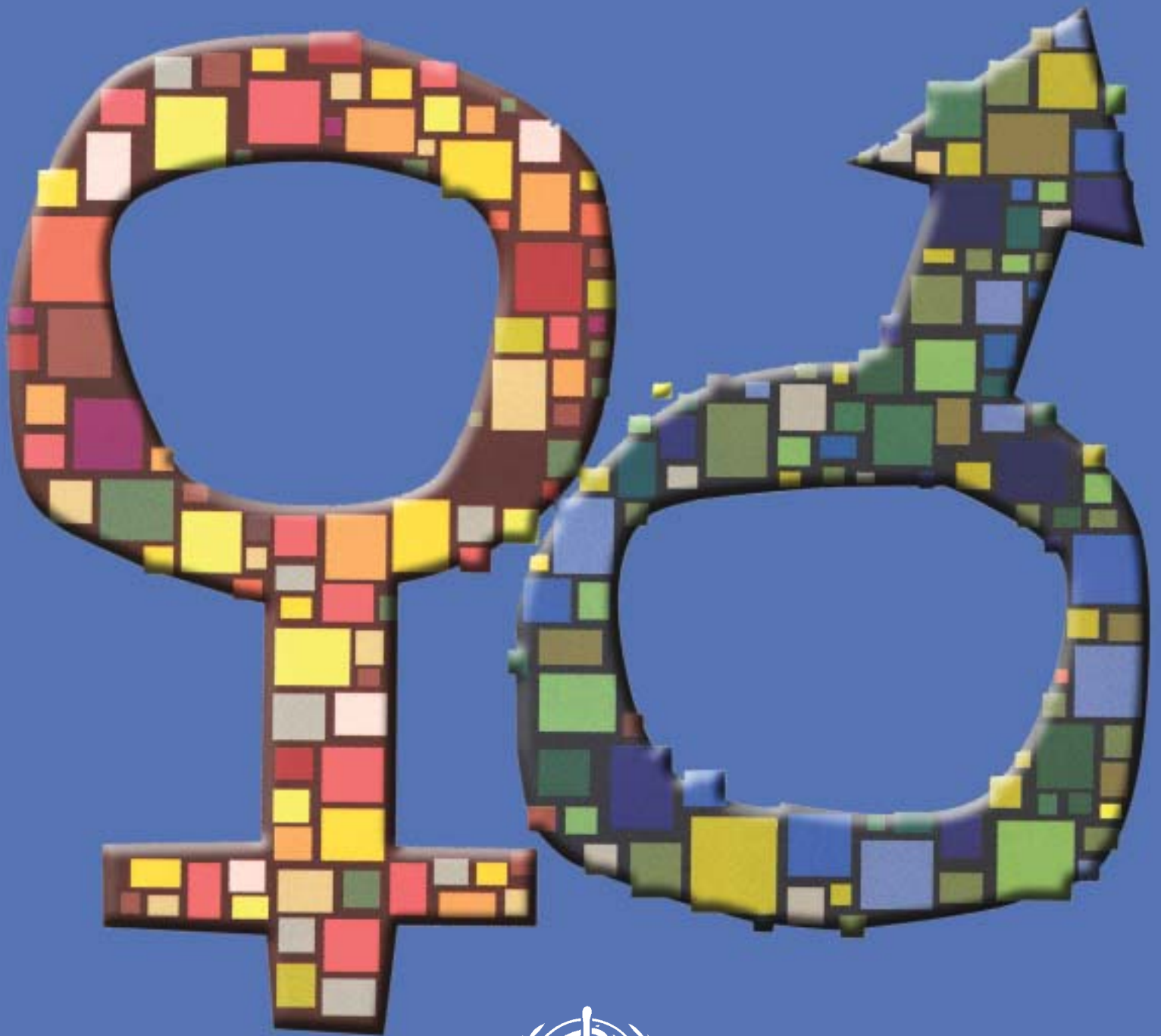


Department of Gender and
Women's Health (GWH)

Biennial Report 2002–2003



Family and Community Health Cluster (FCH)
World Health Organization

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January 2004



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Acknowledgements

Prepared with the assistance of Dr Anthony L. Waddell, Writer/Editor

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All images courtesy of Dr Henrica A.F.M. Jansen, Department of Gender and Women's Health

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CONTENTS

INTRODUCTION

Background	2
GWH vision and strategies	3

PART 1: BUILDING THE EVIDENCE AND RAISING AWARENESS

1.1: Building the evidence	6
1.2: GWH priority areas: Gender-based violence against women and HIV/AIDS	9
1.3: GWH – advocating for change	16
1.4: Gender, health and human rights	19

PART 2: IDENTIFYING APPROACHES AND DEVELOPING THE TOOLS

2.1: Integrating gender into health policies, research and programmes	22
2.2: Addressing and preventing gender-based violence against women	26
2.3: Integrating gender into HIV/AIDS programmes	28

PART 3: INCORPORATING A GENDER PERSPECTIVE INTO THE WORK OF WHO

3.1: Mainstreaming gender in the work of WHO	30
3.2: WHO Gender Policy: Gender Team and Gender Task Force	31
3.3: Working with WHO regional offices and other WHO departments	32

PART 4: ADVOCACY, NETWORKING AND PARTNERSHIPS

4.1: Collaborating with Member States	33
4.2: Building partnerships and networking	34

CONCLUSION

Annex I: WHO Gender Policy	36
Annex II: Gender glossary	37
Annex III: Gender and Women's Health (GWH) selected publications	38

The WHO Department of Gender and Women's Health (GWH)

INTRODUCTION

Background

The true extent to which inequalities and discrimination based upon a person's sex can adversely affect their health and well-being is only now beginning to be fully recognized. Only in the last few years have the factors that lead to differential health outcomes between the sexes been systematically identified and attempts made to address them. The roles socially assigned to men and women (i.e. gender roles) and unequal gender relations frequently interact with social, biological and economic variables to produce different and often inequitable patterns of exposure to health risk, and differential access to – and utilization of – health information, care and services. Such differences directly affect health outcomes, and evidence documenting the multiple connections between gender and health is steadily growing.

In accordance with its long-established concern with health equity as set out in its constitution, the World Health Organization (WHO) remains determined in its efforts to integrate gender considerations into all areas of its work as a matter of principle and as part of good public health practice. To this end, the WHO Department of Gender and Women's Health (GWH), along with its many partners, has continued in its work during 2002–2003 to collect, analyse and disseminate information, develop materials and methodologies for gender analysis, implement advocacy programmes, and support countries in their efforts to integrate gender into policy and planning. As part of this, GWH has continued to work to ensure that gender considerations are properly addressed in health research, policies and programmes, and that such considerations are fully integrated into all aspects of WHO's work – a process known as *mainstreaming gender*.

Although much has been achieved to date, it is fully acknowledged that even greater efforts are required if we are to translate the improved understanding of how gender affects the health of women and men into policies, programmes and health systems that respond adequately to their different needs and circumstances, and that reduce the unacceptable inequities and inequalities that all too often exist between them.

Recognizing the need to move from commitment to implementation and to turn its vision of gender equality into reality, GWH convened two consecutive meetings in order to identify key areas of work, and effective strategies for mainstreaming gender issues in health. The first of these meetings took place with WHO/GWH regional advisors and focal points from 25–26 November 2002. To build upon the discussions and outcomes of this first meeting, GWH then invited leading gender experts to take part in a broader consultation process. The Consultation with Gender and Health Experts was held from 27–29 November 2002 and included brief presentations, group discussions and small working group sessions. The specific objectives of each of these meetings are presented in **BOX ONE**.

BOX ONE: GWH STRATEGIC MEETINGS DURING 2002 – SPECIFIC OBJECTIVES

WHO/GWH regional advisors and focal points (25–26 November 2002)

- Reach consensus on vision and objectives, and identify common areas of interest and effective strategies for gender and women's health.
- Share experience and materials on gender and health among WHO regional offices and headquarters.
- Discuss communication, advocacy and dissemination issues at regional and country level.
- Develop a workplan on common areas of interest for 2004–2005.

Consultation with Gender and Health Experts (27–29 November 2002)

- Identify cutting-edge issues for work on gender and women's health to which WHO can contribute.
- Provide input to WHO/GWH's proposed vision, objectives, content areas and strategies for future work, and identify priority areas of action.
- Make recommendations to WHO on strategies, mechanisms and content areas to strengthen WHO's work on gender and health in WHO regional offices and headquarters, and with planners and policy-makers at country level.

Of particular interest to WHO in general and to GWH in particular was obtaining responses to the following questions:

- Are the vision, goals, and objectives of GWH the most appropriate and useful, given WHO's mandate to provide global leadership in health, and in view of recent developments in global health research and policy?
- Are the suggested strategies the ones that are most likely to lead to the achievement of our vision, goals and objectives? Are there other important strategies that GWH should consider?
- Does the current work of GWH address the most important gender issues in health? If not, what other areas of work should the department consider including in its work?
- What institutional arrangements are necessary for WHO to achieve the goals outlined in the WHO Gender Policy?
- What would be a shared vision, objectives and effective strategies for gender and women's health?
- What would be a synthesis of key priority gender issues of global importance, and key players in relation to health research, policy and programming?
- What are the recommendations to WHO/GWH on priority areas of work in terms of content and strategies?
- What are the recommendations to WHO on mechanisms, strategies and actions most needed in the organization for moving the gender-mainstreaming agenda forward?

To support Member States in the development of policies, strategies and interventions that effectively address high priority and neglected issues of women throughout the lifespan, and in the creation of a body of evidence on the impact of gender on health and of tools, norms and standards to improve gender responsiveness of health interventions and promote gender equity in health.

GWH vision and strategies

The GWH vision

Better health for girls, women, boys and men throughout the lifespan, through the promotion of gender equality and equity in health

As summarized in the WHO programme and budget document 2004–2005¹, the objectives of GWH as it works towards the realization of its vision are:



¹ World Health Organization Proposed Programme Budget 2004–2005. PBI/2004–2005.

GWH strategies

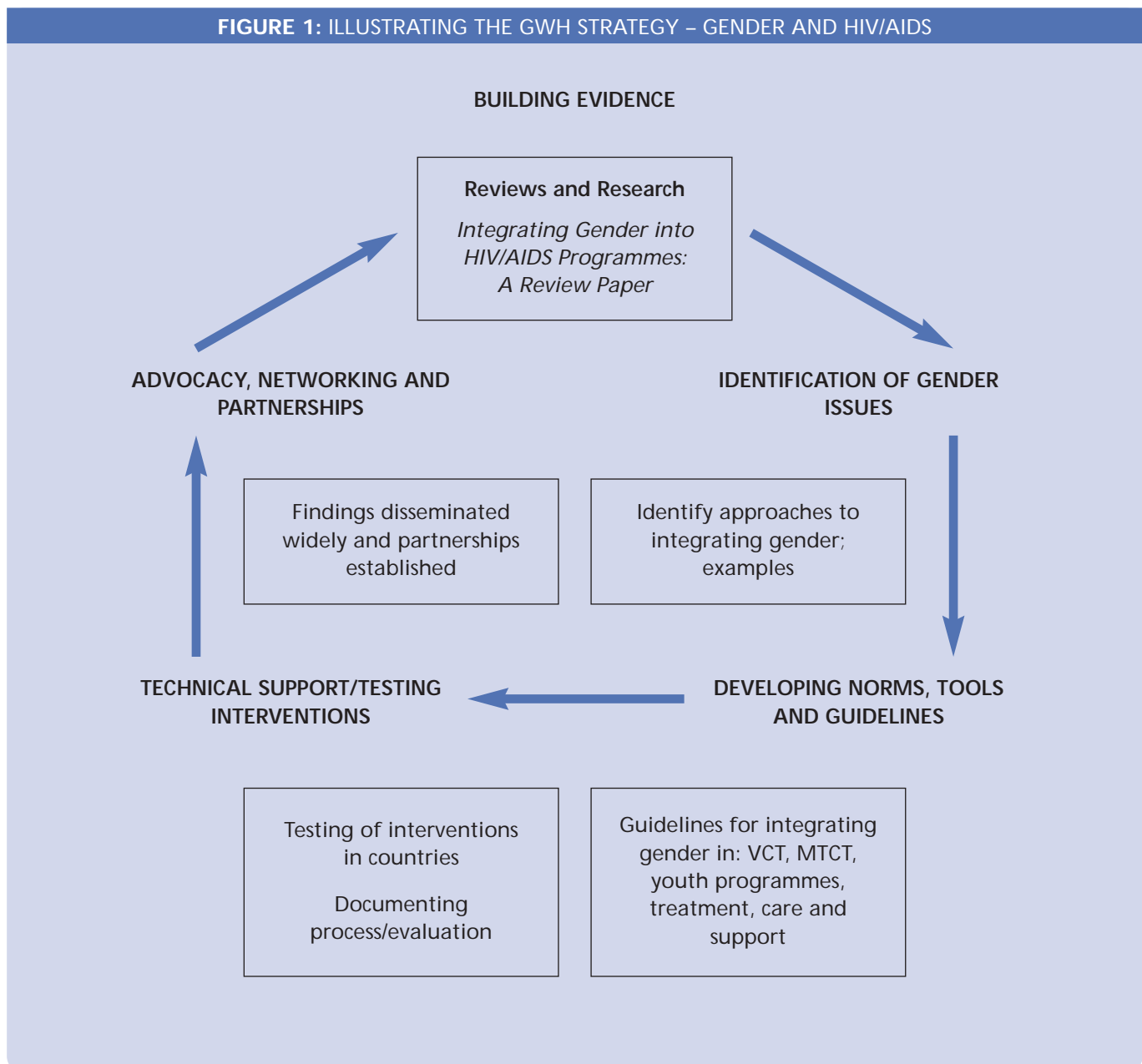
Towards meeting these objectives, GWH has developed and refined its sequence of strategic activity areas as follows:

- Build the evidence through reviews and research, and by documenting the experiences of implementing interventions.
- Develop norms, tools and guidelines for interventions.
- Support interventions through technical collaboration with countries.
- Undertake advocacy, networking and the building of partnerships.

Each of the above steps reinforces and affects the other steps. When dealing with specific issues the first step is typically to review the available evidence in order to identify the key issues that need to be addressed. Such a review may show that there are large knowledge gaps which limit understanding of the ways in which

gender affects the issue in question, and GWH will engage directly in (or advocate for) the conducting of the necessary research. This will then feed back into the review of evidence. Once the key issues are identified, norms, tools and guidelines are developed to ensure that existing interventions and programmes address gender issues. If necessary, new “gender-sensitive” interventions and programmes are designed and then tested for their feasibility, efficacy, effectiveness and cost-effectiveness. Based upon the results of this, the tools and guidelines are modified and then disseminated for use in the implementation of gender-sensitive programmes and interventions, and to help put in place the policies that will support them. Finally, ongoing monitoring and evaluation helps to modify and fine-tune programmes and policies, and provides the evidence for evaluating their impact. An illustration of how this works in practice is presented in **FIGURE 1** which highlights the work of GWH in the area of gender and HIV/AIDS.

FIGURE 1: ILLUSTRATING THE GWH STRATEGY – GENDER AND HIV/AIDS



This document is an account of the work of GWH during the 2002–2003 biennium in all of its activity areas presented in accordance with the main strategic activities listed above and reiterated in **BOX TWO** (PARTS 1, 2 and 4). In addition, an overview is

presented of the complementary and vitally important role of GWH in incorporating a gender perspective into the work of WHO across the entire range of its activities (PART 3).

BOX TWO: THE GWH STRATEGY AS REFLECTED IN THE STRUCTURE OF THIS DOCUMENT

PART 1: BUILDING THE EVIDENCE AND RAISING AWARENESS

To demonstrate through research and evidence how sex differences and gender inequalities impact on health, health systems and health services, and to use the results of these efforts to advance gender equality and equity in health

PART 2: IDENTIFYING APPROACHES AND DEVELOPING THE TOOLS

To develop, pilot and evaluate norms, standards, interventions and research to address and prevent gender discrimination and its consequences, both generally and in health care, and to eliminate gender-based violence

PART 3: INCORPORATING A GENDER PERSPECTIVE INTO THE WORK OF WHO

To develop the skills, capacities and capabilities within WHO needed to generate disaggregated data, analyse it from a gender perspective and apply the findings of this process to the policies and programmes of technical departments at WHO headquarters, regional offices, and within countries

PART 4: ADVOCACY, NETWORKING AND PARTNERSHIPS

Collaborating with Member States, and advocating in conjunction with United Nations and other agencies on the importance of addressing gender issues in the health policies, programmes and research of regional institutions and national governments, and building the necessary networks and partnerships.



PART 1: BUILDING THE EVIDENCE AND RAISING AWARENESS

1.1: Building the evidence

Increasingly, national governments are attempting to follow an evidence-based approach when setting national health priorities, and developing health programmes that respond adequately to these. The lack of sound evidence on the many ways in which gender norms and values, and gender inequality, affect health status and access to health care may mean that national priorities do not accurately reflect the experience of all people, particularly women and other disadvantaged groups.

GWH therefore accords high priority to the building of a sound evidence base on how gender roles and norms and gender discrimination affect health. Given the existing gender inequalities in access to power and resources, the focus has for good reason been unavoidably on women's health. However, gender analysis also helps in understanding and addressing the health and well-being of men. For example, a review of sex differences in road traffic injuries has revealed that gendered high-risk behaviours lead to significantly higher mortality rates for young men from such injuries.

The GWH gender and health information sheets

The department has therefore commissioned reviews of the evidence on sex differentials and gender in relation to different health issues and has highlighted the results of this process in a series of information sheets and other publications. Each of the four-page information sheets pulls together the available information on gender considerations in relation to specific health conditions and problems, and identify knowledge gaps. Each of the sheets highlights what is known about sex and gender differences for the topic concerned in terms of: risks and vulnerability, health-seeking behaviour, responses from health services, health outcomes and long-term social and economic consequences. Following this overview, the information sheets outline the implications of these gender differences for programmes and policies, and present areas for further research.

Eight information sheets have now been published, covering gender and health issues in relation to:

- ageing
- blindness
- disasters
- HIV/AIDS
- mental health
- road traffic injuries
- tobacco
- tuberculosis.

GWH will continue to work towards a more complete coverage of health subjects in conjunction with the relevant WHO departments. Information sheets on Gender and Malaria; Gender and Nutrition; Gender and Medication Use; and Gender, Work and Health are now being finalized and will shortly be available. Such joint advocacy work promotes the importance of gender in health and informs target groups of the impact of integrating gender concerns into their work. As part of increasing its coverage of these and other health issues GWH has undertaken preliminary activities in the following emerging key areas.

Adolescent sexual and reproductive health

Gender roles and norms related to sexuality and reproduction, and gender power dynamics, are central to sexual and reproductive well-being. Adolescence in particular is a time when gender roles and norms are fluid and evolving, influenced by biological changes as well as by a variety of external factors such as parental attitudes, peer pressure and media influences. Despite this, information on how adolescents perceive gender roles and norms related to sexuality and reproduction, and on gender power relations among adolescents and young people, appears to be very limited. Furthermore, few interventions on adolescent sexual and reproductive health seem to have addressed gender concerns or promoted gender equality as a strategy for improving sexual and reproductive health. Because of the importance of having a sound evidence base from which to create well-designed interventions that have a positive effect on gender relations among young people, GWH in collaboration with CAH² has carried out a review of:

- gender issues and concerns of adolescents and young people in a wide variety of settings;
- interventions that have addressed these issues;
- an analysis of the success or otherwise of these interventions;
- the identification of transferable concepts from successful interventions.

This review process involved examining and evaluating data from sources such as: the literature on reproductive health, sexual health and behaviour, and family planning; HIV/AIDS studies; training programmes; mass media health pieces; and mental health literature dealing with life skills and related issues. Each of these sources was assessed in terms of their success in changing gender perceptions and behaviour, and on how much it contributed to the theoretical understanding of gender power relations between adolescents. Work has also been done on reviewing gender-based violence among adolescents, and identifying prevention programmes that look promising or have been evaluated as successful. This background information will be used to integrate gender into guidelines being developed by CAH for different types of intervention programmes for adolescents.

Trafficking of women

Contrary to popular belief, slavery has not been eradicated. Trafficking is a contemporary form of slavery in which thousands of individuals, mainly women and children, are subjected to violence and abuse for the purposes of sexual and commercial exploitation. Information collected from WHO regional offices shows that virtually every country is affected by trafficking; whether as the source, transit area or destination.

Trafficking is an abuse of human rights, and often results in:

- increased vulnerability and exposure to multiple health risks, including violence, infectious diseases, stress, depression and other mental health problems, and little opportunity to make healthy choices;
- reproductive and sexual health problems such as sexually transmitted infections, including HIV/AIDS, unwanted pregnancies, unsafe abortions, and infertility.

GWH has conducted an in-house review to assess the potential role that WHO could play in a global response to the problem of trafficking. Following two video conferences with WHO regional offices and face-to-face meetings in-house, GWH produced a discussion paper which proposes a framework for the implementation of a public health response to the issues surrounding trafficking.

GWH has also worked with the London School of Hygiene and Tropical Medicine (LSHTM) and the European Union to adapt the *WHO Ethical and Safety Recommendations for Research on Domestic Violence Against Women* for use with trafficked women. The resulting document – *WHO Ethical and Safety Guidelines for Interviewing Trafficked Women* – is now available (**Annex III**). A review of the health implications of trafficking is also being completed in conjunction with the LSHTM.

GWH has met with the International Office of Migration to discuss potential collaboration on the issue of trafficking and health with a view to developing an information sheet on the subject. GWH also participates in an interagency working group on raising the profile of trafficking and smuggling in human beings. The meetings provide an opportunity to facilitate and exchange information on trafficking and smuggling, and to foster interagency cooperation on a bilateral and/or multilateral basis.

Women's health in emergencies

In conjunction with HAC³ GWH has been looking at ways of strengthening the work of WHO in the area of women's health in emergencies. A literature review on women's health in emergencies was carried out and a questionnaire sent to HAC staff and focal points in other departments in WHO regional offices and headquarters in 2002. The results of this questionnaire highlighted the currently limited role of WHO in this area and misunderstandings about the potential utility of addressing gender in such settings. At the same time, specific areas of interest were identified and all the review and questionnaire results have now been compiled into a short discussion document with the aim of developing concrete proposals for work in this area with HAC.

GWH is also participating in HAC-coordinated discussions on developing the specific role of WHO in responding to people's ill health during crises. Important gender issues include addressing gender discrimination and gender-based violence in conflict and other emergency situations. In July 2003, GWH participated in the biennial workshop of the United Nations interagency network on women and gender equality – Gender and post-conflict reconstruction: lessons learned from Afghanistan. The department also regularly provides input to resolutions and documents on issues such as the status of women, and women and children in armed-conflict situations.

Gender in health systems

Two exploratory reviews have been carried out in this area – one on sex differences in reported health status, and another on sex differences in the utilization of health services. GWH is initiating preparatory work on incorporating a gender dimension to the WHO health system performance measurement framework and tools. This effort will build on existing work on gender and health service responsiveness, and will be carried out by EIP⁴ in collaboration with the Gender Team (section 3.2). Specific products envisaged include:

- a paper on the framework used to investigate responsiveness, from the gender and user perspectives;
- setting up of a small in-house working group on the subject of gender and health system performance measurement;
- in consultation with the working group, preparation of a discussion paper outlining how gender considerations can be incorporated into the existing health system performance measurement framework and tools.

Gender and nutrition

The central importance of nutrition in health and well-being, and the effects of gender differences and discrimination is an area of work that GWH intends to develop further. There is already clear evidence of gender differences in nutritional status in childhood, and in some countries a greater proportion of boys than girls are malnourished, while in others the opposite is true. The reasons for such differences between countries are not known. Preliminary work has now been undertaken in two specific areas.

- The high prevalence of anaemia in women of reproductive ages – in which gender-based inequalities are an important factor – is a major health concern in many developing countries. GWH is now producing a health information sheet on gender and nutrition, including anaemia.
- GWH has also commissioned a review paper on gender and obesity, an area of concern that is likely to increase in importance in the coming years.



Gender, work and health

At the June 2002 International Congress on Women, Work and Health, WHO organized a panel to present and discuss gender and work-related issues. The panel included presentations on gender and health concerns in relation to:

- agricultural work
- industrial work
- sex work.

The edited papers together with an overview of gender and occupational health issues are being collated into a publication on gender, work and health. This will be published jointly with OEH⁵ in 2004.

Gender-relevant indicators in health research

In recent years, fuelled by such international meetings as the 1994 Cairo Conference on Population and Development and the 1995 Beijing World Conference on Women, interest has grown in the ways in which sex and gender – and the gender arrangements of any given society – affect health. But if health professionals are going to be able to investigate and intervene meaningfully in gender and health problems, they will need sound relevant data. GWH has therefore prepared a document – *Guidelines on Gender-Relevant Indicators in Health Research (Annex III)* – in order to help health workers collect the type of information they will need to effectively explore and address gender-related health issues. The document is divided into three sections – an introductory chapter explaining the rationale for the guidelines and the theoretical framework which dictated the choice of indicators, and two further sections on national level and individual/household level indicators. Together with WHO regional offices, GWH is now reviewing this and other documents on gender-sensitive or gender-relevant indicators for health in order to identify 10–15 core indicators. The aim is to develop a common list across all of WHO, to which countries and WHO regional offices can add, and which can then be used in countries for action-oriented advocacy. This work is linked to the process of “en-gendering” the Millennium Development Goals, and in particular those which are related to health (see section 1.3 and **BOX SIX**).

1.2: GWH priority areas: Gender-based violence against women and HIV/AIDS

Violence against women (VAW)

Violence against women occurs in many forms and in many settings. It can be psychological, physical or sexual. It can occur at home, in the workplace or in the community at large. In many societies, it is often perpetuated, exacerbated and legitimized by gender values and norms that discriminate against women and that sanction the use of violence against them. Hence, it is also referred to as gender-based violence against women.

Violence against women is an important risk factor for ill health in women and leads to a wide range of injuries, and mental and physical health problems. These include reproductive and sexual health problems such as sexually transmitted infections including HIV/AIDS, unwanted pregnancy, and gynaecological complications. Since much of this violence is hidden or unreported and often takes place in the home, it is difficult to document and thus prevent. This is however an undoubted and major public health problem, and according to the United Nations Secretary-General is:

... perhaps the most shameful human rights violation. And, it is perhaps the most pervasive. It knows no boundaries of geography, culture or wealth⁶.

For all these reasons, violence against women is an important and long-established priority for GWH. In 1996, the then WHO Women’s Health and Development programme organized the first WHO Consultation on Violence Against Women. This meeting brought together women’s health advocates, researchers and service providers working in the field of violence against women to review existing knowledge of the problem and current and ongoing activities, and to identify gaps and make recommendations to WHO. These recommendations served as the basis for the initial WHO plan of action on violence against women (**BOX THREE**).

4 WHO Evidence and Information for Policy cluster

5 WHO Occupational Health and Environmental Health department

6 International Women’s Day Press Release SG/SM/6919 WOM/1113, 8 March 1999.

BOX THREE: LONG-TERM OBJECTIVES OF GWH IN THE PREVENTION OF VAW

Our long-term aims are to identify strategies for preventing all forms of violence and to decrease morbidity and mortality among women experiencing abuse. To this end, we have defined the following specific objectives.

- Increase knowledge of the extent and magnitude of the problem.
- Disseminate information widely among those in a position to use it to good effect.
- Identify strategies to reduce the incidence and prevalence of violence against women by their partners.
- Improve the capacity of health workers to assist women suffering abuse of all kinds.
- Support national governments in efforts to create suitable anti-violence policies.
- Advocate for greater recognition of the implications of violence against women.

The WHO Multi-Country Study on Women's Health and Domestic Violence Against Women

The focus of WHO in this area has been on building the knowledge base for policy and action and strengthening the role of the health sector in the prevention of violence against women and in providing care for those experiencing abuse. A major undertaking in this has been the *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women* which was developed in direct response to the lack of data on the magnitude and nature of the problem, particularly in resource-poor settings.

This study – now in its sixth year – is the single largest investment in gender-sensitive research that WHO has so far undertaken. It is the first study to gather data on the prevalence of violence against women and women's health that is comparable across countries. It uses a standard methodology, including a standardized training approach for all interviewers, with the objectives being to:

- obtain reliable estimates of the prevalence of different forms of domestic violence against women in a number of countries;
- document the health consequences of domestic violence against women;
- identify the risk and protective factors for domestic violence against women;
- explore and compare the strategies and services used by women who have experienced violence.

The study is policy and action oriented and at country level is carried out in partnership with local research institutions, ministries of health and other government agencies, and NGOs. This has helped to

ensure political support for a sensitive issue, and appropriate responses to the findings. Each country research team included at least one women's organization involved in working with women experiencing violence. Their participation and experience has contributed to the design and implementation of the research, while ensuring advocacy for policy change in the countries concerned at the end of the study.

The quantitative component of the research itself consists of a household survey in each country of a representative cross-section of women and girls – 1500 in a large city and 1500 in a representative province. The survey poses direct questions about the respondent's experience of specific violent behaviours over specified time frames. Follow-up questions cover violence during pregnancy, injuries suffered as a consequence of the violence, what help was sought and obtained (if any), and what services were used. Background questions cover the women's socioeconomic status, education, general, mental and reproductive health, and use of health services. Countries are chosen for the study on the basis of the following criteria:

- the absence of existing population-based data on violence against women;
- the presence of local anti-violence groups able to use the data for advocacy and policy reform;
- the presence of strong potential partners known to WHO;
- a receptive policy environment;
- the absence of recent war-related conflict;
- regional diversity.

During 2000–2003 large population surveys were conducted in eight culturally diverse countries: Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Thailand, and the United Republic of Tanzania. The study has also been replicated in its entirety (or in amended form) in: Chile, Ethiopia, Indonesia, New Zealand, and Serbia and Montenegro. A summary of the overall progress of the study during 2002–2003 is shown in **BOX FOUR**.

While the study is ongoing all the research teams meet annually to share their experiences and lessons learned in the field, discuss and agree upon the next steps, build ownership and promote South-to-South collaboration. Over the next few months, work will start or continue on:

- the first country reports for Bangladesh, Brazil, Japan, Namibia and the United Republic of Tanzania;
- a cross-country analysis and the first WHO report of findings of the study;
- fact sheets for individual countries and themes (cross-country comparisons);

- the launch of reports nationally and internationally;
- publication of a CD containing the study materials: Ethical Guidelines, Protocol, Questionnaire (with detailed question-by-question description), and Manuals;
- a meeting of country research teams at the Rockefeller Foundation Study and Conference Center in Bellagio from 26 April to 2 May 2004 to reflect on and analyse the experience of six years of carrying out the research;
- a paper on Training Methodology in Violence against Women to be published in a special issue of *Violence against Women* for papers presented to the International seminar towards a cross-cultural analysis of family violence, Family Violence in Montreal, 2003.

The findings of the study will also be widely disseminated through leaflets, reports, scientific journals and WHO publications, and will target widely differing technical, political, and public audiences. The Study Consultative Committee in each country will ensure that the findings are translated into concrete changes in policy and interventions. It should be noted that the study has already generated commitment and involvement at all levels, and has led to measurable achievement. Around 400 interviewers have been trained in the countries involved in the study, resulting in a pool of trained and motivated people in each of the countries concerned. These and other policy and activity outcomes of the study are dealt with more fully in section 2.2.

BOX FOUR: THE WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN

PROGRESS IN 2002–2003

2002

- At WHO headquarters, recruitment of a communications officer and development of an advocacy and information dissemination plan
- Development and implementation of strategies for using the information for policies and intervention development with countries
- First country report with initial results published in Peru
- Presentation of methodology and initial results at the 6th World Conference on Injury Prevention and Control in Montreal (May 2002) and at the XIV International AIDS conference in Barcelona (July 2002)
- Fifth meeting of research teams in Washington, D.C. (August): reviewed first results and discussed first country reports, steps for secondary analysis and brainstorm advocacy and information-dissemination strategies at local, national and international levels; next stages agreed
- Ongoing revision of core questionnaire based on experience in countries
- Collaboration with new countries undertaking the study – New Zealand and Serbia and Montenegro.

2003

- Meeting of Expert Steering Committee in March 2003 to discuss current status of the study, interpretation of results of first-level analysis, identification of priorities for second-level analysis, dissemination and advocacy activities
- Preliminary country reports with initial results finalized in Namibia and Thailand
- Training and data collection conducted in New Zealand and Serbia and Montenegro
- Data analysis ongoing in the United Republic of Tanzania and Serbia and Montenegro
- Core questionnaire, question-by-question description of questionnaire, and protocol updated
- Presentation of WHO methodology and preliminary results at the Second South African Gender Based Violence And Health Conference, May 2003 in Johannesburg, South Africa; and at the International seminar towards a cross-cultural analysis of family violence, organized by le Centre international de criminologie comparée (CICC) de l'Université de Montréal and le Centre de recherche interdisciplinaire sur la violence familiale et la violence faite aux femmes (CRI-VIFF), June, Montreal Canada
- Meeting of members of the core research team for the study in Washington, D.C. (October 2003) to develop a draft of the first WHO Report of Findings from the *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women*, to review tables and analysis, identify and carry out further analysis, and identify key messages emerging from such analysis
- Presentation of results to a meeting on Non-consensual Sexual Experiences of Young People in Developing Countries, New Delhi (September); to the XVII FIGO World Congress in Chile, November; and at the American Public Health Association, 131st Annual Meeting (November 2003) in San Francisco, CA.
- Publication of a paper in a *Health and Human Rights* special issue on violence presenting an overview of the design and methodology of the study
- Publication of ethical and safety recommendations in Spanish and French.

Any effective response to VAW needs to be informed by evidence of its true magnitude, consequences and causes. The WHO study illustrates how collecting such evidence, in partnership with researchers and women's organizations, can both fill a gap in our knowledge while strengthening the anti-violence movement as it works towards change.

The Sexual Violence Research Initiative (SVRI)

Sexual violence is both a public health problem and a violation of human rights. It occurs across continents and cultures and has a profound impact on physical and mental health, both immediately and for many years following its occurrence. However, there is a lack of reliable data particularly from resource-poor regions of the world. Data is therefore needed on the magnitude and nature of the problem, its health impact and its risk factors, so that the burden of the problem can be estimated and knowledge of why it persists improved. Equally, there is a need for more knowledge concerning existing interventions and their effectiveness.

The Global Forum for Health Research (GFHR) and WHO have been supporting the process of setting up the *Sexual Violence Research Initiative* (SVRI) building on the experiences of the *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women* and on the various initiatives supported by the GFHR. An international meeting in Melbourne, Australia in May 2000, attended by representatives from all regions of the world and several networks of organizations working on sexual violence, agreed that a global initiative for research into sexual violence is urgently needed.

The SVRI aims to build an experienced and committed network of researchers, policy-makers, activists and others to ensure that sexual violence is addressed from the perspective of different disciplines and with a

multicultural outlook. It is intended that through the SVRI, research and research capacity will be built up in a range of developing countries. The initiative will also enable approaches and interventions to be documented, evaluated and shared, research and evaluation methodologies to be developed and implemented, and successful programmes transplanted. The initiative will also seek to influence donor agencies to include sexual violence in their agendas. Current research priorities identified by the SVRI include:

- nature and magnitude of sexual violence, including qualitative research on masculinity and other risk factors;
- health consequences of sexual violence;
- women's responses to sexual violence;
- medico-legal responses to sexual violence;
- alternative forms of justice in cases of sexual violence.

The overall objective of the SVRI is to promote and disseminate research as part of responding to and reducing the impact of sexual violence in low-income and middle-income countries through a process of identifying gaps, building capacity, supporting research, raising awareness, and building partnerships. Key activities include:

- providing information and updates on sexual violence research and research methods through an interactive web site on sexual violence;
- promoting research on sexual violence through Requests for Proposals on priority areas which will advance knowledge and intervention development;
- creating a network that links researchers from different parts of the world, and facilitating web site and e-mail discussion groups;
- organizing a biennial conference.

A coordinating group, chaired by GWH, has been established and technical support is also being provided to the initiative. A proposal for the first two years (Phase 1) of the SVRI has been developed in collaboration with the other members of the coordinating group, and initial GFHR funding has been received.

Within WHO, close links have been developed with VIP⁷ since its creation in 2000. During 2002–2003, GWH contributed to two chapters of the 2002 *World report on violence and health* dealing with sexual violence and intimate partner violence, and is now collaborating in the development of a number of normative documents (see section 2.2).



7 WHO Department of Injuries and Violence Prevention

Violence against women is an important factor in the transmission of HIV

Some women experience either actual physical violence or the threat of it when attempting to negotiate safer sex with the use of condoms. Research has shown that in many settings women often avoid bringing up the issue of condom use for fear of triggering a violent male response.

Violence in the form of coerced sex or rape may also result in the acquisition of HIV, especially as coerced sex may lead to the tearing of sensitive tissues and increase the risk of infection. In studies among young women, reported levels of coercive sexual intercourse are often very high. Sexual minorities such as gay men also encounter sexual coercion in many countries, and are similarly at risk of HIV infection.

In conflict situations a number of aggravating factors further fuel the HIV/AIDS pandemic. These include the breakdown of families and communities, forced displacement, poverty, the collapse of health services, and physical and sexual violence. Women more than men are at risk of rape and sexual assault in conflict situations, and consequently of HIV infection.

The intersection of gender-based violence (GBV) and HIV/AIDS has been a key area of work for GWH. A review of the role of gender inequality, and GBV in particular, on the uptake of voluntary testing and counselling, and on the disclosure (and outcomes of disclosure) of HIV status has recently been completed. Work with UNAIDS in this area has intensified in the last year, and specific attention is being paid to looking at programmes that successfully address both epidemics of VAW and HIV/AIDS.

Gender and HIV/AIDS

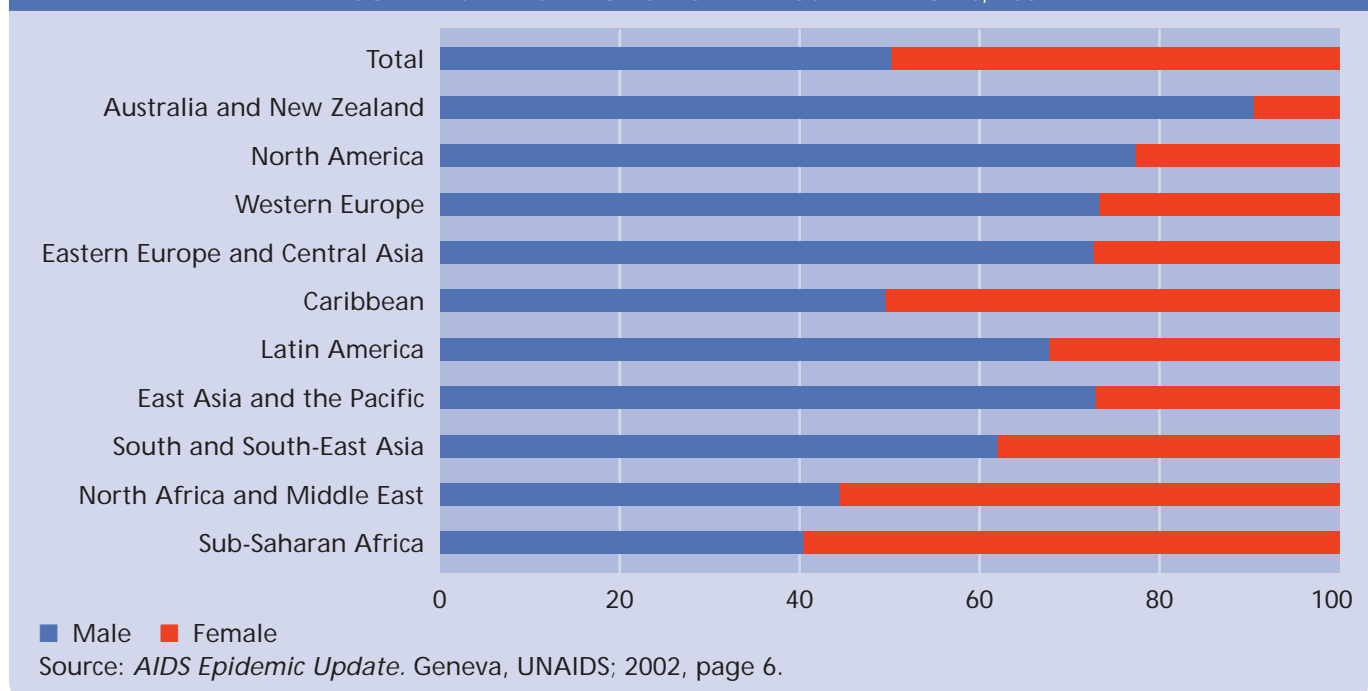
The historical gap in HIV prevalence rates among men and women is narrowing every day. In the early stages of the pandemic, HIV infection occurred predominantly among men, but at the end of 2002 almost 50% (19.2 million) of the 38.6 million adults living with HIV/AIDS globally were women (FIGURE 2).

However, this increasing similarity in prevalence disguises a number of important differences between women and men in the underlying mechanisms of HIV/AIDS infection, and in the social and economic consequences of HIV/AIDS. Such differences stem from biology, sexual behaviour, and socially constructed gender-based disparities in the roles and responsibilities of women and men, and in their access to resources and decision-making power. Although a number of studies have now examined the impact of gender inequalities on the vulnerability of women to HIV/AIDS, comparable information on gender, men and HIV/AIDS remains very limited. Nevertheless, a number of important factors in the differential risk and impact of HIV/AIDS are now emerging.

Gender norms can increase vulnerability to HIV infection, especially in young people

In almost all cultures masculinity is associated with virility, and with a tendency to view sex as a form of conquest. At the same time, because ignorance is construed as a sign of weakness, men are often reluctant to seek out correct information on HIV/STI prevention. The role of same-sex relations among young men in enhancing risk of HIV infection is also often ignored in many settings, where sex between

FIGURE 2: SEX DISTRIBUTION OF HIV-POSITIVE ADULTS, 2002



men is socially stigmatized and often illegal. As in so many areas, the limited availability of data contributes to the near invisibility of this issue.

The early initiation of sexual activity among girls is directly related to the practice of early marriage for girls in many developing countries. For many women, being vulnerable to HIV is a direct consequence of being married. Social norms that accept extramarital and pre-marital sexual relationships for men, combined with the inability of women to negotiate safer sex practices, make HIV infection a risk even for women who have only had one partner in their entire lives. For such women “remaining faithful” is no protection. In addition, high rates of gender-based violence (including violence by intimate partners) increasing levels of forced first sex among adolescent girls, and the sexual abuse of children are major contributing factors to the HIV epidemic among women.

Furthermore, the sexual partners of young women are often much older than themselves and this exposes girls to an increased risk of STIs (including HIV). This is worsened by the fact that many young women know little about their bodies, contraception and STIs, in part due to the fear that seeking information on sex or condoms would label them as sexually active, regardless of the true extent of their sexual experience. As a result of all these factors and others, studies are increasingly indicating a higher HIV prevalence among young women (aged 15–24 years) compared to young men of the same age across a range of settings. To compound this situation, poverty, lack of education and limited income-earning opportunities often force women into sex work, again exposing them to a higher risk of HIV infection.

Pregnancy, HIV/AIDS, and childbearing raise specific issues for women

Pregnancy-related complications, such as haemorrhage, expose women to the risk of HIV infection related to the transfusion of blood or blood products.

Studies from developed countries indicate that pregnancy does not affect the progress of existing infection in HIV-positive women who show no symptoms, or in those in the early stages of infection. Care should be taken however to avoid generalizing these results to the developing world, since there has been little research on this topic in such settings.

In developing countries, there is a high risk of infant death associated with maternal HIV infection. Since HIV can be transmitted through breast milk, breastfeeding presents a dilemma for many women. Those who decide to discontinue breastfeeding in favour of infant formula may reduce the risk of HIV

transmission to their child, yet may expose the infant to diseases resulting from an unclean water supply, as well as to malnutrition. In addition, the use of infant formula can alert others to the mother’s HIV status and lead to stigma and discrimination.

Gender is a factor in health-seeking behaviour

The stigma associated with HIV/AIDS is a major factor preventing many women and men from accessing services. Women may be more affected by stigma and discrimination than men because of social norms concerning acceptable sexual behaviour in women, and because women are often more economically vulnerable than men. Gender differences in decision-making may also affect access to health facilities – for example while men may make independent decisions to seek voluntary counselling and testing (VCT) services, women in the same societies may be obliged to discuss testing with their partners before accessing the service. Once again, violence can constrain the ability of women to access treatment and care, and renders them more vulnerable when sick.

The cost of HIV/AIDS treatment renders it unaffordable for most families in developing countries. While the price of treatment affects both sexes, the unequal economic power of men and women may make access to treatment particularly difficult for women.

It is estimated that perfect use of the female condom may reduce the annual risk of acquiring HIV by more than 90% among women who have intercourse twice weekly with an infected male. However, the price of the female condom (4–10 times that of male condoms) makes it inaccessible to most women.

There are gender differences in the social and economic consequences of HIV/AIDS

Both women and men living with HIV/AIDS experience discrimination and stigma. However, there are gender differences in the way stigma affects women and men. In a number of study settings it has been found that men with HIV are hardly questioned about how they became infected, and were generally cared for. By contrast in the very same settings, women were often accused of having had extramarital sex (whether or not this was the case) and received lower levels of support.

Men, on the other hand, may be under pressure to keep their HIV infection status secret for fear of dismissal from work, and of being unable to play their traditional gender role as breadwinner.

Integrating gender into HIV/AIDS policies and programmes

For all the reasons outlined in this section and more, there is now an urgent need to bring a meaningful gender dimension to HIV/AIDS policies and programmes if real progress is to be made (BOX FIVE). In order to update and build upon previous efforts in this area, GWH initiated in 2002 a process to help national level HIV/AIDS programme managers to integrate gender-based issues and needs comprehensively within HIV/AIDS policies and programmes – a process described more fully in section 2.3.

What research is needed to bring a gender dimension to HIV/AIDS policies, programmes and interventions?

- Much more research is needed on gender and HIV/AIDS issues for men (such as the impact of masculinity on vulnerability to HIV infection) as well as on gender-related factors that impede their access to HIV/AIDS testing and treatment.
- Increased investment must be put into the researching and development of microbicides or other effective female-controlled methods of preventing HIV transmission that do not prevent pregnancy and do not involve the use of a condom. Promising research on such methods is already under way and should be expanded and supported.
- Research into gender differences in risk perception and behaviour across different age groups and in different settings would help in the design of more relevant information, education and communication (IEC) interventions in HIV-prevention programmes.
- The role of non-consensual sex in increasing the risk of HIV infection in adolescent girls and boys is an important area for further research.
- More research is also needed on the response of health systems to HIV-positive adolescents, and on gender differences in the barriers adolescents face in gaining access to health services. Effective interventions should be designed to overcome these barriers.
- There is limited research on integrating the inputs and perspectives of women and men into the design and delivery of HIV treatment and care. These include expressed opinions on individual-versus-couple counselling; disclosure and partner notification processes; location of services; and differences in all of these in terms of gender, age and setting.

- The ways in which different service delivery settings (e.g. preventing HIV infection in infants, or voluntary counselling and testing) influence the process of disclosure of HIV-positive status to partners (and the consequences of this for women and men) need to be better understood. This is a necessary part of designing programmes that minimize adverse consequences such as intimate partner or family violence against HIV-positive women.

BOX FIVE: BRINGING A GENDER DIMENSION TO HIV/AIDS POLICIES AND PROGRAMMES – SELECTED IMPLICATIONS

- Male and female condom promotion efforts need to recognize, identify and address gender issues that inhibit condom use.
- HIV/AIDS, peer-education, and sex-education programmes for adolescents that incorporate broader gender issues into their framework should be fostered – such programmes can help to show how norms related to masculinity and femininity may increase risky sexual behaviour, and can help young people to work towards more equal and responsible relationships.
- Voluntary counselling and testing (VCT) services should take into account the risk of violence to a client when evaluating different approaches to disclosure – for example by offering counsellor-mediated disclosure if that would help to minimize adverse consequences.
- Both men and women should be involved in programmes to prevent HIV infection in infants – antenatal services can educate men about sexuality, fertility and HIV prevalence to raise their awareness and sense of responsibility, and to reinforce the view that both men and women are responsible for pregnancy and for preventing HIV transmission.
- Community home-based care approaches that are currently being integrated into national AIDS programme strategies need to promote the role of men as caregivers in the family and community, and to provide adequate support and guidance to enable male participation. At the very least, such programmes should acknowledge that reliance on “home care” is at present largely reliance on “women’s care”.
- Indicators developed for monitoring the implementation of the Declaration of Commitment on HIV/AIDS adopted by 189 countries at the United Nations General Assembly Special Session on HIV/AIDS in June 2001 need to go beyond providing sex-disaggregated data. A review of these indicators and suitable modification to adequately reflect progress in addressing gender issues in HIV/AIDS would be very important for equity as well as effectiveness.

1.3: GWH – advocating for change

A succession of resolutions of the General Assembly and other United Nations bodies in the last decade have called for accelerated efforts to achieve equity and equality between women and men, a greater attention to the global agenda of women's health, and effective integration of gender into the policies and programmes of the United Nations system. Gender mainstreaming was thus adopted as an across-the-board mandate for all United Nations systems by ECOSOC in 1997.

This important event followed on from a number of earlier initiatives, particularly the International Conference on Population and Development (ICPD) held in Cairo in 1994 (and the associated ICPD *Programme of Action* presented in the conference report⁹); and the 1995 Fourth World Conference on Women held in Beijing (and the Beijing *Platform for Action*, again contained in the corresponding report⁹). Five-year reviews of the progress made since both of these events have also provided invaluable further guidance as well as evidence of the determination of the international community to highlight the central role of gender in efforts to promote human health and development^{10, 11}.

Gender and the Millennium Development Goals

In September 2000, all these important advocacy efforts culminated in the adoption by Member States of the *United Nations Millennium Declaration*¹² and of the goals contained in the follow-up document¹³. These goals – now referred to as the “Millennium Development Goals” (MDGs) – summarize key commitments made by Member States at United Nations conferences during the 1990s. Within each of the eight MDGs a number of targets have been identified, and indicators of progress have been developed. The MDGs and their associated targets and indicators represent an important focus for the work of GWH. As part of its commitment to play a full part in helping to bring about the changes called for, GWH has prepared a document entitled “*En-gendering*” the *Millennium Development Goals (MDGs) on Health* ([Annex III](#)). With this publication, GWH demonstrates the ways in which gender considerations permeate a whole range of health and development issues and highlights the ways in which gender impacts upon each area. **BOX SIX** illustrates some of the insights and related factors addressed in the document which programme planners and researchers need to be aware of if gender concerns are to be meaningfully addressed.



WHO has been participating in the efforts of other partners, such as the World Bank, UNDP, Gender and MDGs Working Group, and a number of Millennium Development Project Task Forces to ensure gender is adequately addressed through the MDG process. GWH along with WHO regional offices has also been involved with the WHO Collaborating Center in Kobe, Japan in the development of a core set of gender-sensitive health indicators.

Millennium Development Goal 1: Eradicate extreme poverty and hunger

In some places the high value placed upon male offspring can lead to girls being nutritionally disadvantaged; either directly or as a result of poorer levels of health care leading to malnutrition. In some settings, societal standards of what passes for “normal” growth for girls may be set unhealthily low.

Millennium Development Goal 4: Reduce child mortality

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

In Asia more young girls die than young boys even though worldwide the under-five mortality rates for both sexes are approximately equal. In any part of the world where there are large variations in son and daughter survival rates, the possibility of gender preference must be addressed. In addition to such direct differentials, the health (including nutritional status) of pregnant women and new mothers, and their access to resources, will inevitably impact upon under-five health and well-being.

Millennium Development Goal 5: Improve maternal health

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Poor nutrition during pregnancy resulting from gender discrimination, societal norms that limit a woman's access to health care in normal and emergency antenatal situations, and poor provision of female education are all major contributing factors to maternal mortality. In addition, certain diseases and gender-based violence experienced during pregnancy can be highly dangerous for mother and child.

Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Nowhere is the importance of a gender approach more important than in the areas of preventing and treating HIV infection, and ensuring the provision of care to those affected. A fatal combination of biological factors and societal norms that have disadvantaged women (particularly young women) has meant that 2002 was the first year in which the number of adult women infected with HIV equalled the number of adult males – a finding that strongly suggests that HIV/AIDS is now spreading fastest among females.

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Malaria, tuberculosis and many other major diseases have a clear gender dimension both in terms of differential susceptibility to them, and in access to proper treatments and care.

Millennium Development Goal 7: Ensure environmental sustainability

Although there is no reason to believe there are major gender differences in areas such as the frequency of use of solid fuels or in access to safe water and sanitation (as these are often family or district level issues), closer inspection reveals important gender differences as a result of the processes of obtaining or using such resources. It is women and children who spend more time indoors and who are therefore exposed to the health-damaging consequences of solid-fuel use. Similarly it is women and girls who most often seek out and transport water where the supply is located away from homes.

8 *Programme of Action of the International Conference on Population and Development (ICPD) in Report of the International Conference on Population and Development, Cairo, 5–13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

9 *Platform for Action in Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

10 Twenty-first special session of the United Nations General Assembly. Agenda item 8. Resolution adopted by the General Assembly. Addendum. *Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development (A/S-21/5/Add.1)*. July 1999.

11 Twenty-third special session of the United Nations General Assembly. Agenda item 10. Resolution adopted by the General Assembly. *Further actions and initiatives to implement the Beijing Declaration and Platform for Action (A/RES/S-23/3)*. November 2000.

12 Fifty-fifth session of the United Nations General Assembly. Agenda item 60(b). Resolution adopted by the General Assembly. *United Nations Millennium Declaration (A/RES/55/2)*. September 2000.

13 Fifty-fifth session of the United Nations General Assembly. Item 40 of the provisional agenda. Follow-up to the outcome of the Millennium Summit. *Road map towards the implementation of the United Nations Millennium Declaration*. Report of the Secretary-General (A/56/326). September 2001.

Advocacy on gender and health

Advocacy at all levels is a crucial part of the role of GWH in raising awareness of the importance of gender in a broad range of health issues. During 2002–2003, the department continued to support other advocacy activities in order to enhance the understanding of gender equality and equity as key aspects in efforts to improve health and well-being, including:

- Holding several seminars and electronic presentations tailored to different departments within WHO in order to publicize the importance and necessity of gender mainstreaming in the work of the Organization. Such seminars also helped to motivate staff members to mainstream gender in their plans of action in order to address gender equality and health equity at country level.
- Producing a set of publications and advocacy materials including posters, electronic presentations, a newsletter, brochure and information sheets (see section 1.1) to raise awareness on gender and women's health issues both within and outside the Organization. Furthermore, the key information contained in this material is intended to impact upon stakeholders and other key players and to encourage them to take action in favour of gender and women's health.
- Working closely with its partners to issue technical publications such as the *WHO Ethical and Safety Guidelines for Interviewing Trafficked Women* (**Annex III**) which was developed jointly with the London School of Hygiene and Tropical Medicine and the Daphne Programme of the European Commission. These guidelines provide a set of 10 basic standards for interviewing women who are in (or have left) a trafficking situation.
- Setting up a dissemination strategy for GWH publications in collaboration with MDI¹⁴. More than 1000 target groups, including ministries of health, NGOs, women's organizations and health services will receive GWH publications.
- Promoting the GWH web site throughout the WHO network and elsewhere. GWH, in collaboration with CCO¹⁵, has informed WHO Liaison Officers and WHO Representatives of the web site and its main features.

- Responding to requests relating to gender and women's health issues, mainly from its partners, the media and the general public.
- Building ongoing relationships with all these groups and providing them with technical publications, key information, advocacy material and stories about our work that may be of general media interest.



14 WHO Marketing and Dissemination department

15 WHO Department of Cooperation and Country Focus

1.4: Gender, health and human rights

The concept of human rights provides an essential framework within which to respond to gender-based discrimination and other social determinants that multiply the effects of gender inequality. Therefore, bringing attention to human rights and particularly the human rights of women, is a core strategy of GWH. During 2002–2003 GWH activities in this area have concentrated upon liaising with United Nations human rights treaty bodies and with groups working on women's human rights, and working on documents which strengthen the understanding of the links between human rights, gender and women's health.

In many cases, women's ill health is the direct result of the violation of the principle of non-discrimination

based on sex, the right to the highest attainable standard of health for women, and many other fundamental human rights such as the right to life and the right to bodily integrity. Likewise, many of the root causes which result in negative health outcomes for women are based upon gender discrimination, and the denial to women of the full enjoyment of fundamental human rights such as the right to education and information, the right to property, the right to participate in decision-making, equality in employment, and equality in marriage. Under international human rights law, governments are held accountable for respecting, protecting and fulfilling these rights which women of all ages are entitled to. A major GWH area of work is violence against women (see section 1.2 above and section 2.2) which is well recognized as one of the most important violations of women's human rights worldwide (**BOX SEVEN**).

BOX SEVEN: VIOLENCE AGAINST WOMEN THE LINKS BETWEEN WOMEN'S HEALTH, HUMAN RIGHTS AND GENDER

Violence is a major public health problem worldwide and the mortality and morbidity caused by it is *avoidable*. Although both men and women are affected by violence, the forms it takes and their effects are different. Most of the violence men suffer occurs in the "public" space, and involves homicide or criminal assault, drug-related crime and violence in war. However, women experience violence most frequently in the family space – for example physical and sexual assault by an intimate partner, or abuse of domestic workers. Sexual violence, including that which occurs in the sex industry, also predominantly affects women. Thus, it is principally women and their health that are affected by domestic and sexual violence. In armed conflict situations, women and children are also increasingly the targets of sexual and other forms of violence, with major impacts on their health. Most of the violence women suffer is directed by men against women as a result of an unequal gender power relationship. Without gender analysis, it is impossible to understand and address the root causes of violence against women.

Why is it necessary to focus on the violence mostly experienced by women?

While the violence men experience is relatively well-recognized, gender blindness in health research has made it difficult even to obtain reliable data on the magnitude of violence against women and its consequences. When a health care system lacks services to identify health risks specific to women, this in itself constitutes discrimination against women.

To address the root causes of violence against women, it is crucial to respect, protect and fulfil fundamental human rights for all women of all ages and under all circumstances. Health providers can also contribute to the implementation of human rights standards.

Examples of relevant rights include:

- *Right to personal security* – the right to life, the right not to be subject to torture or to cruel, inhumane or degrading treatment or punishment, the right to liberty and security of person, the right to equal protection according to humanitarian norms in time of international or internal armed conflict, freedom from slavery and servitude.
- *Equality in access to resources and opportunity* – the right to equal protection under the law, the right to the highest attainable standard of physical and mental health, the right to just and favourable conditions of work, the right to education and information, the right to property, credit, and social security.
- *Equality in decision-making* – the right to equality in the family and in the marriage, the right to privacy and confidentiality, freedom of association.

Gender and human rights approaches are complementary

Equality and non-discrimination are basic principles of human rights, and apply equally to both women and men by virtue of the inherent dignity of individuals. People are entitled to be free from discrimination of any kind, including discrimination based on sex. The enjoyment of the highest attainable standard of health is also recognized as a human right. As a set of values universally agreed upon and backed up by legally binding agreements, the human rights discourse sets out the full realization of gender equality, and equity in health, as legitimate goals for human society. However, to fully ensure gender equality and equity, constant effort to strengthen further the integration of gender in human rights is necessary. In reality the human rights discourse has been developed based mainly upon the experiences of men, and has lacked full recognition of the gender dimension in itself. Thus, to fully ensure gender equality and equity, the degree of gender mainstreaming in human rights needs to be further strengthened.

A fuller gender perspective pays attention, for example, to the power balance in relationships between women and men. Although some of the

identified gender-based differences may be harmless to both women and men, others may have a strong discriminatory impact. Where the power relationship between women and men is unequal and inequitable, the incorporation of a gender perspective becomes paramount. Here, a gender perspective and a human rights perspective meet. In fact a human rights discourse is an intrinsic component of a gender perspective, since it provides legitimacy for gender equality and equity and sets these as the final goals of gender mainstreaming. Conversely, gender mainstreaming is one of the prerequisites of a meaningful human rights discourse if the principles of equality and non-discrimination in all aspects of human life are to be achieved.

Therefore, a rights-based approach, namely the protection and promotion of women's human rights at all life stages, is also key to improving women's health. This can be achieved by supporting governments in implementing their human rights treaty obligations, by empowering women and men as active agents in public health, and by changing gender discrimination and gender norms that systematically undermine women's health and which also affect men's health. These are crucial steps in achieving gender equality and health equity.



GWH human rights activities

GWH is participating in an inter-cluster task force on developing a WHO Health and Human Rights Strategy and meets regularly with RHR¹⁶, CAH¹⁷ and VAB¹⁸ to discuss human rights work in the context of the Family and Community Health cluster. GWH is working with these and other departments in the cluster to develop indicators (see section 1.1) that can be used to monitor the realization of the right to the highest attainable standard of health. In WHO headquarters and regional offices GWH is working on developing a core list of gender-relevant health indicators to assist in collecting the information required to effectively explore and address gender-related health problems. The department also interacts with the Special Rapporteur on Violence Against Women, other United Nations agencies, a number of United Nations Treaty Monitoring Bodies, and WHO regional and country offices.

Over the past six years, RHR and GWH have also been involved in an international initiative to develop a training curriculum – *Transforming health systems: gender and rights in reproductive health*. This curriculum is the product of a multistage, international collaborative process. The aim has been to build institutional capacity in training centres around the world so that they can offer regionally appropriate, high-quality training in gender and rights in reproductive health covering aspects of research, service delivery and policy development. It was designed to increase the number of programme managers, planners, policy-makers and trainers with both a gender perspective in reproductive health, and the technical skills needed to contribute to increasing the accessibility, quality and comprehensiveness of gender-sensitive reproductive health policies and programmes. The training course has been running in several regions all over the world.

GWH in collaboration with ETH¹⁹ has also been working to strengthen country reporting on health to the Committee on the Elimination of Discrimination against Women (CEDAW) and to ensure constructive follow-up to the Committee's recommendations. As part of this, GWH contributes to the submission of WHO reports to the Committee on priority women's health issues in Member States. The aim is to assist Member States in institutionalizing regular rights-based monitoring and reporting on women's health. GWH has also commissioned a handbook for WHO country representatives and other national partners on *United Nations international human rights treaty body mechanisms: CEDAW and its relationship to women's health*. This handbook seeks to explain how CEDAW can be used to promote women's health in countries.



Activities in this area are now being streamlined and WHO reporting to all Treaty Bodies will be coordinated by the Strategy Unit in the Director-General's Office. A publication – *Improving Women's Health: A Rights-Based Approach* – is being prepared which targets public health practitioners, and which demonstrates the links between women's health and human rights. It will show how health practitioners can recognize human rights violations in respect to women's health, how they can prevent such abuses and how they can promote women's health using human rights as a tool.

16 WHO Department of Reproductive Health and Research

17 WHO Department of Child and Adolescent Health and Development

18 WHO Department of Vaccines and Biologicals

19 WHO Department of Ethics, Trade, Human Rights and Law

PART 2: IDENTIFYING APPROACHES AND DEVELOPING THE TOOLS

2.1: Integrating gender into health policies, research and programmes

The application of a gender-sensitive approach does not just mean recognizing the differences between women and men. The ultimate goal of gender mainstreaming, as adopted at ECOSOC in 1997, is to achieve gender equality²⁰. Thus, wherever a negative impact on health based on gender roles or gender power differentials is identified, the issue needs to be addressed in a way that achieves gender equality.

When a gender analysis is applied, it helps to elucidate how the disadvantages women face are caused by the interaction of biological factors and gender-based discrimination. Because of the gender blindness of the health system, problems which exclusively or predominantly affect women often do not receive due attention. When a health care system lacks services to prevent, detect and treat illnesses specific to women, then that also constitutes gender-based discrimination against women. Gender norms and roles also can impact men's health in negative ways – for example through high-risk behaviours associated with injuries, violence, and unsafe sex. Establishing priorities for health research and action requires better mechanisms to monitor the health of women and men and its determinants.

A systematic strategy is therefore required in order to reflect the importance of sex and gender in research and interventions aimed at improving the health of women and men. This applies both to the service provided and to the system providing the service. Gender analysis shows that in order to promote gender equity in health, efforts must be made to bring greater attention to women's health issues, particularly those that are invisible or due to gender discrimination. This standpoint is confirmed in the *Platform for Action*²¹ adopted at the Fourth World Conference on Women in 1995.

Nor are gender considerations routinely integrated into health research, resulting in gaps in knowledge on the interactions between gender and specific health problems. A WHO resource kit for the integration of gender considerations in health research is therefore being developed by GWH (BOX EIGHT).

BOX EIGHT: WHO RESOURCE KIT FOR THE INTEGRATION OF GENDER CONSIDERATIONS IN HEALTH RESEARCH

A resource kit is being developed by GWH in order to:

- raise awareness of the need to integrate gender into health research;
- provide practical guidance on how to do this;
- identify policies and mechanisms that can contribute to the en-gendering of health research.

The resource kit will comprise several sub-products including:

- A conceptual framework of health research, and how and where it is relevant to integrate gender dimensions.
- A review of the mechanisms and policies which are being used by different institutions to integrate gender into health research.
- Topic-specific booklets on en-gendering the research process at all levels (e.g. research questions, methodologies, variable construction, etc). Each of these booklets aims to review the particular topic from a gender perspective, identify best practices and gaps in addressing gender in research on that topic, and make recommendations. They will also cover different types of research, topics and methods and highlight the "added value" of addressing gender or alternatively what can be missed if gender is not included in research. The specific topics on which work has been commissioned so far include reproductive health and rights, tuberculosis, lung cancer, cardiovascular diseases, mental health, and ageing.

In addition, GWH and EIP²² are currently preparing an edited volume on gender analysis and health. The volume is based on commissioned papers and aims to cover a range of health topics which have not previously been considered from a gender perspective. It includes chapters on a range of communicable and non-communicable diseases as well as on methodological considerations such as gender biases in existing research and databases, and in studies of self-reported health.

In addition to a generic tool kit entitled *Gender Harms* (BOX NINE) GWH has also been working in collaboration with other WHO departments to develop guidelines for gender programming in specific WHO priority areas. As part of its work in providing guidance on the importance of gender analysis, GWH has produced an electronic presentation entitled *Gender Matters* that provides specific examples related to the major activity areas of specific WHO departments and clusters.

BOX NINE: Gender Harms

Understanding Sex Differentials in Global Health

Preface

Introduction

Health Outcomes

- Gender and HIV/AIDS
- Tuberculosis and Gender
- Insecticide-Treated Bednets for Malaria Control: The Role of Gender
- Asthma and Gender
- The Impact of Cooking Smoke on Acute Respiratory Infection: Sex Differences
- Sex Differentials in Blindness and Eye Disease, and Gendered Dimensions of Eye-Care Services

Health Behaviours

- Sex Differences in Alcohol Consumption and Abuse: Implications for Screening and Treatment
- Sex, Gender and Traffic Injury: "Doing Gender" through Risk-Taking
- Gender Differences in Suicide-Related Behaviours

Social Context

- Poverty and Health: Gendered Pathways
- The Essence of Woman in Tablet Form: Gender and Drug Promotion
- Gender Differences in Social Support, Health and Disability in Later Life

Research Methods

- Information Needs for Measuring Gender-based Health Inequalities
- Sex Differences in Self-reported Health Status: An Analysis of National Household Surveys

Mainstreaming Gender in Health: WHO Manual for Health Managers

This WHO manual for health managers (Annex III) was developed in response to the need for a simpler set of tools, and consists of questions that can be used to screen policies, programmes, research and guidelines to highlight areas in which more attention to gender issues is required. The tool kit is meant for use primarily by staff at WHO headquarters, regional offices, and country offices both in their work within the Organization and with Member States. However, it should also prove useful for health practitioners generally.

The simplified example shown in TABLE 1 illustrates the use of a sample tool in analysing health and health-seeking behaviour in relation to malaria. The process immediately highlights potential gender biases and issues which may need policy or programming attention. The headings refer to the various areas that need to be considered with a gender perspective. The left column lists aspects of the disease or its origins which may differ according to gender. For example, biological differences between women and men can play a role in how vulnerable a person is to malaria.

TABLE 1 includes enough information to give an idea of how the matrix works. Boxes have been left blank where information was not supplied in the source material. For an analysis of an actual situation, personnel would draw on a wider range of information sources.

Having seen how gender plays a significant role in the incidence of malaria, it becomes easier to adapt programmes to take this into account. For example, the goals of a malaria prevention programme might then include:

- using health promotion methodologies to increase the active engagement of both women and men in malaria prevention and treatment;
- decreasing the incidence of malaria during pregnancy;
- developing strategies to facilitate the use of preventive measures outdoors in order to reduce the risk to male farmers;
- strategies to ensure women and children use bednets.

Indicators of programme success could similarly be expanded to include gender-specific results, such as the proportion of women, men, girls and boys utilizing bednets on a regular basis, or a decline in the incidence of malaria among pregnant women.

20 The United Nations uses the concept of *gender equality*. In health, gender equality may not be adequate to address the differential health needs of women and men arising from their biological differences. Hence, we have used *gender equity* in relation to health. (see Annex II).

21 *Platform for Action in Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

22 WHO Evidence and Information for Policy cluster

TABLE 1: EXAMPLE OF GENDER ANALYSIS IN RELATION TO MALARIA

	Effect of the different roles and activities of men and women	Effect of men and women's gender norms/values	Effect of access to, and control over, resources	Influence of biological differences between women and men
Vulnerability	May influence exposure e.g. India: men sleeping on farms away from home unlikely to use bednet; women harvesting maize before daylight in peak biting time or running food stall at night.	Clothes worn can affect proportion of body exposed; men may spend more leisure time outdoors		Pregnant women are more "attractive" to mosquitos; increased infection rate
Health-seeking behaviour	Bednet maintenance and consequently, re-impregnation is generally women's responsibility: it can be hampered by costs or time required (i.e. links to resources).	In some communities men are given priority use of bednets to ensure that as breadwinners, they have a good night's sleep. In many cases men get priority because of higher status.	Economic factors are major determinant in acquiring bednets; women more inclined to buy nets than men but less likely to control household income so have to use own income which is limited; economic factors are also main reason for non-use of services.	Asymptomatic nature of malaria in pregnancy means that pregnant women are not likely to seek care.
Ability to access health services		Recommended routine chemoprophylaxis and treatment of malaria in pregnancy is hampered by the range of cultural, social and economic factors that also hinder antenatal care attendance; women more likely to use traditional healers; may not attend antenatal care because of pregnancy-related taboos; where there is a preference for the male child, mothers may take their male infants with malaria more often to health centres, and be prepared to walk further with them		[may not be applicable]
Preventive and treatment options, responses to treatment or rehabilitation	Women, as caregivers, are more likely to follow recommendations regarding treatment	Preventive programmes are usually community-based; where social norms mean that women cannot participate; there has been limited success.	Financial considerations are usually the most important in whether a full course of treatment is completed – links to women's lesser access to income	Non-involvement of women in vaccine trials may result in vaccines that have unforeseen side effects in women
Experience of health service and health providers	Women, as mothers, are the target of programmes to get children to health centres but tendency for women to be blamed for the failure of such programmes	Cases of women refusing examination by male providers; Burkina Faso – inadequate histories taken of women but not of men; New York – delayed diagnosis of women but not of men	In areas where there has been a resultant shift from subsidised bednets to full payment, their use has declined and hence vulnerability increased. Gender a critical factor here both because women have less control over household income and because they are more inclined to give priority to buying bednets.	[may not be applicable]
Outcome of health problem	India study showed male mortality rate significantly lower than female for falciparum malaria [Causes not clear: needs further research]	In societies where there is a preference for the male child, the outcomes may be unfavourable to girls even though malaria incidences are the same for both	Poor outcomes for pregnant women may be further exacerbated by gender factors within the sociocultural context and economic status of the women that present barriers to health service utilization and good health (**)	Poor prognosis during pregnancy
Consequences				
How do men and women respond when someone else has experienced this problem? Does the response depend upon gender of either party?				
How does society in general respond to this problem?				
Incidence	No significant difference but may appear different if data used is from health service rather than within community since less women may use service			
Prevalence	Men:		Women:	

Gender Analysis in Health: A review of selected tools

Gender-analysis tools identify the questions that need to be asked in order to understand a given situation from a gender perspective. In doing so, they also provide a research agenda. As a number of tools for gender mainstreaming developed by bilateral and multilateral agencies already exist, it seemed appropriate for WHO to undertake a critical review to evaluate their usefulness rather than immediately embarking on a process of developing its own tools. The resulting document – *Gender Analysis in Health: A review of selected tools* – was published in 2003 (**Annex III**).

Since many of the tools were not developed specifically for health, but offer frameworks and explanations that can be applied to health, the evaluation of the various tools was carried out in two stages. The first stage focused on the general content of the tools and revealed that most tools developed by bilateral agencies concentrate on the macro level of policy development, while NGO and training tools tended to look more at implementation issues. In the second stage the extent to which each tool could be used to understand and address the impact of gender on the following dimensions of health and health care was examined:

- social determinants of health and illness (other than gender);
- health-seeking behaviour;
- quality of care;
- health promotion;
- impact of health financing;
- policy;
- consultation and participation.

The review concluded that many of the tools are too complex for use by those who do not already have considerable expertise in gender analysis and were more useful for training and in building the capacity for gender analysis.

Integrating gender into the curricula of health professionals

Integrating gender considerations into the training and curricula of health professionals is a crucial part of gender mainstreaming in health. Evidence of the high cost of ignoring gender considerations in the training and working practices of health professionals is increasing. Lack of gender awareness can, among other things, lead to delays in diagnosis or inappropriate treatment for certain disorders, causing avoidable mortality, morbidity and disability. It can also result in the implementation of health programmes and services which do not address the major factors associated with a health problem, or meet population health needs, resulting in wasted expenditures.

GWH is currently collaborating with RHR²³ in an initiative aimed at mainstreaming gender and rights in the in-service training of health professionals responsible for reproductive health programmes. Facilitating the integration of gender into the pre-service training of health professionals in Member States was identified as an important priority area for WHO at the 2002 meeting of its regional gender focal points, as well as by gender experts.

Preparatory work was undertaken during 2003 in producing a plan of action for work in this area – an initiative aiming to contribute to the process already under way in WHO regional offices. In the WHO Regional Office for the Western Pacific, a project to develop a kit containing modules on gender, poverty and specific health topics, meant for use in pre-service medical and nursing training, has been undertaken, while in the WHO Regional Office for South-East Asia initiatives are being developed to mainstream gender in the medical curricula.

2.2: Addressing and preventing gender-based violence against women

Any effective response to violence against women must be multilayered and involve all sectors. Such a response also needs to deal not only with the immediate practical needs of women experiencing abuse but also the long-term follow up and assistance which will be required. It must also work towards changing cultural, social and legal norms which permit such violence to occur, and promote the establishing of approaches to reduce or prevent violence in the future. Such a wide-ranging process can only occur if the health sector works with other sectors such as education, legal, judicial and social services.

The *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women* (see section 1.2) has demonstrated that it is possible to undertake scientifically sound research which is also policy and action oriented, and which builds upon the expertise of women's organizations by making them equal partners. Such organizations have been an integral part of the research teams in all of the countries, and have played key roles at all stages including the formative research, field-testing of the questionnaire, training of field staff, and providing support to the research teams. Because of the links established with key support providers, women identified during the study as needing help could be referred to the appropriate resources. Small, pocket-sized leaflets with the addresses and contact information of help providers have been widely distributed and used both in the study and in the wider community.

In each of the study countries, teams have been established that are continuing to work together beyond the duration of the study. The study results are being widely discussed at the country level and several practical outcomes have already resulted (**BOX TEN**).

BOX TEN: PRACTICAL OUTCOMES OF THE WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN

As a direct result of the study, a number of practical steps have been taken in light of the issues raised, including:

- In Peru, the team worked with local health, police and municipal authorities to sensitize them to the problem of violence against women and the gender issues involved.
- In Brazil, the issue of gender-based violence has become part of the agenda of the Ministry of Health and was incorporated into its programmes of family health and women's health. The ministry has also established a taskforce to study violence, including violence against women, in more detail.
- The demand from women in violent situations for individual services and assistance increased as a result of political interventions at the regional level in Brazil.
- In Thailand, institutions are now working together to disseminate the study's findings and reinforce ongoing work. The research results have also fed into the development of the National Plan of Action for the Elimination of Violence Against Women and Children.



Ethical and methodological issues in VAW research

The focus of the work on violence against women has been on developing tools for the collection of better data, primarily through improved research methodology. Work on the evaluation of interventions for prevention of intimate partner violence has also taken place. As attention and concern around violence against women has mounted, many more researchers and donors have become interested in pursuing work in this field. WHO has therefore developed various tools to help prevent methodological mistakes or breaches of ethical standards which may put women at risk, including:

- a core protocol and questionnaire for research into VAW;
- a practical guide on research methodologies in VAW for researchers and advocates;
- ethical and safety recommendations for conducting research into domestic violence against women.

Conducting research into domestic violence against women raises particular and important ethical, safety, methodological and interviewer-training issues. Moreover, experience has shown that such studies can be conducted with full regard to ethical and safety considerations and that, when interviewed in a nonjudgemental, non-threatening environment, many women are willing to discuss their experience of violence. In order to guide research in this area GWH has developed recommendations that build upon the collective experience of the International Network on Violence Against Women (IRNVAW). The resulting document – *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women (Annex III)*– is designed to be used by anyone carrying out such research and by those initiating or reviewing it. A number of examples taken from the document are shown in **BOX ELEVEN**. Already the ethical considerations applied to the study of women's health and domestic violence have served as a useful guideline for other social science studies conducted on sensitive issues. This is particularly important given that such considerations have often been neglected in the past. These guidelines have been translated into French and Spanish.

Sexual violence

Sexual violence constitutes a significant, and largely hidden, health problem which particularly affects women. Health staff can provide comprehensive, gender-sensitive health services to people who have experienced sexual violence, can collect and document the evidence necessary to establish the circumstances of the violent act, and can also function as an important referral point for other services that may be

BOX ELEVEN: ETHICAL AND SAFETY RECOMMENDATIONS FOR RESEARCH ON VIOLENCE AGAINST WOMEN

The following are examples of actions that will help ensure that women are not put at risk during the process of data collection:

- The safety of the respondents and the research team is paramount, and should guide all project decisions.
- Prevalence studies need to be methodologically sound and need to build upon current experience of how to minimize the under-reporting of abuse.
- Protecting confidentiality is essential to ensure both women's safety and data quality.
- All research team members should be carefully selected and receive specialized training and ongoing support.
- The study design must include actions aimed at reducing any possible distress caused to the participants by the research.
- Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.

needed. A gap exists however, between the service needs experienced by those subjected to sexual violence and the existing level of health services provided in most countries in such cases.

In recognition of this, GWH and VIP²⁴ are developing normative guidance to strengthen the capacity of the health sector to respond to people who have experienced sexual violence. Guidelines to assist health professionals in the provision of good quality and comprehensive medico-legal health care (including forensic evidence collection) are now in the final stages of preparation prior to publication. In addition, a document on policy guidance in the provision of adequate health services is also nearing completion, and will provide a conceptual framework outlining basic health service needs in cases of sexual violence, and offering alternative strategies to achieve minimum standards, depending on the local socioeconomic context. Policy-makers can use the framework to define their own health policy goals, and to develop a policy model that addresses health service needs in a manner that is appropriate to local priorities and existing resources. In order to prepare this policy-guidance document, WHO is also undertaking three pieces of cross-regional research on key medico-legal service issues where limited information exists in the literature, namely:

24 WHO Department of Injuries and Violence Prevention

- Comparative analysis of criminal law related to sexual violence in the six WHO regions – the final product will shortly be completed and will be published jointly by WHO and UNIFEM.
- Situational analysis study – a study will be carried out in seven countries in a representative sample of facilities in different regions, in order to obtain baseline comparative data on the existing structure and resources of the medico-legal and health services that provide assistance to those who have experienced sexual violence, and on the process of service delivery.
- Models of service delivery – models of health service delivery will be reviewed across regions, including innovative models which are currently favoured but remain unevaluated or evaluated only in limited settings, such as one-stop centres or forensic nursing.

Female genital mutilation (FGM)

WHO has undertaken a review of work in the area of FGM, set up standards, frameworks and guidelines, and developed a variety of tools to address the problem (BOX TWELVE). Currently, WHO is moving towards implementation, monitoring and evaluation at the national level. Responsibility for work in this area is now being led by WHO regional offices, particularly the WHO Regional Office for Africa, with further decentralizing taking place to the country offices. While working most intensively with countries in the WHO African Region, WHO is also collaborating with partner institutions in the WHO Eastern Mediterranean Region and in the WHO European Region.

BOX TWELVE: WHO ACTIVITIES ON THE ELIMINATION OF FGM

An advocacy meeting – FGM: Global Dissemination Workshop on Training Materials for Nurses and Midwives was held from 3–7 December 2001 in Harare, Zimbabwe.

Three manuals for use in the field have now been published:

Female Genital Mutilation: A Teacher's Guide. 2001, WHO

Female Genital Mutilation: A Student's Manual. 2001, WHO

Female Genital Mutilation: Policy Guidelines for Nurses and Midwives. 2001, WHO

A management training and orientation meeting – Dissemination Workshop on Training Materials for Integration of Female Genital Mutilation Education into Nursing and Midwifery Curricula – was held in conjunction with the advocacy meeting in Harare. Several of the manuals have now been translated into French.

2.3: Integrating gender into HIV/AIDS programmes

Despite the growing body of evidence that shows clear differences between women's and men's experiences of living with HIV/AIDS (see section 1.2) gender issues have not been routinely integrated into HIV/AIDS intervention programmes. Where such programmes do address gender issues, they tend to be small-scale, community-based interventions aimed at a specific segment of the population, such as sex workers. It is clear that mainstreaming gender into HIV/AIDS programmes is long overdue.

As a first step towards creating guidelines for use in national programmes, WHO held an Expert Consultation in Geneva in June 2002 bringing together national HIV/AIDS programme managers and experts from a range of relevant fields. In advance of this, a review paper²⁵ was prepared to provide participants with background information and a proposed conceptual framework for considering the issues and challenges of integrating gender into programmatic and policy action. This conceptual framework covered many approaches to the integration of gender in programmes, ranging from the unintentionally harmful to the empowering:

- Interventions can cause harm by reinforcing damaging gender and sexual stereotypes that can perpetuate the pandemic.
- Gender-sensitive approaches recognize that men and women's needs often differ and that there must be an attempt to meet those needs.
- Gender-transformative approaches not only recognize the impact of gender but also attempt to change gender roles and the underlying gender inequalities which put individuals at risk.
- Empowering interventions address the pandemic by empowering women and girls to protect themselves from infection and from other effects of the pandemic.

The review concluded that there is no single, simple way to integrate gender into HIV/AIDS programmes. Neither is there one approach that will guarantee success. Nevertheless, it is possible and necessary to integrate gender into programme considerations. GWH has therefore prepared draft guidelines for achieving such mainstreaming which focus on five specific programme areas:

- voluntary counselling and testing (VCT)
- prevention of HIV infection in infants
- programmes for adolescents
- treatment, care and support
- empowerment of women.

²⁵ *Integrating Gender into HIV/AIDS Programmes: A Review Paper (Annex III).*

The goal is to assist countries in including gender considerations into their HIV/AIDS programmes at both national and local levels. The development of the guidelines has involved a wide range of sources, and GWH continues to work with UNAIDS, UNFPA, and UNIFEM, as well as governments, NGOs and specialists with experience in addressing gender issues in HIV/AIDS programmes. It is expected that the guidelines will be piloted in collaboration with HIV²⁶ and WHO regional offices in three to five countries in different WHO regions during early 2004, with full implementation by the end of that year.

Violence against women and HIV/AIDS

Another recent and important GWH work²⁷ has documented the presentations, discussions and recommendations of a meeting called to examine in detail the strong links which exist between HIV/AIDS and violence against women. A number of important conclusions were reached including:

- There is an increased risk of HIV infection through physical trauma arising from forced sex.
- Women's ability to negotiate safer sex may be limited by violence or the threat of violence.
- Sexual abuse in childhood may result in increased risk-taking in adolescence or adulthood.
- Women who test positive for HIV and who share the test results with their partner may be at increased risk for violence.



One inevitable conclusion of this review was that meaningful HIV/AIDS prevention activities for women can only be developed if the extent of violence against women worldwide is recognized and acted upon. The meeting identified several areas for further research and made concrete recommendations for action (**BOX THIRTEEN**).

BOX THIRTEEN: VIOLENCE AGAINST WOMEN AND HIV/AIDS – RECOMMENDATIONS FOR ACTION

1. Develop guidelines for integrating violence questions into research on HIV.
2. Review and distil lessons learned from existing HIV and VAW interventions.
3. Develop guidelines for maintaining confidentiality of HIV status in situations where violence may occur.
4. Develop and test risk-assessment tools for use as part of the VCT programme.
5. Review interventions in different sex-work settings to identify what worked and the lessons that can be drawn.
6. Develop a community resource book of participatory exercises to address issues of gender, violence and power.
7. Support research into the underlying factors that contribute to violence and HIV.
8. Support research into child sexual abuse.
9. Develop a reference document on issues to be considered in the development of national policies on the provision of post-exposure prophylaxis to rape survivors.

As stated above, women who test positive for HIV and who share the test results with their partner may be at increased risk for violence. As a first step in addressing this sensitive – and for many women dangerous – area, GWH has now produced a comprehensive review²⁸ of published literature and of selected field experiences on this issue. Highlighting the policy and programme implications of the findings for voluntary counselling and testing (VCT), the review also provides guidelines for partner notification and disclosure so as to minimize adverse effects and address gender-based violence. Its findings will be used to inform the guidelines on HIV voluntary counselling and testing now under development by WHO.

GWH leads a group within the Global Coalition on Women and AIDS which works on the prevention of violence against women and is spearheaded by UNAIDS. Together with UNIFEM and a range of NGOs the group is planning a major campaign to address VAW as a key factor in women's vulnerability to HIV/AIDS at community level.

²⁶ WHO Department of HIV/AIDS

²⁷ *Violence Against Women and HIV/AIDS: Setting the Research Agenda (Annex III)*.

²⁸ *HIV Serostatus Disclosure to Sexual Partners: Increasing Rates, Overcoming Barriers and Minimizing Negative Outcomes for Women (Annex III)*.

PART 3: INCORPORATING A GENDER PERSPECTIVE INTO THE WORK OF WHO

3.1: Mainstreaming gender in the work of WHO

GWH is charged with helping WHO programmes and departments undertake the challenge of integrating gender considerations into their work. The goals of the department are to increase health professionals' awareness of the role of gender norms, values and inequality in perpetuating disease, disability and death, and to promote societal change to eliminate gender as a barrier to good health for women and men. ECOSOC defines "mainstreaming gender" as:

... the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between women and men is not perpetuated. The ultimate goal is to achieve gender equality²⁹.

Furthermore, as stated in **Annex II** (see Footnote 44):

Mainstreaming gender is both a technical and a political process which requires shifts in organisational cultures and ways of thinking, as well as in the goals, structures and resource allocations... Mainstreaming requires changes at different levels within institutions, in agenda setting, policy making, planning, implementation and evaluation. Instruments for the mainstreaming effort include new staffing and budgeting practices, training programmes, policy procedures and guidelines.

Institutional change to allow for mainstreaming gender is essential for WHO programming to achieve the goal of health equity and needs to be addressed at two levels:

- Firstly, in order for WHO's technical staff to address gender perspectives in their activities they themselves need to be based in an institution which promotes gender equality in its own culture, management systems, priority setting and resource allocation. This means that WHO must ensure that its managers both understand and support the need for addressing gender relations and that its staff have the capacity and resources to promote gender equality and equity in all their work.
- Secondly, in WHO's relationships with counterpart institutions – be they government departments of health, research institutions, or NGOs – the translation of WHO's intention for gender mainstreaming into practice will be affected by the extent to which the counterpart institution supports WHO's concern to address gender inequality and health inequity. WHO may have to include the institution's profile with respect to gender mainstreaming as a criterion for selection of counterpart institutions for collaboration. Alternatively, it could help enhance the counterpart organization's ability to address gender in their programmes and their institutional structures. This is particularly important in relation to health systems, since no new programme-specific intervention, whether on immunization, tuberculosis or violence against women, can be expected to address gender issues if the implementing organization does not have the policy commitment and resources to do so.

Questions and answers on gender and health

A booklet is being developed on gender equity and equality, and on supporting gender policy and gender mainstreaming in WHO, to provide information for those working in WHO regional offices, headquarters, or elsewhere who wish to orient themselves on gender and health issues. It is a part of the GWH mandate to facilitate gender mainstreaming within the Organization and in countries.

29 E/1997/L.30 Para Adopted by ECOSOC 14.7.97.

3.2: WHO Gender Policy: Gender Team and Gender Task Force

The goal of the WHO Gender Policy (**Annex I**) is to contribute to better health for both women and men through health research, policies and programmes which give due attention to gender considerations and which promote equity and equality between men and women. In order to achieve this goal, WHO will analyse and address gender issues in planning, implementing, monitoring and evaluating policies, programmes, projects and research. By doing so, the Organization expects to:

- increase the coverage, effectiveness and efficiency of interventions;
- promote equity and equality between women and men throughout the life course;
- ensure that health interventions do not promote or reinforce inequitable gender roles and relations;
- provide qualitative and quantitative information on the influence of gender on health and health care;
- support Member States in reaching their goals.



The WHO Gender Team and Gender Task Force

A WHO Gender Team and a Gender Task Force were set up in order to achieve the goals of the WHO Gender Policy.

The Gender Team is made up of gender focal points who represent departments and clusters in WHO headquarters and regional offices. Its functions include promoting and expanding the consideration of gender into all policies and programmes as well as raising the awareness and understanding of the importance of a gender approach to public health. The Team will collaborate on documenting the successful integration of gender in health policies and programmes, for example through case studies and guidelines.

The Gender Task Force brings together senior level managers, including two regional directors and three executive directors. It reports directly to the Director-General on the progress of gender mainstreaming in WHO. The Director-General and Cabinet will then set out the administrative and operational mechanisms for the implementation of the WHO Gender Policy throughout the Organization.

The Gender Team has met regularly during 2003 and a preliminary list of possible products for the next five years has been agreed upon (**BOX FOURTEEN**). The Team is also discussing ways of promoting joint work across departments and clusters. WHO regional and country offices are similarly expected to develop their own mechanisms, appropriately staffed and resourced, and to develop strategies with the Gender Team to promote the integration of gender issues in health systems. This will be done mainly by working with ministries of health, other sectors, NGOs and civil society.

BOX FOURTEEN: PRELIMINARY LIST OF PRODUCTS FOR THE WHO GENDER TEAM

Product	Proposed deadline
Position paper on gender mainstreaming	2003
WHO Resource kit for the integration of gender considerations in health research	2004
WHO monograph with case studies (best practices/success stories/ lessons learned) of successful integration of gender into specific programmes	2006
WHO guidelines for gender analysis of country health systems	2005–2007

3.3: Working with WHO regional offices and other WHO departments

GWH is continually working to strengthen the collaboration between WHO headquarters and regional offices and among the regional offices themselves. Specific activities include:

- visits to WHO regional offices to discuss the implementation of the WHO Gender Policy with senior management and technical departments (WHO Regional Office for South-East Asia, WHO Regional Office for the Western Pacific, and WHO Regional Office for Eastern Mediterranean during 2002–2003);
- inputs into regional office documents addressing gender concerns;
- discussion and exchange of ideas on Work Plans, and the development of joint Work Plans to the degree possible, particularly with the WHO Regional Office for Africa;
- resource mobilization and support for regional office activities such as seed funds provided by headquarters to each regional office to initialize gender mainstreaming into activities during 2002–2003;
- the designation of certain regional office staff as global focal points for identified activities – e.g. WHO Regional Office for Europe (trafficking of women) and WHO Regional Office for the Americas (gender and health sector reforms);
- working with all WHO regional offices and with the WHO Collaborating Center in Kobe on the development of a core set of gender-sensitive indicators;
- quarterly video conferences;
- regular updates of news and activities;

- obtaining feedback on materials such as the *Gender Matters* presentation and the WHO manual for health managers on mainstreaming gender in health (see section 2.1).

A significant proportion of staff time is also spent providing assistance in integrating a gender perspective into the documents, guidelines, publications and other aspects of the work of WHO technical departments. Examples of this include guidelines for mainstreaming gender in the WHO Health InterNetwork project; and the School Health Programme's psychosocial checklist. Collaboration with other departments was a feature of the development of the gender information sheets (see section 1.1). In addition, presentations on gender and health issues in emergency situations were given during induction training programmes run by HAC³⁰ and the possibility of integrating gender more systematically into such programmes is now being explored. GWH also worked on the integrated management of adolescent and adult illness, community initiatives on making pregnancy safer, and on WHO Regional Office for Africa joint planning within FCH. GWH participates actively in meetings related to adolescent sexual and reproductive health run by CAH³¹. GWH also contributed to the sexual health initiative of RHR³² and to its Integrated Management of Adult and Adolescent Illness and Community Initiatives. GWH also reviewed and contributed to the development of a number of documents produced by HIV³³, including the *Global Health-Sector Strategy for HIV/AIDS*. Close collaboration with UNAIDS and other agencies was also developed, including participation in the Interagency Task Team on Gender and AIDS.

30 WHO Department for Health Action in Crises

31 WHO Department of Child and Adolescent Health and Development

32 WHO Department of Reproductive Health and Research

33 WHO Department of HIV/AIDS



PART 4: ADVOCACY, NETWORKING AND PARTNERSHIPS

4.1: Collaborating with Member States

Today, every country in the world is a party to at least one human rights treaty which prohibits discrimination based on sex, as well as on other grounds such as race, colour, language, religion, political or other opinion, national or social origin, property, birth, and so on. WHO's own constitution states that:

*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*³⁴.

More specifically, many states have pledged to take all appropriate measures to:

*... modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women*³⁵.

WHO is in a position to assist Member States through technical collaboration to integrate gender into public health and related activities. A protocol is to be developed for ensuring that a suitable policy environment and appropriate institutional mechanisms exist to support and sustain the process of gender mainstreaming in health. Furthermore, the purpose of producing the normative documents, tools and guidelines described in this document is to ensure that they are used in countries for integrating gender into policies, programmes, projects and research carried out by national health programmes and in institutions within Member States. GWH works in close collaboration with the WHO regional offices on this. For example, the guidelines for integrating gender into HIV/AIDS programmes and in health research will be piloted in selected countries in collaboration with regional and country offices, before they are finalized for wider dissemination.

Another example of technical collaboration with countries is a gender-sensitive blindness intervention project currently being implemented in the Kilimanjaro region of the United Republic of Tanzania. It aims to demonstrate how to design and implement a gender-sensitive intervention at the local level, and the various activities that need to be undertaken in order to win support from politicians and health officials for such an initiative. One example of such an activity was a four-day meeting held in Moshi in June 2002 on "Gender and Blindness: Eye disease and use of eye-care services". The first day of the meeting was for high-level officials and policy-makers from the Ministry of Health and from the donor community. The next three days focused on sensitizing district level health officials, staff of the participating health facility, and project staff on gender issues in eye disease and use of eye-care services. The meeting then produced a set of recommendations for policy and programmes and for further research (**BOX FIFTEEN**).

A training initiative based on the *Transforming Health Systems: Gender and Rights in Reproductive Health* manual (**Annex III**) provides another example of technical collaboration with countries. The initiative is being carried out jointly with RHR³⁶ and is intended to build capacity in southern countries to train programme managers in gender, rights and health. The curriculum consists of six modules. The first three (Gender, Social Determinants of Health, and Rights) are foundation modules that provide conceptual tools and skills. The other three modules (Evidence, Policy, and Health Systems) are application modules. In these, participants receive repeated opportunities to apply gender and rights concepts and tools. Currently the manual is being disseminated and technical support provided with a view to adapting it to meet the requirements of specific country contexts.

34 Covenant on social, political and economic rights.

35 Article 5 under the Convention on the Elimination of All Forms of Discrimination Against Women.

36 WHO Department of Reproductive Health and Research

**BOX FIFTEEN: POLICY AND PROGRAMME ISSUES
ARISING FROM THE BLINDNESS STUDY
SOME EXAMPLES**

Policy issues

- Programme managers in blindness-prevention programmes need to assess gender equity in service utilization as well as the potential barriers to the use of such services. Furthermore, they should use sex-specific indicators for all programme activities.
- Eye-care agencies should follow WHO gender policy and critically evaluate gender roles within their own organizations and develop their own strategies for gender equity in the work environment.

Programme issues

- Women's roles in the community and the household result in them bearing the primary burden of trachoma. Trachoma-control activities must therefore be emphasized at the community level, in particular the "F" and "E" components of the SAFE strategy: facial cleanliness and environmental hygiene.
- All eye-care facilities should have counsellors or designated personnel, preferably of both sexes, whose duties include the provision of good quality education to patients presenting for cataract surgery.
- Many different approaches are needed to promote health education in a gender-sensitive fashion within communities.

Taking advantage of the annual meeting of WHO country representatives (WRs), GWH presented a questionnaire to assess the integration of gender issues into the work of the WRs and country liaison officers (CLOs). The feedback received indicated the need for more training in this area and better dissemination of material already available from GWH.

4.2: Building partnerships and networking

Building partnerships and networking is one of the main strategies of GWH for bringing about gender mainstreaming in health. The department regularly responds in detail to inquiries from researchers and organizations seeking technical advice on issues related to gender and health, and violence against women. Technical input for violence against women and gender mainstreaming is also provided through personal participation in meetings and seminars. Given the nascent stage of development of gender mainstreaming in technical areas of health, these activities serve as important stepping stones towards the wider dissemination of new developments and thinking in this area.

GWH also has three official collaborating centres on women's health:

- The Key Centre for Women's Health of the University of Melbourne, Australia.
- The Women's Health Research Centre of the University of Toronto, Canada.
- The Collaborating Centre for Policy and Practice Development in Women's Health and Gender Mainstreaming in Glasgow.

The department is seeking to expand the network of collaborating centres on gender and gender-based violence. Initial discussions have been held with the PATH Programme on Gender and Human Rights and with groups in South Africa.

At the same time, informal collaboration continues to take place with a large number of institutions and women's organizations around the world. The well-established *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women* (see section 1.2) and the recently launched Sexual Violence Research Initiative are both carried out in collaboration with women's organizations, and with research and governmental institutions working on gender and health. GWH also links with other large gender and health initiatives, for example the Gender and Health Equity Network (GHEN). GHEN is documenting experiences of integrating gender into health policies at the district level in China, India, Mozambique, and Viet Nam.

The possibilities of establishing links with groups and initiatives working on men and gender equity in health are currently being explored, especially those which have a gender perspective and which examine the ways in which the social construction of masculinity influences men's health.

GWH is participating in the Interagency Task Team (IATT) on Gender Equality and HIV/AIDS. This is one of twelve task teams being supported by UNAIDS to undertake specific activities on theme-specific dimensions of work on HIV/AIDS. GWH has in addition contributed to the development of factsheets prepared for an HIV/AIDS and Gender resource packet. The WHO background review on integrating gender into HIV/AIDS programmes (see section 2.3) will be included in the IATT resource packet. During the biennium GWH further strengthened its collaboration with UNAIDS by participating in the planning and development of the Global Coalition on Women and AIDS to be launched in February 2004.

GWH has also provided input on gender and health to several of the task forces of the Millennium Project, has contributed to the UNDP/World Bank group on "en-gendering" the MDGs, and collaborates very closely with UNIFEM and UNFPA as well as with a range of women's NGOs.

CONCLUSION



Despite its ambitious aims, GWH continues to be a small department working with very limited resources, both in terms of personnel and funding. Nevertheless, GWH has achieved a great amount over the last two years, and its agenda is expanding and evolving. In March 2002, WHO formally adopted the WHO Gender Policy ([Annex I](#)) in order to contribute to better health for both women and men through health research, policies and programmes which give due attention to gender considerations and which promote health equity and equality between men and women. GWH, together with the newly constituted cross-organizational Gender Team, is responsible for providing guidance and support in integrating gender

considerations into all aspects of WHO's work at headquarters, in WHO regional offices, and in Member States. The adoption the WHO Gender Policy has given new impetus to the work of GWH but this now needs to be matched with the resources and support necessary for its implementation. The biggest challenges faced by the department at present include:

- How to move from diagnosis of the problems to interventions that address them – stimulating more research on gender-sensitive interventions.
- How to stimulate interest and develop knowledge and skills so that all departments in WHO include sex-disaggregated data and gender analysis in their work.
- How to obtain resources from both regular and extrabudgetary sources to match the mandate and respond to the needs of departments, countries and others working on this agenda.
- How to make gender equity a core value for the Organization – the need for attitudinal change.

And these are challenges worth facing. The benefits of integrating a gender perspective into work on priority health issues such as HIV/AIDS, tuberculosis, malaria, sexual and reproductive health, and child and adolescent health and development are being increasingly recognized, and the potential rewards of such integration are enormous. Indeed, it would not be an exaggeration to say that good, comprehensive, and effective work on these and other health problems simply cannot be done if the gender dimension is ignored. Too often, however, health professionals continue to see gender as some sort of “add-on” that can be done by a specialized office somewhere, but which they need not think about in their daily work. Changing this attitude – i.e. making gender an essential reference point in all health endeavours through research, programme design, and advocacy – is an ongoing task in which GWH is determined to play its full part.

Annex I: WHO Gender Policy

Integrating Gender Perspectives in the work of WHO

Background and rationale

1. WHO's Constitution states that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". Fifty years after this Constitution was adopted, it is increasingly well recognized that there are differences in the factors determining health and the burden of ill health for women and men. The dynamics of gender³⁷ in health are of profound importance in this regard and they have long been overlooked.
2. Society prescribes to women and men different roles in different social contexts. There are also differences in the opportunities and resources available to women and men, and in their ability to make decisions and exercise their human rights, including those related to protecting health and seeking care in case of ill health. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services. These differences, in turn have clear impact on health outcomes. Evidence documenting the multiple connections between gender and health is rapidly growing.
3. Responding to this reality and in line with its long-standing concern with health equity WHO will, as a matter of policy and good public health practice, integrate gender considerations in all facets of its work. This action is also in harmony with the decision, now being implemented across the United Nations system³⁸, that integration of gender considerations, that is gender mainstreaming, must become standard practice in all policies and programmes. It will be the Organization's policy to ensure that all research, policies, programmes, projects, and initiatives with WHO involvement address gender issues, as clearly stated in the PB 2002–2003 policy framework³⁹. This will contribute to increasing the coverage, effectiveness, efficiency and ultimately the impact of health interventions for both women and men, while at the same time contributing to achievement of the broader United Nations goal of social justice.

4. WHO is also committed to advancing gender equality in its own workforce, as well as in scientific and technical advisory bodies, and among temporary advisers and consultants. Strategies to close the gender gap by the end of this decade fall into the broader context of diversity, and are in line with World Health Assembly Resolution WHA50.16 on the "Employment and Participation of Women in the Work of WHO"⁴⁰ and other resolutions of the WHA and the United Nations General Assembly⁴¹. Integrating gender considerations into technical programmes and achieving equality between women and men in staffing are complementary policies.

Goal and objectives

5. The goal of this policy is to contribute to better health for both women and men, through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between women and men⁴². WHO will analyse and address gender issues in planning, implementation, monitoring and evaluation of policies, programmes, projects and research in order to achieve the following objectives:
 - increase coverage, effectiveness and efficiency of interventions;
 - promote equity and equality between women and men, throughout the life course, and ensure that interventions do not promote inequitable gender roles and relations;
 - provide qualitative and quantitative information on the influence of gender on health and health care; and
 - support Member States on how to undertake gender-responsive planning, implementation and evaluation of policies, programmes, and projects.
6. These objectives will be achieved through the incorporation of gender analysis in the work of WHO at headquarters, and in regional and country offices. This analysis will examine the differences in the relationships between women and men and their roles, and how these differences impact on:
 - protective and risk factors;
 - access to resources to promote and protect mental and physical health, including information, education, technology and services;
 - the manifestations, severity and frequency of disease, as well as health outcomes;
 - the social and cultural conditions of ill health/disease;
 - the response of health systems and services;
 - the roles of women and men as formal and informal health care providers.

This analysis will include identification of ways to overcome constraints so that improved health outcomes for women and men can be achieved.

Organizational arrangements for implementation

7. Successful realization of this policy will require consistent and active participation by all staff at WHO headquarters, and regional and country offices. Responsibilities and actions will require collaboration and effective linkages across departments and levels of WHO.
8. Senior management will take the necessary steps to ensure the policy is translated into action in both technical and management aspects of WHO programmes. They will transmit the policy to technical and administrative staff and monitor its consistent and effective application throughout the work for which they are responsible. They will be accountable to the Director-General for successful incorporation of gender considerations in their work.
9. This policy applies to all work throughout the Organization: research, programme planning, implementation, monitoring, evaluation, human resource management, and budgeting. Effective implementation of the policy will require senior level commitment and validation, and organizational support for activities to advance the knowledge and skills of staff for efficient gender analysis in their area of work. Directors will be expected to institutionalize mechanisms for building capacity among their staff, and to provide the information, training and technical support staff needed to ensure the policy's success.
10. General guidance and support will initially be provided by the Gender Unit of WHO/FCH, in collaboration with gender focal points in other departments and clusters, and in WHO regional offices. However, all programmes will be expected to collect disaggregated data by sex, review and reflect on the gender aspects of their respective areas of work, and initiate work to develop content-specific materials. This analysis will help ensure the integration of gender considerations in all work with which WHO is associated in different technical fields.
11. Regional and country offices will be expected to develop their own mechanisms, appropriately staffed and resourced, and collaborate with headquarters to develop strategies to promote the integration of gender issues in health systems, working mainly with ministries of health, other sectors, NGOs and civil society.
12. The headquarters Gender Unit will assist and support the development of methodologies and materials for gender analysis, standardized terminology to ensure coherent communication about gender issues, a strategy for appropriate capacity building across the Organization, and mechanisms for monitoring and evaluation. The Gender Unit will also have responsibility for on-going collection and dissemination of information, such as case studies of "good practice" in mainstreaming gender in health, as well as contributing to the building of an appropriate evidence base on gender-related health issues in the Organization. The headquarters Gender Unit will collaborate with gender focal points throughout the Organization, to ensure continuous implementation of this policy and the above activities.
13. The resources and administrative and operational mechanisms for implementation and monitoring effectiveness of this policy throughout the Organization will be set forth in directives of the Director General and Cabinet.

37 See [Annex II: Gender Glossary](#).

38 General Assembly, 52nd Session. Document A/52/3, Chapter IV, part A. 18 September 1997.

39 WHO Proposed Programme Budget 2002–2003, page 9 ("Gender considerations are being incorporated in the planning and achievement of expected results in all areas of work").

40 Resolution WHA 50.16 (1997) specifying 50% target for recruitment rate of females from professional and higher levels, subsequently increased to 60% by the Director-General in 1998, and 50% target for female representation on scientific and technical advisory bodies, as temporary advisers and consultants. The policy outlined in Cluster Note 99/10 supports the resolution to reach gender parity by the end of the decade.

41 WHA Resolution 50.15 Recruitment of international staff in WHO: geographical representation (1997) and Resolution 55/69 Improvement of the status of women in the United Nations system, adopted by the United Nations General Assembly (A/RES/55/69, February 2001). The Medium-term Action Plan for Employment and Participation of Women in the Work of WHO (2000–2005), focuses on measures to improve the in-flow of women to WHO as well as their retention, with a view to attaining the gender equity.

42 "Women and men" in this document, refers to women and men of all ages.

Annex II: Gender glossary

Gender is used to describe those characteristics of women and men, which are socially constructed, while sex refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles.

Gender analysis identifies, analyses and informs action to address inequalities that arise from the different roles of women and men, or the unequal power relationships between them, and the consequences of these inequalities on their lives, their health and well-being. The way power is distributed in most societies means that women have less access to and control over resources to protect their health and

are less likely to be involved in decision-making. Gender analysis in health often highlights how inequalities disadvantage women's health, the constraints women face to attain health and ways to address and overcome these. Gender analysis also reveals health risks and problems which men face as a result of the social construction of their roles.

Gender equality is the absence of discrimination on the basis of a person's sex in opportunities, in the allocation of resources and benefits or in access to services.

Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognises that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

Gender mainstreaming The ECOSOC Resolution defines mainstreaming gender as

... the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between women and men is not perpetuated. The ultimate goal is to achieve gender equality⁴³.

Mainstreaming gender is both a technical and a political process which requires shifts in organisational cultures and ways of thinking, as well as in the goals, structures and resource allocations... Mainstreaming requires changes at different levels within institutions, in agenda setting, policy-making, planning, implementation and evaluation. Instruments for the mainstreaming effort include new staffing and budgeting practices, training programmes, policy procedures and guidelines⁴⁴.

Annex III: Gender and Women's Health (GWH) selected publications⁴⁵

WHO Ethical and Safety Guidelines for Interviewing Trafficked Women. Geneva, World Health Organization, 2003. Produced by the Health Policy Unit, London School of Hygiene & Tropical Medicine with support from the Daphne Programme of the European Commission and the World Health Organization.

Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.1).

Guidelines on Gender-Relevant Indicators in Health Research. In preparation.

WHO Multi-Country Study on Women's Health and Domestic Violence Against Women. Geneva, World Health Organization, 2002 (WHO/FCH/GWH/02.2).

"En-gendering" the Millennium Development Goals (MDGs) on Health. In preparation.

Gender Analysis in Health: A review of selected tools. Geneva, World Health Organization, 2002.

Transforming Health Systems: Gender and Rights in Reproductive Health. In preparation.

Mainstreaming Gender in Health: WHO Manual for Health Managers. In preparation.

Integrating Gender into HIV/AIDS Programmes: A Review Paper. Geneva, World Health Organization, 2003.

HIV Serostatus Disclosure to Sexual Partners: Increasing Rates, Overcoming Barriers and Minimizing Negative Outcomes for Women. In preparation.

Violence Against Women and HIV/AIDS: Setting the Research Agenda. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.08).

43 E/1997/L.30 Para Adopted by ECOSOC 14.7.97.

44 Development and Gender, Issue 5: Approaches to institutionalizing gender, Gender in Brief, Institute of Development Studies, University of Sussex, England, May 1997.

45 Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; e-mail: bookorders@who.int)

