
- ☐ Interdepartmental task force on gender
- ☐ None
- ☐ Don't know
- ☐ Other

24b If other, please specify .....

25 How would you rate your department/unit's efforts in addressing gender?

Poor	
Unsatisfactory	
Satisfactory	
Good	
Can't say/don't know	

26a What support would you need in the future in order to be able to address gender into your work? (Please select all that apply)

- ☐ Opportunities to learn or further develop skills in gender
- ☐ Regular discussions with my supervisor on addressing gender in my work
- ☐ Funds to be allocated for work on addressing gender
- ☐ Technical support from gender focal point(s)/units
- ☐ Data/evidence on gender in my area of work
- ☐ Adjustments in my other responsibilities so that I can give more time to work on gender
- ☐ Resource materials (e.g. publications, tools, websites) on gender
- ☐ Additional human resources (i.e. staff, consultants) to work on gender
- ☐ No support is needed
- ☐ Don't know
- ☐ Other

26b If other, please specify .....

Thank you very much for taking the time to fill out this survey. Your responses will help in implementing the WHO strategy on integrating gender analysis and actions into its work. If you have any questions about the WHO Gender Strategy or its other work on gender, please email: genderhealth@who.int.

Annex 2

Guide for planning focal point interviews to assess integration of gender in WHO's management (Strategic Direction 2)

Section 1: Basic demographics

This section is to be completed by the interviewer either before or after the interview.

1 Consent given by respondent ☐

2 Respondent ID:

HQ/RO e.g.	Day Interview completed	Month Interview completed	Interviewer initials	Serial Number
WPRO	03	06	e.g. HLO (Helen L'Orange)	(range 001–030)
SEARO	04	07	RC (Rinchen Chophel)	001

3 Interviewer name: .....

4a Date interview completed

Day	Month

4b Interview conducted by

Phone	Face-to face

5a At what level of the Organization are you working?

Headquarters	skip to question 7a
Regional Office	skip to question 6a
Country Office	skip to question 6b
Other	skip to question 8a

5b If other, please specify .....

6a If you work for a Regional Office, please specify the Regional Office you work for?

Regional office	AMRO/PAHO
	WPRO
	SEARO
	AFRO
	EMRO
	EURO

6b If you work for a Country Office, please specify the Country Office you work for?

.....

7a For headquarters staff, please specify the name of your Department or Unit:

.....

7b For Regional or Country Office staff, please specify the name of your Division/Unit/Department:

.....

7c In 2006–2007, did your Department/Division/Unit have any collaborative activities with the gender focal point/gender unit/gender department in WHO Headquarters/Regional Office/Country Office.

No	Yes	Don't know

8a What is your designated grade?

UG	
D	
P	
G	

8b What is your grade level (i.e. 1, 2, 3, 4, 5, 6 or 7):

9 Are you:

Female	
Male	

10 How long have you been employed by WHO?

< 1 year	
Between 1 and 5 years	
> 5 years	

Section 2: Operational planning

In this section, we will ask you to recall the extent to which there was a consideration of inequalities between women and men in relation to health and health care as part of the operational planning process for the Medium-Term Strategic Plan (2008–2013).

11 Were there discussions in your operational planning (i.e. Strategic Objective or department/unit/team's work planning) meetings on the ways to address inequalities between women and men in relation to health?

No	Yes	Don't know

12 In defining the issues and challenges for your Strategic Objectives (SO), was there a consideration of how inequalities between women and men affect health?

No	Yes	Don't know

13 Were inequalities between women and men addressed in the development of at least one of the organization wide expected results (OWERS) for your Strategic Objective?

No	Yes	Don't know

14 Were inequalities between women and men addressed in the development of at least one headquarters (HQER)/regional expected results (RER)?

No	Yes	Don't know

15 Were inequalities between women and men addressed in the development of at least one office/country-specific specific expected results (OSER)?

No	Yes	Don't know

16 Were inequalities between women and men addressed in the development of your department/area/unit/team/country 2008–2009 workplans in at least one product or service or activity?

No	Yes	Don't know

17 Were resources budgeted for at least one OSER or product or activity or service that addressed inequalities between women and men?

No	Yes	Don't know

18 Were resources actually allocated to at least one OSER or products or activities or service that involved addressing inequalities between women and men?

No	Yes	Don't know

19 What were the challenges faced in addressing inequalities between women and men in the operational planning process?

.....

.....

20 What factors helped in addressing inequalities between women and men in the operational planning process?

.....

.....

Section 3: Implementation of workplans

The questions in this section are aimed at identifying the extent to which inequalities between women and men in relation to health and health care were addressed in your department/area/unit/team/country's implementation of its 2006–2007 biennial workplan.

21 Were the inequalities between women and men in relation to health addressed in the implementation of at least one of your department/area/unit/team/country's products or activities or services?

No	Yes	Don't know

22 Was collection sex-disaggregated data promoted in your department/unit/team/country office's products or activities or services or discussions with ministries of health?

Always/ consistently)	Sometimes/not consistently	Never	Work of the dept/unit/division does not require promoting sex-disaggregated data	Don't know

23 Were sex-disaggregated data used in the publications produced by your department/area/unit/team/country?

Always/ consistently)	Sometimes/not consistently	Never	Work of the dept/unit/division does not require promoting sex-disaggregated data	Don't know

24 Was there any financial expenditure on products or activities or services that addressed inequalities between women and men in relation to health?

No	Yes	Don't know

25 Were there human resources allocated to products or activities or services that addressed inequalities between women and men in relation to health? (Please select all that apply)

- ☐ Full time WHO staff
- ☐ Part time WHO staff/gender focal point
- ☐ External consultant
- ☐ No human resources were allocated
- ☐ Don't know

26 What challenges affected the implementation of 2006–2007 biennial workplans in terms of addressing inequalities between women and men?

.....

.....

27 What factors helped in the implementation of the 2006–2007 biennial workplans in terms of addressing inequalities between women and men?

.....

.....

Section 4: Monitoring and evaluation of workplans

The questions in this section assess the extent to which the process of monitoring and evaluating the biennial workplans addresses inequalities between women and men in relation to health and health care. The WHO Performance Monitoring and Assessment Guidelines for 2006–2007 require departments/units/teams/countries to review at least every six months the status of the delivery of products and services.

28 While monitoring progress on your 2006–2007 biennial workplan, were you asked to assess whether inequalities between women and men were addressed in any of the products or activities or services? (Please select all that apply):

- ☐ Yes, by your supervisor
- ☐ Yes, as outlined in programme monitoring guidelines
- ☐ No, was not asked
- ☐ Don't know

29 Were there any discussions in your department/unit/team/country office on addressing inequalities between women and men as part of monitoring your workplan? (please select all that apply):

- ☐ Yes, with supervisor
- ☐ Yes, with colleagues
- ☐ Yes, in staff meetings
- ☐ There were no discussions
- ☐ Don't know

30 Were the relevant indicators to monitor the outcomes of your workplan disaggregated by sex?

Always/ consistently)	Sometimes/not consistently	Never	Work of the dept/unit/division does not require promoting sex-disaggregated data	Don't know

31 Were the relevant indicators to monitor the outcomes of your workplan analysed to assess whether inequalities between women and men were addressed/reduced?

Always/ consistently	Sometimes/ not consistently	Never (0) Skip to Q.34	Work of the dept/unit/team does not require analysis of inequalities in men and women's outcomes. Skip to Q.34	Don't know

32a As a result of the monitoring, did you take corrective actions to address inequalities between women and men in the work that you were responsible for? (please select all that apply)

- ☐ Build team capacity on gender (e.g. through training and tools)
- ☐ Use tools to address gender in your work
- ☐ Increased resources allocated for work on gender
- ☐ Sought technical assistance on gender
- ☐ Other
- ☐ None was taken (skip to Question 34)

32b If other, please specify .....

33a Did you receive support to enable you to take corrective actions to address inequalities between women and men in the work that you were responsible for? (please select all that apply):

- ☐ Supervisor encouragement
- ☐ Financial resources
- ☐ Technical support
- ☐ Gender training
- ☐ Tools to address gender
- ☐ Human resources (e.g. additional staff or consultants)
- ☐ Other
- ☐ No support was received

33b If other, please specify .....

34 What challenges affected the monitoring of progress in addressing inequalities between women and men in your biennial workplans?

.....

.....

35 What facilitating factors supported the monitoring of progress in addressing inequalities between women and men in your biennial workplans?

.....

.....

Thank you for your time. Do you have any questions about this survey? If you need further information about this survey or the WHO Gender Strategy, please contact the following individuals as relevant to your location.

1. Joanna Vogel – VOGELJ@emro.who.int
   (EMRO, Technical Officer, Gender in Health and Development)
2. Isabel Yordi – iyo@euro.who.int
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7. Avni Amin – amina@who.int
   (HQ, Technical Officer, Department of Gender, Women and Health)

Annex 3

Criteria for assessing and scoring whether WHO publications included gender analysis (Strategic Directions 3)

Name of WHO publication: Year: Language: Region (HQ, RO, country): Type of publication (a. evidence, b. policy, c. tools/guidelines, d. seminal report, e. regional/country health profile/analysis): Subject area of publication (e.g. HIV, mental health):				Additional remarks (specify context in which words are used or make additional qualifying comments)
	Yes (1)	No (0)	Not applicable/ not relevant (97)	
1. Does the document include one or more "explicit" statements/ references to gender equality or gender equity?				
2. Does the document have one or more "implicit" or indirect references to gender?				
3. Does the document refer to consultation/ partnerships with women's groups in the consultation process (examine annexes of the document or preface, acknowledgements sections of the document for mention of collaborations/partnerships/ consultations)?				
4. Does the document recommend use of sex-disaggregated data?				
5. Does the document use/present sex-disaggregated data, where relevant?	Yes always/consistently/ throughout (2)	Yes sometimes/inconsist-ently/not throughout (1)	Never (0)	
6. Does the document analyse/interpret the differences between women and men's outcomes, needs, roles, norms (i.e. gender analysis)?	Yes always/consistently/ throughout (2)	Yes sometimes/inconsist-ently/not throughout (1)	Never (0)	
7. Does the document specify at least one action/recommendation to address gender (use Table 1 Worksheet for word search)?				
8. Does the document use inclusive, non-sexist language (e.g. use "women and men" or "boys and girls" throughout, or where appropriate use "Chairperson" or "Madame Chair" rather than "Chairman" and avoid using "he" to refer to both sexes)?				

Annex 4

Search terms for reviewing whether senior management speeches included at least one reference to gender (Strategic Directions 4)

TABLE 1 **Word search criteria for content review of WHO publications**

KEYWORDS	# MENTIONS = EXPLICIT REF.	COMMENTS = IMPLICIT REF.
"gender"		
"gender equality"		
"equality/inequality/inequity between women and men"		
"gender equity" or health equity for women and men		
gender-based discrimination		
unequal resources or power or access for women and men or power dynamics/relations		
"women's empowerment"		
"masculine" and/or feminine		
"gender-based violence" or "violence against women"		
"sexual and reproductive health"		
"human rights" or "women's rights"		
"differential or specific health needs/outcomes of women and/or men"		
sex-disaggregated data		
MDG 3		
Total # Words in Speech		

Notes on Word Search

1. Boundary for search-term criteria

Not acceptable if there is mention of the word women, men, sex or gender without any reference to their inequalities, power, differential needs, access to services, etc. (i.e. gender is often used as a synonym of sex, as in "gender-disaggregated data").

Not acceptable criteria for addressing gender if the sentence or phrase perpetuates the notion of women's roles as mothers or caretakers of children and families without making any reference to their own health and well-being. Similarly, references to family planning or reproductive health that do not refer to providing choices, empowering women to make reproductive choices and decisions, etc. are not sufficient to qualify as having addressed gender. Therefore, also review the context in which the search terms are used and explain in the table the context in which the word or phrase is used.

2. Revise the word or phrase search depending on the specificity of the terms or phrases used

For instance, if the term "differential health needs of women and men" does not yield anything, try "different health needs of women and men" or "different needs of women and men" or "different health outcomes of women and men". Similarly, if "sex-disaggregated data" does not yield any results, then search for "disaggregated data" and then see if there is any reference to sex disaggregation in the sentence. Use the Boolean indicators "and", "or" in order either to get a broad sweep of content or to narrow down the content further.

Annex 5

Percentage of women in professional long-term posts by WHO grade-levels (P4-D1/P6, D2 and UG) across the six regions and headquarters

% OF WOMEN IN PROFESSIONAL POSTS BY WHO GRADE-LEVEL	BY REGION							
	AFR	EMR	EUR	AMR	SEAR	WPR	HQ	OVERALL
UG	0	0	0	100 (n=3)	0	0	28	25
D2	50 (n=1)	0	50 (n=1)	0	50 (n=1)	0	23	24
D1/P6	24	13	17	39	20	15	25	22
P5	21	26	35	39	30	21	37	30
P4	25	40	45	34	31	30	56	37

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