A POLICY DIALOGUE ON BETTER EVIDENCE TO IMPROVE WOMEN'S HEALTH THROUGH GENDER AND HEALTH STATISTICS

Meeting Report

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Contents

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Executive Summary

The need for gender-based health data and analysis has reached a critical juncture worldwide, as studies continue to show crucial areas where the health of women and girls is at risk, has not improved, or shows uneven gains, as a result of unaddressed gender-based health inequities. Gender equality and women's empowerment is recognized as a priority on the world stage as one of the Millennium Development Goals (MDGs). The World Health Organization (WHO) has made several commitments and recommendations recognizing the need for better evidence and information systems to monitor the progress of gender equity and women's health, including the WHO Gender Strategy, the Pan American Health Organization (PAHO) Gender Equality Policy, the WHO Commission on Social Determinants of Health, and the WHO Director-General's 2007 commitment to improve the health of women.

In light of this recognition, the WHO, with the support of the Ministerial Leadership Initiative of the Aspen Institute for Global Health and Development and the United States Agency for International Development (USAID), co-hosted the meeting entitled A Policy Dialogue to Strengthen Evidence to Improve Women's Health through Gender and Health Statistics (henceforth, "the Policy Dialogue"). The event was a three-day consultation, held from 25 to 27 October 2010, in Washington, D.C., and hosted by PAHO. It was attended by country representatives (including ministries of health, civil society, and research institutions), WHO regional representatives (including units and focal points working in health statistics, health equity, and gender), partner organizations, and other experts in gender and health statistics (see Annex D). The aims of the meeting were twofold. One was to provide a forum for exchanging country experiences and lessons learned. The other was to build consensus to identify follow-up actions related to:

(1) strengthening gender-based data generation;

(2) strengthening gender and health equity analysis;

(3) and

(4) promoting data use for decision-making and policy development.

The challenges, successes, lessons learned, and potential actions to address each of the above action areas were shared through presentations provided by country delegates and WHO regional representatives and partner organizations, as well as in commissioned papers and small and large group discussions. The meeting's discussion culminated in WHO regional action plans as well as the document entitled A Call to Action for Better Evidence to Improve Women's Health through Gender and Health Statistics *(*henceforth, "a Call to Action). The Call to Action

serves as the basis upon which WHO regions, countries and partners can advocate for the advancement of gender and health statistics for the improvement of women's health. Guided by a set of principles, the recommended actions address ways in which countries can strengthen data generation and health equity analysis, and disseminate and effectively use data for decision-making and policy development.

The recommended actions are as follows:
I. To strengthen the generation and analysis of gender and health data

1. Establish consensus by means of continued dialogue between users and producers of gender and health data, particularly on common understandings, concepts and/or definitions related to gender, equity and health statistics;
2. Key priorities and domains needed for gender-based analysis of health inequities, with particular emphasis on the following areas:
a. disaggregation of health information by sex and age;
b. information on key determinants of health (socioeconomic status, ethnicity, gender-based violence, urban/rural location, political participation, access to health services, access to and control over resources, etc.);
c. Indicators for global, regional, subregional, and national monitoring of gender-based health inequities;
3. Ethical considerations related to data collection, analysis and use.
a. Develop, adapt or strengthen tools to generate and analyze gender and health data.
b. Develop and/or strengthen sustainable institutional, group and individual capacity for data collection, sharing, analysis and use, by:
i. Increasing gender awareness among producers and users of health data through various strategies, including curriculum revision for the training of health-care providers;
ii. Increasing the gender analysis skills of various producers and users of health data;
iii. Establishing mechanisms to support data collection, sharing, continued disaggregation, and flow, using information and communication technology and other means.
d. Procure and allocate adequate human and financial resources.
e. Promote data sharing and interoperability across relevant information systems.
f. Empower individuals, groups (e.g. civil society organizations, health professionals, etc.) and communities to improve their capacity and skills to generate demand for gender and health data.

II. To use gender and health data effectively in policy actions

1. Build and develop sustainable group and individual capacities to use data to inform health policies across a range of stakeholders by, for example:

a. exchanging experiences among partners;

b. enhancing the gender awareness and gender planning/programming skills of decision-makers;

c. generating demand for data on gender and health for policy use.

2. Ensure data access for a range of stakeholders involved in advocacy and decision-making at all levels of a national health system.
3. Translate information for different stakeholders into proactive, simple messages in a diversity of formats, such as policy briefs, case studies, etc.
4. Identify strategic venues for dissemination of gender and health data through policy forums, workshops, the Internet, etc.
5. Leverage partnerships with key actors, such as the media, in order to disseminate and share information on gender and health.
6. Monitor progress, establish accountability and evaluate impact of evidence-to-policy outcomes in gender and health through social monitoring and other strategies.

I. Introduction

It has been persistently found internationally that obtaining sex-disaggregated data is a critical first step to understanding gender-specific health trends, and that this is subsequently linked to improving women's health. The recent report *The World's Women 2010: Trends and Statistics* highlights the need for gender-based statistics, noting that achieving gender equality and women's empowerment, one of the Millennium Development Goals (MDGs), is not yet consistently reflected in countries' statistical data.

Health statistics must be meaningful, and they are most effective and beneficial when they include demographic variables that can reflect the gender-related influences on health, i.e. when they are stratified by sex, geography and ethnicity, and further stratified by the determinants of health. When statistical data are reported in this form, they accommodate an analysis of inequitable differences within a population. Gaining knowledge of the different ways that gender influences experiences with disease, access to health care, and quality of life is crucial to reducing health inequities and subsequently improving women's health.

Some countries, including Malaysia and Nepal[1], have made a commitment to improve their reporting of gender within health statistics. They accomplish this through production and use of sex-disaggregated data, quantitative and qualitative data, and accurate data that also reflect differences in culture and ethnicity within their countries. Other countries, such as Costa Rica and Ghana, have built upon similar commitments to demonstrate progress by actively involving civil society in the generation, analysis, and dissemination of gender and health statistics. However, many challenges remain in order for countries to generate comprehensive data, analyze it within a gender-based framework, and disseminate and then use it in a way that influences policy development and change.

The Policy Dialogue to Strengthen Evidence to Improve Women's Health through Gender and Health Statistics (henceforth, "the Policy Dialogue") was a three-day consultation hosted by the Pan American Health Organization (PAHO) from 25 to 27 October 2010 in Washington, D.C. The meeting provided a forum for international representatives from the health, statistics and gender sectors to exchange experiences and ideas that support the development of statistics reflecting gender, equity, and country priorities for achieving gender equity in health. Three papers were commissioned by WHO to provide a background and frameworks for consideration in using gender and health statistics, and for discussion at the Policy Dialogue (see pages 6 and 18-20).

[1] References to specific countries in the report come out of country-level presentations or from comments made by country representatives during general plenary discussions.

The Policy Dialogue highlighted the concept that health begins with good statistics and evidence. More specifically, the meeting's discussions were intended to lead to progressive policies to improve women's health through better generation, analysis, and use of gender and health statistics.

This meeting report summarizes the discussions that occurred during the Policy Dialogue, which constituted an important step in strengthening WHO institutional responses regarding gender and health statistics, and in sharing and engaging with partners in the process. This report is intended to be a user-friendly document to assist countries, WHO, and its partners to advance their respective agendas on gender and health statistics. To achieve this end, this report is organized and structured according to the three main themes from the meeting:

(1) strengthening generation of gender and health data
(2) strengthening analysis of gender-based health inequities
(3) promoting the use of gender and health data in policy actions.

The document A Call to Action for Better Evidence to Improve Women's Health through Gender and Health Statistics (henceforth, "the Call to Action") was collaboratively developed by meeting participants. It consolidates the main themes from the discussion and sets out the key principles and actions required of various stakeholders (e.g. governments, civil society, development partners, and researchers) to provide better evidence to be used in the improvement of women's health.

II. Definition of Key Concepts

There are several terms that are used in reference to the topic of gender and health statistics, such as "sex," "gender," "equity," and "equality," that are at times used interchangeably and cause some confusion. In order to fully appreciate the content of the dialogue that took place during the meetings, it is important that these terms be defined here so that there is a common understanding of the meeting's content and outcomes, described in this report. The definitions below are taken from the various presentations made by gender and health statistics experts at the meeting.

"Sex" refers to the biological and physiological characteristics that define being male and female[2].

"Gender" refers to the socially constructed characteristics of women and men, such as norms, roles, and relationships of and between groups of women and men. It varies from society to society and can be changed.

"Equity" means fairness, and is based on the different needs, preferences and interests of different social groups (e.g. men and women, or different ethnic or age groups). This may mean that different treatment is needed to ensure equality of opportunity. This is often referred to as substantive equality (or equality of results) and requires considering the realities of the lives of different social groups.

"Equality" refers to equal chances or opportunities for different social groups to access and control social, economic and political resources, such as protection under the law, health services, education and voting rights. It is also known as equality of opportunity or formal equality.

"Gender analysis" is a process that identifies, assesses and informs actions to address inequality that comes from (1) different gender norms, roles and relations; (2) unequal power relations between and among groups of men and women; and (3) the interaction of contextual factors with gender, such as sexual orientation, ethnicity, education or employment status.

"Gender-based inequities in health" are unnecessary, avoidable and unjust health inequities that exist due to the social construction of gender.

"Gender equality in health" means full health potential can be achieved because there are no avoidable, unfair or unjust impediments to health based on gender norms and power relations.

[2] It is recognized that sex, i.e. male and female biology, is more a continuum than a strict dichotomy, and is influenced by individual genetic make-up. However, health and other data are typically collected only by the categories "male" or "female".

III. Why Improving Statistics on Gender and Health is Important for Women's Health

A number of key global health actors, including the World Health Organization, have identified improving evidence related to gender and health, including through relevant statistics, as a priority for improving the health of women. For example, from 1 to 12 March 2010 the UN Commission on the Status of Women undertook a review, covering a fifteen-year period, of the implementation of the Beijing Declaration and Platform for Action (1995) and the outcomes of the Twenty-third Special Session of the General Assembly. A review of the report on the session revealed that global public health and gender equality are recognized as being central to achieving the Millennium Development Goals.

> Participants noted the importance of **collecting data disaggregated by sex**, ethnicity, socio-economic status and, over time, in the area of public health. Such data needed to be **analysed from a gender perspective**, and the insights and results of such analysis had to be **fully used in policy- and decision-making**[3]

This conclusion from the review is significant, as the need to collect, analyze and use sex-disaggregated and gender-sensitive health statistics was included in the 1995 Platform for Action (paragraph 104), and every successive review has noted the lack of progress in this area. It will be critical to ensure that progress is made before the next review, in 2015.

The government of the United States of America, through its various agencies (e.g. USAID, The United States President's Emergency Plan for AIDS Relief (PEPFAR), the Centers for Disease Control and Prevention (CDC)) and initiatives such as the Global Health Initiative (GHI), have specified woman- and girl-centered programming as a core approach, including the identification and use of appropriate gender-sensitive health indicators for measuring and monitoring progress. It is expected that the Policy Dialogue outcomes will contribute to the operational priorities of GHI's woman- and girl-centered programming, such as strengthening monitoring and evaluation of this priority through collection and analysis of sex- and age-disaggregated data, as well as efforts to promote policies to improve gender equality in health. Improving the health of women is also one of the three priority policy areas for the Ministerial Leadership Initiative (MLI) of the Aspen Institute for Global Health and Development. The MLI, in partnership with others, including WHO, seeks to build the leadership capacities of ministries of health to develop sound, evidence-based health policies.

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[3] United Nations Commission on the Status of Women (2010), "Report on the fifty-fourth session (13 March and 14 October 2009 and 1-12 March 2010)", Economic and Social Council, Official Records, 2010, Supplement No. 7, emphasis added.

The UN Secretary General's Global Strategy for Women and Children's Health (2010) has generated commitments to implement the strategy from a wide range of stakeholders, including countries, civil society, and bilateral and multilateral organizations. The World Health Organization is co-leading the Commission on Information and Accountability for Women and Children's Health, which in May 2011 proposed core indicators for tracking progress on maternal and child health, as well as an accountability framework for tracking resources.

The World Health Organization has the following four institutional mandates related to gender and the health of women: (1) the WHO Gender Strategy (Resolution 60.25, 2007); (2) the PAHO Gender Equality Policy (Resolution CD46.R16, 2005); (3) the WHO Commission on Social Determinants of Health (Resolution 62.14); and (4) the WHO Director-General's inaugural commitment to hold WHO accountable for improving the health of women (and the subsequent 2009 WHO report *Women and Health: Today's Evidence, Tomorrow's Agenda*).

1. The WHO Gender Strategy has four Strategic Directions, one of which is to promote sex-disaggregated data and gender analysis. A baseline assessment of the WHO Gender Strategy showed that less than one-half of publications present sex-disaggregated data, or use gender analysis. As well, WHO staff identified a lack of evidence, including a lack of disaggregated data, as a key barrier to addressing gender in their work.

2. The PAHO Gender Equality Policy has a stated goal of contribut[ing] to the achievement of gender equality in health status and health development through research, policies, and programs which give due attention to gender differences in health and its determinants, and actively promote equality between women and men. Implementation is to be achieved by collecting, analyzing, and sharing data disaggregated by sex and other relevant variables.

3. The WHO Commission on Social Determinants of Health (CSDH), including the Women and Gender Equity Knowledge Network's report to CSDH, highlighted the need to have data on health status, behaviors, and utilization and expenditure disaggregated by sex and age. The authors of the Women and Gender Equity Knowledge Network point out that:

> "The importance of having good quality data and indicators for health status disaggregated by sex and age from infancy through old age cannot be overstated. Without gender-sensitive and human-rights-sensitive country-level indicators to guide policies, programs and service delivery, interventions to change behaviours or increase participation rates will operate in a vacuum. Surprisingly, in many situations data are not presented in a sex-disaggregated way even if they have been collected. But health status indicators alone are not enough. Data on health behaviour affecting different household members are essential to understand how households allocate health resources and who benefits from them. These data, by sex, age and other

stratifiers are critical if work on health equity is to go beyond its historically narrow focus on economic differentials alone.[4]"

4. The WHO Director-General's commitment to improve the health of women was reflected in the launch of the 2009 WHO report *Women and Health: Today's Evidence, Tomorrow's Agenda*. The report indicated that some measures of women's health were not improving at the same rate as for men, and women's rates of chronic disease, injuries and mental illness were increasing. In addition, insufficient attention was given to the distinct needs of girls and older women. There were also health inequities between and within countries, and there was a startling "paucity of reliable data." The report called for policy dialogue and action in four areas:

- building strong leadership and institutional response;
- making health systems work for women;
- leveraging changes in public policies, i.e. women's health in all policies;
- building better evidence/knowledge base and information systems for monitoring progress on women's health.

The strategies outlined for building better evidence/knowledge base and information systems were:

- strengthening civil registration systems and investing in strategic information systems to better count births, deaths and causes of death by sex and age;
- improving data for monitoring performance of the health system with regard to increasing coverage and reducing inequities;
- investing in research, especially operations research, on programs and policies to improve women's health.

IV. Objectives of the Policy Dialogue among Producers and Users of Gender and Health Data

The Policy Dialogue responded to the various international and country-specific calls to improve the evidence base on gender and women's health, including through generation and analysis of disaggregated health and other data. The aim of the Policy Dialogue was to strengthen evidence and inform policies to improve women's health through gender and health statistics. As outlined above, the objectives of the dialogue were to identify actions to:

(1) strengthen the generation of gender and health data;

[4] Women and Gender Equity Knowledge Network (2007), "Unequal, unfair, ineffective and inefficient. Gender Inequity in Health: Why it exists and how we can change it." Final Report to the WHO Commission on Social Determinants of Health, emphasis added.

(2) strengthen the gender and equity analysis of health data; and,
(3) promote the use of gender and health data for policy actions.

The modality for achieving these objectives was to foster a dialogue between producers and users of gender and health data. Producers included researchers, statisticians and health information systems experts, from countries, international and UN agencies, and bilateral and other multilateral agencies, as well as academic institutions. Users included gender advocates, policymakers and researchers from international agencies, national governmental bodies, and civil society organizations. Through the Policy Dialogue they exchanged country and partner experiences, successes, challenges and lessons learned in generating, analyzing, and using disaggregated health and other types of gender-related data for improving health policies.

The WHO commissioned three papers to help frame the discussions[5]:

- *Better evidence to improve women's health with gender health statistics: Health indicator frameworks*, by M. Haworth-Brockman and H. Isfeld, Prairie Women's Health Centre of Excellence;
- *Monitoring health inequalities: Methodological issues,* by S. Harper, McGill University;
- *Challenges and examples in reporting sex-disaggregated data from a gender and equity perspective*, by S. Gruszin, J. Glover and D. Hetzel, University of Adelaide.

Presentations relating to data generation, analysis, dissemination, and use for policy development were given throughout the three-day meeting by representatives from countries (e.g. ministries of health, statistical offices and bureaus, civil society, and researchers), WHO regional and country representatives, partners (e.g. The United Nations Chidren's Fund (UNICEF), the UN Statistics Division, regional economic and social commissions, and USAID), and other experts in gender and health equity statistics, data, and research. (Refer to Annex D for a list of meeting participants.) Furthermore, consultation participants had an opportunity to discuss in small groups the challenges related to the three themes, so as to present to the broader group core strategies toward strengthening the area in question. Finally, the meeting participants, again within small groups, created action plans that were representative of each of the WHO regions, i.e. African Region; Region of the Americas; South-East Asia Region; European Region; Eastern Mediterranean Region; and Western Pacific Region.

The content of the presentations and small group discussions, as well as that of the plenary discussions, is summarized in the following three sections of this report. They are organized according to the three themes: strengthening generation of gender and health data; strengthening gender and equity analysis of health data; and promoting use of gender and health data for policy actions.

[5] See also pages 18 to 20.

V. Key Themes and Issues from the Policy Dialogue

A. Strengthening Generation of Gender and Health Data

1. Examples of Good Practices

Country presentations and the discussions that followed them highlighted several areas of good practice and lessons learned in strengthening the generation of health data. This section presents examples of good practices to strengthen (a) data collection, (b) harmonization and coordination of health information systems, and (c) data quality and reporting.

(a) Strengthening collection of data on gender inequalities affecting health

A Good Practice

Dr. Mary Ellsberg of the International Center for Research on Women made a presentation about good practices in data collection regarding violence against women on Day 1 of the Policy Dialogue. Key highlights included:

Collaboration between activists on women's issues, researchers, and statisticians in the collection of data;

Ethical and safety guidelines, including:

- Protecting safety; —the need for privacy, including relocation of the interview if necessary; careful introduction of the study; interviewing only one woman per household; and training interviewers to change the subject of discussion in case of interruption.
- Protecting confidentiality; no names on questionnaires; informed consent; findings presented in sufficiently aggregated form such that individual women cannot be recognized; permission and safe-keeping for tapes and photographs.

Careful selection and training of all research team members, including a good introduction to domestic violence issues, and a space for trainers to address their own biases and stereotypes or their own experiences of abuse.

- Supporting the research team by: giving interviewers the chance to withdraw without prejudice; having regular briefing sessions with the team; and
- helping interviewers understand their role vis-a-vis women experiencing violence.
- Minimizing distress to participants by: asking questions in a supportive and non-judgemental manner, and
- training interviewers to deal with distress and end all interviews positively.

See: http://www.who.int/gender/violence/womenfirtseng.pdf

(b) Harmonization and coordination of health information systems

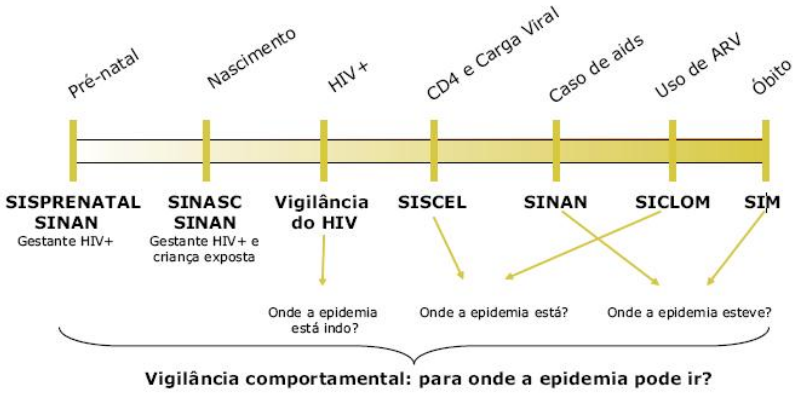
In Brazil all of the health information systems associated with STD/AIDS are combined into one database, which is coordinated by the STD, AIDS and Hepatitis Department of the Secretariat of Health Surveillance. These systems include the National Notifiable Diseases Information System (SINAN), the Laboratory Test Control System (SISCEL) and the Mortality Information System (SIM).

Brazil

Different information systems from the Ministry of Health of Brazil are used to monitor health inequities and gender inequalities, such as the ones regarding domestic and sexual violence against women and adolescents (VIVA) and the incidence of HIV/AIDS in women and adolescents (SINAN).

Data are collected through a number of survey formats, i.e. health surveillance, vital statistics, health care provision and household surveys, and are collected and reported by sex on risk and protective factors, health actions, morbidity, and mortality.

As shown in Figure 1, data are collected through a variety of sources and compiled and then released to help keep track of the epidemic.



Data are published at: www.sistemas.aids.gov.br/monitoraids

- A number of data sources are used, including health administration sets and population-based surveys, e.g. Survey of Knowledge, Attitudes and Practices of the Brazilian Population (PCAP); Sentinel Surveillance of Pregnant Women; and Survey of Brazilian Military Conscripts.
- Public managers and representatives from civil society can access the data and suggest indicators.

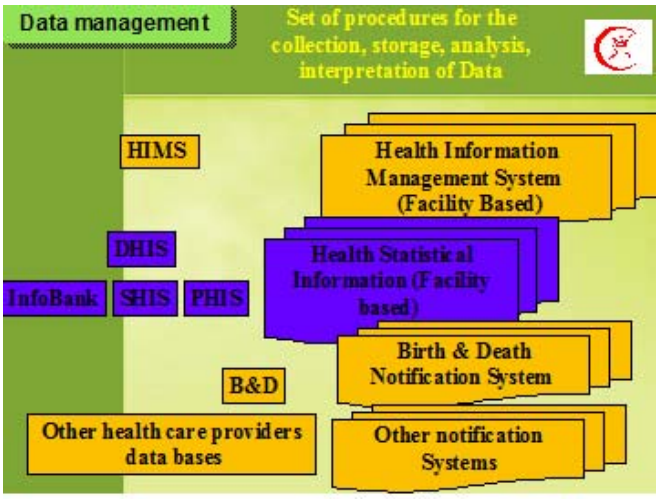
In Oman the data produced are based on the demand for data by program managers within different ministries. There is collaboration among the different parties about the type of data to be produced, as well as a willingness and commitment among the parties to produce the necessary data.

Oman

Data have been collected since 2005, disaggregated by sex, age, nationality, and geography in most data collection forms. Indicators are available on a yearly basis before midyear of the following year.

All data collection forms are designed to disaggregate data by sex, age, nationality and geography. Health program managers are encouraged to make their products gender-sensitive.

The health statistics published by the ministry of health provide regular updates on statistics on population, births, conceptions and abortions, life expectancy and mortality. Figure 2 shows the different components of the system.



The Central Health Information Department collaborates with managers of relevant programs and other end-users, and has the responsibility of setting standards, controling quality, and overseeing the use of information.

Periodic assessments are carried out to measure the extent of information use and to devise measures for improvement.

Future directions and challenges will be to:

- enhance collaboration with other health service providers (data collection);
- explore the possibility of electronic linkage between regions to ease the flow of data transfer;
- explore the possibility of introducing Geographic Information Systems (GIS) in order to increase the efficiency of the health information system.

(c) Improving technologies, reporting mechanisms and data quality

In Ghana a computer-based District Health Information Management System (DHIMS) was developed and designed for use at the sub-district, district, regional, and national levels. The DHIMS was successfully implemented within most districts and regions using the system. The system provides sex-disaggregated data on health indicators for the purpose of informing decision-making at all levels.

Ghana

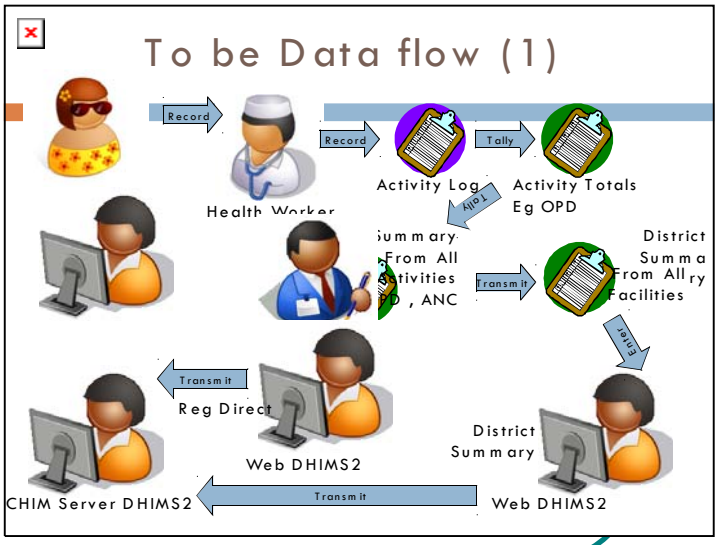
Various programs and initiatives have been undertaken that need to be monitored over time, and their effect on bridging the equity gap needs to be assessed. This entails generating accurate, gender-sensitive data that reveal gender biases, to facilitate the formulation of more effective policies.

Over the past ten years the Ghana Health Services (GHS) has gradually moved from being a predominantly paper-based HIMS to being an almost completely computer-based HIMS. Implementation of the computer-based DHIMS at the district, regional, and national levels has been very successful, as almost every district and region now uses DHIMS. Some sub-districts are able to use DHIMS as well. Figure 3 illustrates the system information flow. The integrated system has the following features:

- It provides disaggregated data on health indicators to inform decision-making at all levels.
- It allows multiple systems to be increasingly used by various service providers to address their health information needs.

Ghana has plans to address challenges and new developments by upgrading DHIMS to DHIMS 2 (to be built on the DHIMS 2 platform using free and open source software). DHIMS 2 will:

- be able to handle transactional data and enable capture of all data generated at the district level;
- help managers and decision-makers analytical reports;have the capacity to districts and regions to access and
- create a "one stop shop" that levels can access online.



2. Key Challenges in Generation of Gender and Health Data

Both the country presentations and the group discussions related to this theme highlighted a number of challenges that impede the generation of good quality gender and health statistics. These are summarized as follows:

– Gaps in existing data sources' provision of needed data, including:

- missing data on specific gender inequalities, as well as several types of health data, such as experience of gender-based violence, unpaid work, risk factors and risk-taking behaviors, causes of illness, qualitative data on gender and health, and geography-specific data;
- gaps in data as a result of limited regional or sub-national data due to weak health information infrastructure, lack of political priority on disaggregated data (including specific concerns like gender-based violence), and aggregation of data at higher levels, resulting in a loss of disaggregated data reported;
- unreliable civil registration systems that are not adapted for disaggregation;
- technological and logistical problems in accessing hard to reach populations.

– Differences in measurement tools and instruments, including:

- Differences in definitions, such as for ”ethnicity”, but also related to whether or how countries are interested in identifying ethnicity as a stratifier.
- Differences in surveys and data sets used by private and public sectors. In some countries donor-driven data collection undermines the ability of countries to coordinate sustainable public sector data collection.
- Uncertainty about which frameworks and indicators should be given priority to provide foundational information on gender and health and to allow for comparisons between countries.
- Differences in capacity and infrastructure. Some countries and regions have lots of data and are challenged by finding common platforms for sharing. Other countries and regions have minimal data and are still dependent on paper files and surveys; in those cases, data collectors may be making choices about which data they are collecting locally.

– Inconsistencies in data quality (including inconsistent availability of data disaggregated by sex, age and other stratifiers), timeliness of data, and completeness of the data sets. Data that are collected by sex are often “rolled up” and reported in the aggregate.

– Limited resources and lack of commitment for resources, human and financial, to strengthen health information systems and to collect different forms of data from different sources. Some countries continue to depend on foreign donors to implement population-based surveys. Participants saw this as related to a lack of political will and interest in generating disaggregated data to monitor gender-based health inequities.

– Lack of sustained capacity and knowledge in data generation, particularly if data collection is donor- or partner-driven. Investments are then not made in country-level skills and infrastructure to collect and manage data.

– Limited engagement of community partners, and in particular civil society organizations, in the definition and collection of both quantitative and qualitative data. This is problematic and is due to a limited number of women-focused NGOs, or to a lack of understanding of the benefits of disaggregated data in advancing the agenda of gender and women's health. Expanding the role of civil society to assist in the collection of disaggregated health and other relevant data for monitoring gender-based health inequities may result in data that are more comprehensive and timely than those that health service providers can generate.

– Lack of coordination among public and private institutions undertaking data collection. For example, in many countries data collected by NGOs and other private sector institutions are not incorporated into the overall health management information systems. The challenge is not that there are too little data, but rather that in some countries there is a great deal of data. Coordination and analysis of these data is required in order for them to be meaningful and beneficial.

– Lack of involvement of gender experts in the design of health information systems and data collection instruments. Their involvement is needed to support the development of more gender-sensitive indicators. It would be most effective if this occurred at the inception of a project and was sustained.

– Lack of integration and/or harmonization among existing data systems. This can apply to:
  - the need for integrating country-level survey and administration data;
  - the need to be able to integrate data that are collected by donors and NGOs with country-level health information and population data systems.

Countries and regions discussed the need for political will to ensure there is effective monitoring and evaluation based on health and gender statistics and data.

3. Suggested Actions

The text below proposes actions required to strengthen the generation of gender and health data. These actions reflect specific suggestions made by the participants during the group and plenary discussions.

Participants at the Policy Dialogue noted that disaggregated data are needed for a number of domains, including:

- Socioeconomic status - gender roles and norms, wealth,education, culture (i.e. ethnic diversity);
- Health - causes of death and illness, physical and mental health status;
- Personal - health behaviors and risk factors, experience of violence, capacity to access health services, location (urban, rural);
- Health services - resources, access (existence, location), utilization, cost and financing, insurance (social protection schemes), quality, sex and age of providers, profile of decision-makers in the health sector.

Participants also highlighted the need to obtain these data from multiple sources, including:

- surveillance data (e.g. reportable disease registries);
- vital statistics;health systems and services information (quality of care);
- population-based health surveys (e.g. demographic health surveys, world health surveys, multiple indicator cluster surveys, etc.);
- epidemiological studies on the impact of violence against women;
- evaluative studies of interventions;
- qualitative data to understand how local gender power dynamics and other social factors influence health risks, and access to and outcomes of health care, and
- why and how change occurs;
- cost/benefit analysis of health interventions (i.e. cost of services and outcomes);
- exit surveys of users of health services with regard to client satisfaction.

Actions to Address Challenges

Establish consensus by means of continued dialogue between users and producers of gender and health data, particularly on:

- key priorities and domains needed for gender-based analysis of health inequities, including:
  - sex- and age-disaggregated data
  - key determinants of health, including gender-based violence and unpaid work;
- Ethical considerations related to data collection..

Actions to Address Challenges

Develop, adapt or strengthen tools to generate gender and health data.

Procure and allocate adequate human and financial resources.

Develop and/or strengthen sustainable institutional, group and individual capacity for data collection by:

- increasing gender awareness among producers and users of health data through various strategies, including curriculum revision for the training of health care providers;
- establishing mechanisms to support data collection, sharing, continued disaggregation and flow, using information and communication technology and other means.

Empower individuals, groups (e.g. civil society organizations, and groups of health professionals), and communities to improve their capacity and skills to generate demand for gender and health data.

Promote data sharing and interoperability across relevant information systems.

From the challenges raised and the actions proposed, it is evident that improving gender and health statistics is not just a matter of collecting more health data. Data also need to be disaggregated, and additional types of information on gender inequalities, both qualitative and quantitative, are needed. Capacity-building is necessary among the producers of data, and attention needs to be paid to reporting mechanisms, timeliness, and quality checks. In addition, the reporting, production and management of data need to be coordinated, with involvement from community and civil society, in order to avoid duplication and enhance integration of different sources and types of health and non-health data. However, data alone do not lead to an improvement in women's health. Rather, the gender and equity analysis of the data and the use of such analyses to take action are the means to connect statistics to policy development that improves women's health.

B. Strengthening Analysis of Gender-Based Health Inequities

This section summarizes country case studies that illustrate ways to conduct gender and equity analysis of data, and also highlights some methodological considerations in conducting such analyses. It also summarizes the key challenges, lessons learned and suggested actions related to this theme.

1. Examples of Good Practice

(a) Disaggregating data by sex and other stratifiers

The presentations by Albania, and then later by John Glover, demonstrated the importance and value of analyzing data that are not only disaggregated by sex, but also by other variables that allow for more detailed analysis.

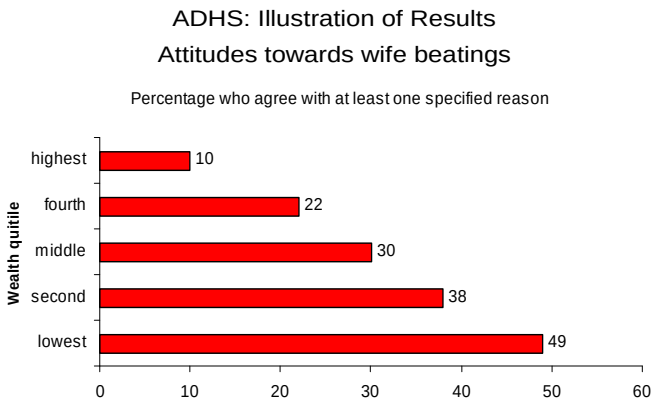
Albania

The Albania Demographic and House Survey (ADHS) is administered to a nationally representative sample of households and is designed to provide estimates for the whole country, for urban and rural areas, and for each of four regions. The data can be disaggregated by age, gender, level of education, and socioeconomic status.

The data are collected and presented by sex—along with other stratifiers, such as age, income, and education—to illustrate where there are gender inequalities. Figure 4, below, shows this type of presentation for acceptance of intra-family violence by wealth.

Existing challenges include:

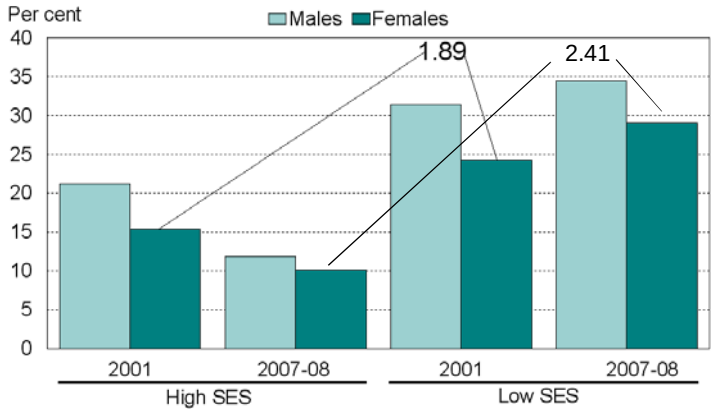
- Strong dependence on foreign donors for implementing population-based surveys.
- Fragility of specialized structures dealing with inequality information.
- Routine information still needs to be adapted to allow further disaggregation.
- Policymakers still focus more on time trends of indicators and are less interested in inequalities.
- Some taboos from the past still remain.
- Fragility of specialized structures dealing with inequality information



A Good Practice

In a presentation on Day 2, John Glover of Adelaide University illustrated how health statistics can be presented by sex and by other stratifiers to uncover where programmatic action can be taken. Figure 5, below, shows smoking rates are shown for 2001 and then for 5 years later, for males and for females, by lowest and highest income group. Disaggregating and presenting the data this way shows some surprising differences between male and female smoking trends.

- Smoking rates declined by 24% from 2001 to 2007–2008 (28% for males, 22% for females).
- Decline was not shared equally. For men there was only a 13.8% decline among the most disadvantaged fifth of the population, compared to 35.3% for the most well-off fifth. For females comparable figures were 17% and 34%.
- The ratio for smoking rates for low to high SES areas was 1.88 in 2001. By 2007–2008 the gap had widened to 2.51. For females, the increase in the differential was from 1.89 to 2.41.



(b) Using multiple types of indicators, including aspects of gender inequalities

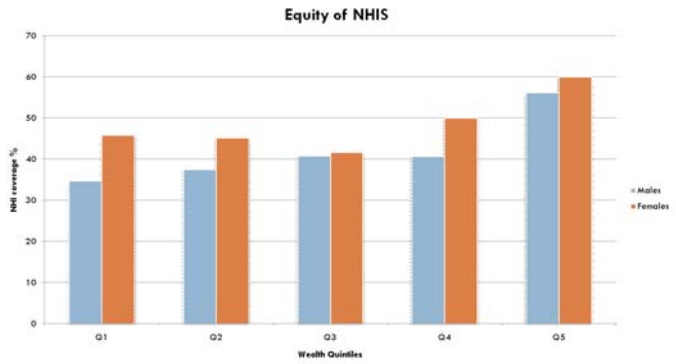
The presentation by Ghana summarized the importance of using multiple types of indicators—including those related to gender inequalities that can lead to unequal health outcomes—in understanding fully the various aspects of gender inequalities in health.

Ghana

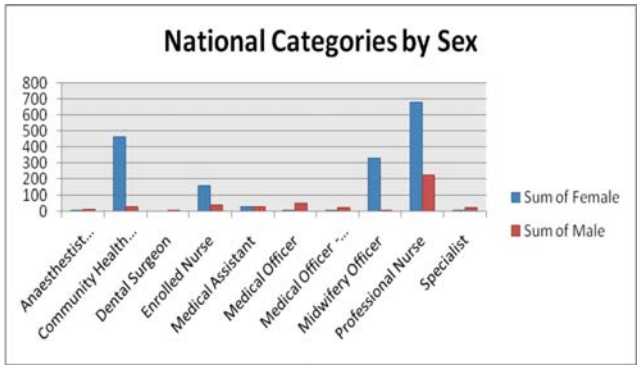
Using the integrated computer systems and data sources described above, Ghana reports on gender inequalities that can result in health differences. Equal access to health care, elimination of biases in health delivery, and eradication of gender disparities in management structure remain priorities.

- Gender monitoring is done within the context of the GHS MDG monitoring framework, and most data generated are disaggregated by age and sex.
- Frameworks and indicators for monitoring are developed through a consultative process, with the involvement of key stakeholders.
- National and sample surveys and other studies are conducted regularly to assess health inequities.
- A rapid appraisal of the implementation of its gender mainstreaming implementation has been undertaken by the system headquarters.

Equity of National Health Insurance coverage (SHINE survey, 2009)



GENDER EQUITY IN EMPLOYMENT



A Good Practice

When creating a summary brochure of health statistics for regional countries, the Western Pacific Region (WPRO, 2005) integrated gender considerations in three ways:

(1) All data are provided by sex, so that direct comparisons can be made for health indicators.
(2) Some health-related indicators are presented in terms of proportions, e.g. the percentage of females to males for education, literacy, and so on.
(3) The brochure includes gender equality indicators.

These three features make the brochure a good example of how gender sensitivity can be integrated into data presentations. See:

http://www.wpro.who.int/internet/resources.ashx/HIN/MDG/core+indicators+brochure+with+definitions.pdf

(c) Political commitment and increasing capacity for gender analysis

Costa Rica

Costa Rica is using international commitments as a framework to strengthen the collection, analysis and utilization of gender-sensitive statistics. The intent is that gender-sensitive statistics will help make inequalities visible so that they can be addressed.

The ministry of health led the process of involving key stakeholders from different sectors. Through a decree, a national working group on gender and health was formed. With regard to health statistics, this group systematizes the data collected by each institution, and sensitizes institutions about producing gender-sensitive statistics. It also analyzes the data and produces a biennial statistical brochure, which includes indicators disaggregated by sex, age, and area of residence. In addition, the group disseminates the information and presents the results of the analysis to the health authorities and civil society organizations.

The main challenge for the working group is accessing financial resources for publications and for analyzing specific relevant topics in health.

The country of Ghana determined that it would be most effective to train individuals at lower levels of the system in gender-based analysis and monitoring gender differences in health services; Ghana has achieved success with this model.

(d) Gender analysts and statisticians working collaboratively

The Global Forum on Gender Statistics is an annual event that brings together statisticians from national statistics offices with gender experts, to discuss how countries can strengthen their production of gender statistics. In 2010 the meeting[6] highlighted strengthening consistent measurement of key gender and health statistics (e.g. standardized measurement of mortality, maternal mortality, disability and women's and men's caring responsibilities), as well as advances in methodologies. Recommendations from the Forum included commitments to:

- strengthen the overall national capacity for data analysis;
- strengthen the capacity of health ministries to use, analyze and disseminate data; and
- improve the assessment of gender-based differences in health and mortality throughout the life cycle.

2. Methodological Considerations in Conducting Gender and Equity Analysis of Data

Three concept papers that WHO had commissioned were presented at the Policy Dialogue, and each discussed methods of organizing and integrating gender in data analyses.

(a) Identifying appropriate frameworks for selection of indicators and data sources

Health Indicator Frameworks

Health indicator frameworks help to systematically organize and conceptualize relationships between health influences and health outcomes, whether they are used for a single topic or an overall situation profile. Frameworks are shaped by policy priorities and data availability, but they should also be meaningful to people's lives and be used to take action that will improve health.

The paper by Margaret Haworth-Brockman of Prairie Women's Health Centre of Excellence, presented on Day 2, describes the strengths and limitations of five different frameworks. Any one of them can be used to organize and analyze gender and health, as long as gender-sensitive indicators are explicitly included and analysis is done by sex and other stratifiers to understand how women's health is influenced by the political and social circumstances of their lives. That is, health indicator frameworks should explicitly demonstrate the diversity found in women's health status and among health determinants, as well as the responses of health care systems. Additionally, gender statistics provide needed context for women's opportunities to be involved in decisions related to their own health and the delivery of health services and programs. Both

[6] The Global Forum on Gender Statistics 2010 was sponsored by the United Nations Department of Economic and Social Affairs, Statistics Division.

frameworks and indicators should be clearly linked to stated goals to improve health and reduce health inequities for women.

(b) Mapping and using different data sources and stratifiers

Gender-sensitive Indicators and Sources for Data

John Glover of Adelaide University presented a paper that discusses the need for gender and equity indicators and stratifiers.

A gender-sensitive indicator captures gender-related changes in society over time, relative to some agreed-upon normative standard or explicit reference group. That is, gender-sensitive indicators do not just describe gender statistics but also provide a comparison, either to men or to other women. They could include:

- women's autonomy and/or empowerment (e.g. domestic and community decision-making)
- attitudinal gender norms (e.g. women must be subservient to men)
- women's participation in the labor force/employment, educational attainment, and so on.

Analysis that is gender- and equity-sensitive places these statistics in the context of social, economic, cultural and political determinants, as well as within the contexts of individual stories in specific cultures or countries at specific times.

This richness of information and analysis can be drawn from a variety of existing data sources, including:

- official national sources, such as censuses, vital statistics, surveys on health, fertility, nutrition, employment, time use, and budgetary and resource allocations;
- administrative records of individuals, such as from hospitals, clinics, disease registries and surveillance systems, and social security, welfare, education and other non-health services;
- geographic area-based records about individuals living in the area, their health status, use of services, etc., as well as local services and facilities available, distribution in the area, local budgets and resource allocations to services in the area, and people using them;
- other research, including quantitative and qualitative studies conducted by research centers, NGOs, universities, communities and international agencies.

(c) Choosing appropriate analytical measures for inequality

In the third concept paper, presented on Day 2, Sam Harper of McGill University described some of the considerations to be taken into account in analyzing and presenting health inequities.

Choosing Health Inequality Measures

Measures of health inequality, illustrated in Figure 8, are not value-neutral. They differ according to:

- Scale of measurement: Is inequality relative or absolute?
- Weighting: Who counts, and for how much?
- Reference points: Different from what?

The choices made are important for evaluation of both the magnitude of health inequality and whether health inequalities are worsening or improving. Monitoring health inequalities requires both precise measurement and value judgments—they are inseparable.

Different social groups may necessitate different measures

Social Group Type	Relevant Dimension	Potential Inequality Measures
Ordinal	Socioeconomic position	Rate Ratio (RR)
	Income	Rate Difference (RD)
	Education	Relative Concentration Index (RCI)
	Assets	Absolute Concentration Index (ACI)
	Others...	Relative Index of Inequality (RII)
		Slope Index of Inequality (SII)
		Many others...
Nominal	Gender	Rate Ratio (RR)
	Ethnic background	Rate Difference (RD)
	Geography	Gini coefficient (G)
	Urbanicity	Theil index (T)
	Sexual Preference	Mean Log Deviation (MLD)
	Others...	Index of Disparity (ID)
		Between-Group Variance (BGV)
		Many others...

S. Harper (McGill) Monitoring Health Inequalities 26 Oct 2010 4 / 23

For example:

- Weighting individuals equally is consistent with practices for estimating population average health and allows for inequality measures to be responsive to demographic change.
- Weighting social groups equally (and therefore individuals unequally, in most cases) may make sense if one is concerned with disproportionate impacts on small or marginalized social groups.

3. Challenges in Undertaking Analysis of Gender-based Health Inequities

The challenges encountered in undertaking analysis of gender-based health inequities include:

– Lack of political will—e.g., lack of commitment, leadership, and accountability—to undertake gender-based analysis. The need for a clear political commitment by governments, evidenced by a plan of action, resources, funding, and explicit gender equality health policies or goals. As

one participant noted “policymakers still focus more on time trends and are less interested in inequalities.”

– Lack of conceptual clarity regarding key terms among all partners. This included the confusion and interchangeable use of the terms "sex" and "gender", a lack of understanding of concepts such as gender equality, gender equity and health equity. For example, addressing health inequity issues may not necessarily address gender inequity issues unless purposive action by gender advocates is taken. There is a need for common definitions of terms and measurements in order to integrate and analyze gender in health data. Participants noted that experts in all realms tend to use jargon, which creates confusion and prevents constructive dialogue and collaboration.

– Lack of capacity for gender analysis, including institutional and individual capacity. Frameworks on which to base the integration of gender into the data analysis are required, along with data producers and users trained in gender analysis.

– Lack of standard, gender-sensitive indicators. Countries identified three main challenges. Primarily, there was discussion calling for an agreed-upon core set of indicators to measure and monitor gender-based health inequities globally. Secondly, gender statistics are not consistently collected and reported. Thirdly, gender statistics are not often integrated with health indicator reporting in the ways suggested by the three concept papers described above.

– Lack of financial and other resources for gender analysis, including time, training (i.e. technical capacity) and personnel (i.e. gender experts).

– Lack of systematic use of qualitative data in conducting gender and equity analysis. Such data are important because they provide the context of an individual’s or group’s experience on a country or sub-country level. However, there is a lack of systematic use of qualitative data as part of the analysis, which may result in outliers (e.g. sub-populations) getting missed, and data being read without local or analogous context.

4. Suggested Actions

Actions to Address Challenges

Establish consensus by means of continued dialogue between users and producers of gender and health data, particularly on:

- common understandings, concepts and/or definitions related to gender, equity and health statistics;key priorities and domains needed for gender-based analysis of health inequities, with particular emphasis on
- indicators for global, regional, subregional and national monitoring of gender-based health inequities.

Encourage collaboration between gender analysts and statisticians to develop improved models and tools for health equity analysis that are easily understood, include gender, and provide clear guidance from a national level on how the analysis is done.

Develop and/or strengthen sustainable institutional, group and individual capacity for analysis by:

- increasing the gender analysis skills of various producers and users of health data;
- encouraging collaboration across departments and sectors for data collection and analysis.

Procure and allocate adequate human and financial resources.

Develop, adapt or strengthen tools to generate and analyze gender and health data.

A lack of political will to advance the gender and health equity agenda was consistently raised by participants as a challenge affecting data generation, analysis, and policy development. Similarly, the need to clarify key gender and health concepts was identified on several occasions throughout the three-day consultation. These challenges seem to be overarching, and their resolution is paramount to achieving success in the other areas. The development of gender and health equity policies, addressed in the next section, is dependent upon a common understanding of the terminology used, as well as the political will to make gender and health equity a realizable priority.

C. Promoting Use of Gender and Health Data for Policy Actions

1. Examples of Good Practice

Several country presentations illustrated good practices in advocacy for generation of data, as well as its dissemination and use, to inform, influence, and change policies to improve the health of women and men. These include:

- efforts to make large datasets available and accessible to researchers and other relevant stakeholders, through the World Wide Web and other mechanisms;
- building partnerships between ministries of health and civil society;
- strengthening the role of civil society in advocating for evidence-based changes in policies;
- working with media to interpret and disseminate data;
- using data on gender-based inequities in health to inform and influence multi-sectoral policies that promote gender equality.

(a) Increasing access to and availability of quality data

- UNICEF has supported countries in conducting Multiple Indicator Cluster Surveys (MICS) that include 100 indicators, with the majority of results available by sex and other characteristics. UNICEF makes the datasets publicly available online so that researchers and other interested people can conduct their own analyses. Other agencies, such as WHO, the United Nations Development Programme (UNDP), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) also use the data for reports. UNICEF also publishes them in peer-reviewed journals and presents them at international conferences.
- The European Union's “wikipedia” on health information is entitled Health in Europe: Information and Data Interface (HEIDI). HEIDI is a two-way information tool for pooling, presenting and updating good quality health information throughout Europe. It contains Information on health status, social determinants, diseases, health systems, trends, and policy aspects of health care. The aims of HEIDI are to create a single portal for health information in the European Union (EU), and to involve the wider EU health community in providing and maintaining health information. The EU provides training to promote national implementation. There are, additionally, interactive tools to encourage the use of the data in situation reports and analyses.

(b) Partnering with civil society to disseminate data

Chile

The Gender Equity in Health Observatory in Chile was officially launched in 2004, with the objective of advancing the agenda of gender and health through the empowerment of civil society. Working with 50 organizations, the Observatory managed the development of databases containing 112 indicators related to data on demographic information, health care, human resources, gender-based violence, and mental health. The databases are comprised of an accumulation of data provided by the ministry of health, as well as other public entities and the private sector.

The data have been analyzed with a gender lens and have been disseminated to the public at large, civil society and institutions, using a variety of different methods, including publications directed at institutions and launching data by means of public events. There is assurance that the data and subsequent analyses are fed back to civil society organizations due to The Law on Transparency and Access to Public Information (2009). From 2004 to 2009 there was significant synergy between the government, statisticians and gender experts, resulting from the government's initiative to establish gender inclusion in public policies. These policies were monitored to ensure compliance with the government's commitment.

(c) Working with media to disseminate data

The Population Council conducted a project called Demographic Data for Development Research Project. In its first phase, the project found that intermediaries can play a significant role in translating data into policy initiatives. Intermediaries are individuals situated between the producers of data (e.g. statisticians) and the users of data (e.g. policymakers), whose role it is to actively disseminate the existing data. The intermediary can be a staff person in a policymaker's office or an office such as an NGO or other advocacy organization that is independent of government. The media can also act as a form of intermediary.

In the second, ongoing phase, the Population Council is working with the media and other intermediaries to build their capacity to interpret and disseminate data and findings more widely to the public. This helps create a public voice calling for governments to continue to live up to their commitment to make data available for a variety of users.

(d) Using data to strengthen gender equality policies across sectors

The country of Costa Rica has achieved progress in advancing equality in health and education through the development of gender equity policies across sectors (i.e. mainstreaming). As in the case of Chile, noted above, the ministry of health led the process of involving key stakeholders from different sectors. The statistical brochures developed through these collaborative efforts have been used in developing national health plans, a national policy on gender equality and equity, a national plan on violence against women, and a policy on sexuality. The indicators also have been used in presentations by governmental units and as inputs for research and academic work.

2. Challenges in Disseminating and Promoting the Use of Data for Policies

Issues related to gender equality remain sensitive in some countries, and as a result progress in the dissemination and use of gender-based health statistics in policy development is slow, with newly established specialized structures being particularly fragile. Obstacles related to these issues include:

- Lack of an information/evidence-based culture in the health sector, which leads to an absence of evidence-based decision-making.
- Changing personnel at decision-making levels due to frequent rotation and changeover of staff.
- Lack of female participation at decision-making levels and other leadership positions to advocate for the dissemination of gender-related data and policy development.
- Lack of adequate capacity among data users, including policy-makers, stakeholders, government functionaries and grassroots-level workers, regarding gender issues and the use of gender-based data.
- Lack of capacity to implement and monitor policies that direct governmental departments and agencies to collect sex-disaggregated data;
- Lack of capacity to incorporate gender issues into department/agency plans, and to set aside funds from budgets to implement plans.
- Lack of mechanisms to report back health data to communities by engaging those that collect and use data (i.e. the public and community organizations) in the dissemination of data findings. Some countries are committing to strengthening their health information systems and incorporating feedback to communities as part of health information system reform.
- Lack of transparency in making data available to stakeholder groups and the public for the purpose of dissemination and collaboration regarding data findings. Support for data sharing is lacking, as even among funders that require data, data are not shared.

Privacy laws, for example in Europe, also have an impact on an organization's ability to share information; however, data can be shared if participants' anonymity is maintained.

- Absence of clear goals for gender equality within the health sector, i.e. how gender impacts and contributes to the final outcomes of a health policy, project or initiative.
- Lack of mechanisms to translate and disseminate data for use by a range of audiences, including different methods, e.g. media, and different formats, e.g. simple and clear messaging.

3. Suggested Actions

Actions to Address Challenges

Build and develop sustainable group and individual capacity to use data to inform health policies across a range of stakeholders by, for example:

- exchanging experiences among partners;
- enhancing the gender awareness and gender planning/programming skills of decision-makers;
- generating demand for data on gender and health for policy use.

Ensure data access for a range of stakeholders involved in advocacy and decision-making at all levels of a national health system.

Translate information for different stakeholders into proactive, simple messages in a diversity of formats, such as policy briefs, case studies, etc.

Identify strategic venues for dissemination of gender and health data through policy forums, workshops, the Internet, etc.

Leverage partnerships with key actors, such as the media, in order to disseminate and share information on gender and health.

Monitor progress, establish accountability and evaluate impact of evidence-to-policy outcomes in gender and health through social monitoring and other strategies.

The challenges associated with promoting the use of data in decision-making and policy development involve a wide array of factors and strategies, including:

- human resources and capacity issues;
- creating a culture premised upon the need and subsequent demand for evidence;

- developing mechanisms for dissemination;
- monitoring the transfer of data into actual policies.

Lack of political will and interest was a challenge mentioned frequently by participants.

VI. A Call to Action for Better Evidence to Improve Women's Health through Gender and Health Statistics

The document A Call to Action for Better Evidence to Improve Women's Health through Gender and Health Statistics was developed as a result of the three days of discussion held at the Policy Dialogue. It was based on a consensus among participants on the key actions needed to generate, analyse, and use data on gender-based health inequities. (See Annex C.) The aim of the Call to Action was to act as an impetus for countries and partners to take action to improve gender and health statistics and reduce gender-based health inequities. The actions outlined in the Call to Action are framed by a set of guiding principles to sustain national, subregional, regional, and international efforts to reduce gender and health inequities.

Guiding principles to sustain efforts to reduce gender and health inequities

– Political will is essential, and must be created and sustained.

– Health ministries are responsible for leading the identification and reduction of gender-based health inequities.

– Health information and national statistical systems are key partners in the production and strengthening of gender and health statistics.

– Multiple stakeholders need to be involved at all stages of strengthening gender and health statistics. These stakeholders are diverse and include:

- different levels of the health sector (community, district, national, subregional, regional, international);
- other sectors and/or line ministries;
- civil society organizations (for women, human rights, ethics, etc.);
- university and health researchers;
- United Nations agencies, and bilateral and multilateral partners.

– Adherence to international, regional, subregional, and national mandates, commitments and obligations is crucial.

– Women from diverse groups must be engaged and empowered at all stages of the process.

VII. Regional Action Plans

On the final day of the Policy Dialogue, the participants were asked to meet in groups that corresponded to each of the six WHO regions: African Region; Region of the Americas; South-East Asia Region; European Region; Eastern Mediterranean Region; and Western Pacific Region. The task of the regional groups was to identify the following: region-specific actions over the next five years; the technical support and mechanisms required to implement the actions; and key partners and roles as they relate to the generation of data, analysis of gender-based health inequities, and data use for decision-making and policy development.

Each region's action plan is found in Annex B of this report. While each region took a slightly different approach to the action plan, the actions they have in common are outlined below.

A. Data Generation

- Map and review existing data sources and data sets, and identify gaps in availability of data (routine and survey data). For example, determine where there is a lack of disaggregated data at all levels, i.e. district, regional, national, and within existing databases; map availability of disaggregated data in existing datasets (both quantitative and qualitative) according to a set of pre-determined criteria.

- Establish a minimum set of indicators. For example, through a consensus-based process, develop a minimum set of indicators to monitor gender-based health inequities.

- Establish a plan with multi-stakeholder involvement to strengthen the production of gender and health data. For example, identify critical capacity gaps that exist in the region with regard to generation of data; improve the availability and quality of data from various sources; and sensitize the producers of health data on gender issues.

B. Analysis of Gender-Based Health Inequities

- Build capacity to conduct gender analysis. For example, identify gaps in capacity for gender-based health equity analysis; establish guidelines with case studies on how to conduct gender analysis, gender impact assessments, and gender needs assessments; and provide training workshops on gender analysis for producers and users of health data.

- Conduct regional- or national-level gender analysis of selected health datasets or topics. For example, conduct gender analysis of key health datasets to demonstrate the methodology and relevance of gender-sensitive health statistics.

- Link gender-based analysis with other forms of analysis and research. For example, link gender-based analysis with economic costing studies. Use qualitative data and studies on the context of gender inequalities to explain gender-sensitive health statistics.

- Establish national or regional mechanisms to strengthen gender analysis activities and outputs. For example, develop regional and national level intersectoral agreements to analyze gender-based inequities in health to reduce duplication; provide standardized formats and templates for national and regional reports to analyze and report on gender-based inequalities in health; and create technical groups to report on gender and health jointly to ministries of health and statistics.

C. Data Use for Decision-making and Policy Development

- Strengthen access to gender-based health data**.** For example, create demand for gender-sensitive health statistics by fostering collaboration among different relevant ministries and departments (e.g. health, social development, gender); promote open access to key datasets that produce gender and health statistics in order for people to analyze and use such data.

- Disseminate information using different formats and venues**.** For example, create policy briefs based on gender and health data to support the development of gender-responsive health policies; develop tools for communicating gender and health data in a user-friendly way; facilitate regular forums on gender in health research; disseminate gender and health information to the media, NGOs and women's organizations.

- Monitor progress of evidence-to-policy outcomes in gender and health**.** For example, strengthen and build national gender and health observatories to facilitate the use of gender and health data in health-related policies and in monitoring these policies.

VIII. Conclusion

The WHO Department of Gender, Women and Health and the PAHO Gender, Diversity and Human Rights Office and Health Information and Analysis Project co-hosted a meeting entitled Policy Dialogue to Strengthen Evidence to Improve Women's Health through Gender and Health Statistics. It was held on behalf of the WHO Gender, Women and Health Network, and was attended by a wide range of country and international experts in gender and health, health statistics and policy, who met for the purpose of strengthening gender and health statistics and their use in health policies to improve the health of women. The meeting's specific objectives were to identify lessons learned and challenges, as well as actions to strengthen data generation, gender and health equity analysis, and promotion of data use in decision-making and policy development. These objectives were met through the engaged participation and thoughtful dialogue of a diverse group of stakeholders, including both producers and users of data.

The meeting's facilitators and participants were successful in arriving at a consensus regarding key actions to improve:

(1) generation of gender and health data;
(2) gender and health equity analysis; and
(3) use of data to inform evidence-based decision-making and policy development.

The Call to Action for Better Evidence to Improve Women's Health through Gender and Health Statistics is a document that emerged from the meeting based on the consensus reached among national, regional and international stakeholders. It highlights the guiding principles and concrete actions to be taken in each of the three areas mentioned above. The next step is for member countries and partners to take concrete steps toward implementing these actions, with the support of WHO.

Annex A: Agenda

A Policy Dialogue to Strengthen Evidence to Improve Women's Health through Gender and Health Statistics
525 Twenty-third Street, N.W., Washington, D.C. 20037, USA, Room C
October 25-27 2010

25 October 2010

Time	Presenters	
8:30	*Registration*	
9:00-9:30	Opening Remarks Socorro Gross M. Velzeboer-Salcedo M. Ali E. Villar	 Assistant Director, WHO/AMRO-PAHO WHO/AMRO-PAHO WHO/EMRO WHO/Headquarters
Panel 1: Introduction: Defining priorities for improving statistics on gender and health **Co-Chairs: E. Loyola (WHO/EURO) and A. Bhushan (WHO/WPRO)**		
9:30 9:45	A. Amin F. Marinho	WHO/Headquarters WHO/AMRO-PAHO
10:00	*Coffee break & Group Photo*	
10:15 10:30 10:45	W. Jones S. Kishor M. Ellsberg	US Health and Human Services ICF MACRO International Center for Research on Women
11:00-12:00	Discussions	
12:00 -13:00	*Lunch*	
Panel 2: Country experiences, advances and challenges in production and analysis of statistics on gender and health **Co-Chairs: I. Yordi (WHO/EURO) and M. Ali (WHO/EMRO)**		
13:00 13:10 13:20 13:30	A. Ylli J. Telles E. Quirós C. Jehu-Appiah	National Institute of Public Health, Albania Oswaldo Cruz Foundation, Brazil Ministry of Health, Costa Rica Ghana Health Services
13:45-14:30	Discussions	
14:30 14:40 14:50 15:00 15:10	S. Jaafar N. Shrestha S. Al Muzahmi R. Vergeire N. Nguyen	Ministry of Health, Malaysia International Consultant, Nepal Ministry of Health, Oman Department of Health, Phillipines General Statistics Office, Vietnam
15:30	*Coffee Break*	
15:45-16:30	Discussions	
Panel 3: WHO Regional experiences, advances and challenges in production and analysis of statistics on gender and health **Co-Chairs: C. Cuellar (WHO/AMRO-PAHO) and E. Villar (WHO/HQ)**		
16:30-17:30	F. Marinho E. W. Soumbey-Alley M. Ali E. Loyola	WHO/AMRO-PAHO WHO/AFRO WHO/EMRO WHO/EURO

	S. Senanayake M. Landry	WHO/SEARO WHO/WPRO
17:30-18:00	Discussions	
18:15	Reception hosted by PAHO	

26 October 2010

Time	Presenters	
8:30	Review of Day 1 I. Araujo	WHO/Headquarters
Panel 4: Frameworks, tools and data sources for strengthening production and use of statistics on gender and health Co-Chairs: A. Kosia (WHO/AFRO) and M. Landry (WHO/WPRO)		
8:45 9:00 9:15 9:30	M. Haworth-Brockman S. Harper J. Glover S. Sharma	Prairie Women's Health Centre of Excellence McGill University University of Adelaide Futures Group
9:30-10:30	Discussions	
10:30	*Coffee Break*	
Panel 5: Engaging partners in strengthening production and use of statistics on gender and health Co-Chairs: J. Vogel (WHO/EMRO) and E.W. Soumbey-Alley (WHO/AFRO)		
10:45 11:00 11:15 11:30 11:45	E. Starbird L. Hooper S. Montaño Concha Colomer Revuelta P. Akwara & H. Newby	USAID UN Statistics Division ECLAC Ministry of Health, Spain UNICEF
12:00-12:30	Discussions	
12:30-13:30	*Lunch*	
Group work: Identifying areas/actions to strengthen production and use of statistics for gender and health Co-chairs: P. Ostlin (WHO/EURO) and I. de la Mata (EC/Health& Consumer Affairs)		
13:30 - 14:00	Group Work Introduction S. Abdool	WHO/Headquarters
14:00-16:00	Themes for Group Work: 1: Strengthening data collection/generation 2: Gender and equity analysis of data 3: Disseminating and using data for programming and policy making	Each group will have a Facilitator, Resource Person and Rapporteur
16:00	*Coffee Break*	
16:15- 18:00	Plenary report back and discussions	

27 October 2010

Time	Presenters	
9:00	Review of Day 2 I. Araujo	 WHO/Headquarters
Panel 6: Perspectives on the use of gender and health statistics to improve women's health policies **Co-Chairs: L. Jara (WHO/AMRO-PAHO) and M. Assai (WHO/EMRO)**		
9:15 9:30 9:45 10:00	S. Palma I. de la Mata W. Baldwin P. Eguiguren	Ministry of Health, Guatemala EC, Health & Consumer Affairs Population Council Gender and Health Observatory, Chile
10:15	*Coffee Break*	
10:30-12:00	Discussions	
12:00-13:00	*Lunch*	
Group work: Developing priority actions for //in-country// work to strengthen production and use of gender and health statistics **Co-chairs: S. Senanayake (WHO/SEARO) and M. Velzeboer-Salcedo (WHO/AMRO)**		
13:00- 13:15	Introducing group work A. Amin	 WHO/Headquarters
13:15- 15:15	6 groups divided by WHO Regions	Each Group will have a Facilitator and Rapporteur
15:15	*Coffee Break*	
15:30- 17:00	Plenary report back	
17:00- 17:30	Next Steps & Closing M. Velzeboer-Salcedo M. Espinal R. Krech	 WHO/AMRO-PAHO WHO/AMRO-PAHO WHO/Headquarters

Annex B: WHO Regional Action Plans

1. WHO Africa Regional Office Action Plan

AFRO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Generation of gender and health data	Identify critical capacity gaps that exist in the region for generation of data Improve the availability and quality of data from various sources Capacity building, sensitization orientation of producers of health data on gender issues	Financial resources Expertise on gender and statistics	Universities, research institutions , UN partners and other development partners and governments, statistical institutions
Analysis of gender-based health inequities	Map available and strategic data sets in the region in which we can undertake gender analysis with the focus on MDG3 and MDG5 Capacity assessment gaps for gender based health equity analysis Conduct gender equity analysis of countries by X	Gender expertise Statistical expertise Financial resources	Research institutions, statistical institutions, civil society, programme managers, individual experts
Data use for decision making	Policy brief on gender health equity focusing on specific issues Disseminate information from national to sub national level Promote ownership and use of data for decision at the sub national/primary level of the system Build capacity for data use at the sub national level Strengthen/build national gender and health observatories	Communication experts Advocacy expertise	Government, civil society, development partners

2. WHO Eastern-Mediterranean Regional Office Action Plan

Overarching decisions

- Target Oman and Afghanistan first, as pilot countries
- Close collaboration between equity, gender, and health information units of WHO EMRO
- Close collaboration between relevant national focal points at country level

Context

- HIS data (Afghanistan/Oman) already being collected disaggregated by sex, age, education, social status, location, and nationality (Oman)
- Oman: review of HIS conducted but not including assessment of gender and health equity
- Gap identified is lack of analysis of this data according to gender and health equity
- Who: Program managers at national level (Oman) and provincial and national (Afghanistan) identified as those responsible (first targets) for data analysis for gender and heath equity

EMRO Regional Priority: Analysis of gender-based health inequities

What	Who	How	When
Share analysis guidelines and tools with Omani and Afghani counterparts	Equity, gender, and health information units EMRO	Email	By end 1st quarter 2011
Knowledge of HMIS procedures in Oman and Afghanistan by gender and equity units EMRO	Gender and equity units EMRO with HIS departments in Afghanistan and Oman	Joint visits, teleconference, emails	By end 1st quarter 2011

EMRO Regional Priority: Analysis of gender-based health inequities

What	Who	How	When
Share and review analysis guidelines and tools	Equity, gender, and health information units EMRO	Literature review, meetings, and collection of tools	By end 1st quarter 2011
Brief and get approval by national counterparts on meeting outcomes and expected next steps	Oman and Afghani participants of Washington meeting	Develop briefs, reports, meetings, advocacy	By end of 2010

3. WHO European Regional Office Action Plan

EURO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Generation of gender and health data	Mapping data sources qualitative and quantitative according to criteria * Quality assessment from an equity perspective* Working group on information needs Minimum set of indicators disaggregated sex, age (routine and surveys) Discussion of minimum set of indicators at regional focal points meeting * Country level Generating demand for gender equity: promoting SDD and GA in HIS policies: country intersectorial mechanism to discuss minimum set of indicators* Building capacity at country level	Intercountry and country groups: existing coordination and discussion mechanims at regional level.	WHO lead plus EU, UN agencies, NGOs OECD, WB, and other data users and providers Institute of Statistics, MoH, Social insurance agencies, universities, NGOs, policy institutions

EURO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Analysis of gender-based health inequities	Guidelines with case studies and best practices on how to make a gender analysis Regional analysis on gender and NCDs: determinants, behaviours and systems response* Gender into European review on SDH * Country level Gender in medical curriculum and school of public health Capacity building: * 1.how to make a gender analysis 2. Gender impact assessment 3. Gender in needs assessment		

EURO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Data use for decision making	Policy brief on Why and How to integrate gender into health policies* Tool for communicating gender equity data in a user friendly way* Dissemination of information: gender assessment and European review*. Using info for H2020 Engaging stakeholders at regional and country level Resolution on the use of SDD and gender analysis in RC Innovative use of media Country mechanism to monitor use of SDD and GA*		

4. WHO Regional Office for the Americas/PAHO Action Plan

PAHO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Generation of gender and health data	Determine where there is a lack of information (or data that has not been sex disaggregated). Revise methodologies for analyzing the data: based on social determinants of health. Reorient national politics and policies to the requirement to collect, sex disaggregate, and use data. Elaborate a regional plan for the collection of data re gender and ethnicity.	Mobilize appropriate resources at country level Connect with national and regional data collection process the regional observatories on reproductive health. Use as sources of data. Provide training to ensure that national Ministries understand their obligations to collect, analyze and use data.	WHO-PAHO Other UN Agencies (UNWomen, UNFPA, etc.) Regional governmental coordinating bodies Observatorios MOHs Ministries of Women, Education, Statistics, etc.

PAHO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Analysis of gender-based health inequities	Create technical groups reporting jointly to Ministries of Health and Statistics Develop for a regional and national-level accord to analyze gender-based inequities (and to reduce duplication) Ensure that analysis of gender and health is included in key national and regional documents Review and revise national laws that impede analysis Improve capacity of regional networks	PAHO – develop reviews of particular gender-related health disparities and of countries´ human rights obligations to collect and analyze data (3a above) PAHO - Promote the use of gender as a legitimate category of data analysis Regional networks – ensure that key themes are discussed and included in workplans and that data is disaggregated by sex. Use networks to analyze data. Add new members to REDLACSIS. Create collaborating centers	WHO-PAHO Regional networks (REDLACSIS) Collaborating centers

PAHO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Data use for decision making	Create demand for health statistics at the regional level Create regional monitoring mechanisms Promote freer access to health information Create a closer relationship between national offices of statistics, epidemiology, and health (especially in the collection of key statistics re MMR, IMR, TFR, contraceptive access and use)	Create an intersectorial and multidisciplinary group of experts Develop virtual courses and use virtual training to improve capacity Create training manuals	National offices of statistics, epidemiology, and health WHO-PAHO (virtual courses)

PAHO Regional Working Group: Actions to improve gender and health statistics

Key next steps for WHO-PAHO and the MOH Gender Focal Point

- Sensitize key actors to the necessity of disaggregating data and conducting gender analysis
- Create (or strengthen) regional and national technical groups
- Regional analysis of current data
- Draft a regional agreement and plan for ensuring gender analysis of key data and use of this data
- Produce documents that include gender analysi

5. WHO South-East Asia Regional Office Action Plan

SEARO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required, by whom	Key partners and roles
Generation of gender and health data	Generate platform for forums with partners to agree upon standardized data system & information needed - Utilize and Strengthen 10 point strategy - Key to strengthen health information system- for strengthening HIS - Inventory of existing data, go back to institutional- level data here disaggregation by age & sex originates -Both quantitative & qualitative- Provide template for Profile, that can be followed in- countries	- need policies about how/what data to collect – standardization and the stratifiers of age, sex, location Analyze how to streamline the data collection,- to keep it manageable Use expertise & gender and health experts- within health region Training data collectors, sensitizing - Financial resources - identify-	- Ministry of Health National statistics groups, academic institutions UN coordination team International agencies, partners SEARO can facilitate process of country-to-country sharing of experts, technical supports
Analysis of gender-based health inequities	New analyses, demonstrating integration & gender analysis, including on existing data for first Profiles – in prep for meeting Need to specify to do analysis by gender lens Combine SDOH/inequity reports and gender analysis Identify key qualitative studies needed Link gender-based analysis with financial analysis Generate new qualitative studies to explain gender context	Technical support for cost-benefit analysis Add gender perspective, bring in technical- advisors, trainers when going into countries - Need good analysis of qualitative and- quantitative information -Involve experts - Financial information on how data collected,- used, meanings of inequities in economic terms	- Gender experts• SDOH experts• Futures Group – Rapid Women analysis• Ministries of Health needed in leadership roles - Then coordination at sub-national• levels -•
Data use for decision making	- Think of multi-stakeholders Advocacy for gender reports through high level ministerial meeting in SEARO Advocate through health promotion activities Along with media, NGOs and women's organizations	- Observatory to monitor data, and to monitor data use - Financial analysis to show benefits of doing gender analysis, costs of *not* doing Gender awareness, sensisizing of ministerial, high level meeting Advocacy plan with academic (medical schools), media and other stakeholders	- Ministry of Health, other ministries related to development of indicators, analysis - Media, women's organizations, NGOs) - Futures Group-

SEARO Regional Working Group: Actions to improve gender and health statistics

Key next steps and responsible partners:

1. **Revisiting existing data and information systems to identify gaps, needs for improvement of data sources**
2. **Meeting with all stakeholders to reach agreement on standardized health information systems, with gender perspective**
3. **Advocate for country-level data collection, profiles of women's health and gender. Plan to upgrade each time.**
4. **Strengthen capacity of all partners on sex-disaggregated data & gender analysis (quantitative and qualitative)**
5. **Advocate for policy-makers and data users**

6. WHO Western-Pacific Regional Office Action Plan

WPRO Regional Working Group: Actions to improve gender and health statistics

Regional priorities	Required actions in the next 5 years to address priorities / Who is responsible	Technical support/mechanisms required to address regional and country actions by whom	Key partners and roles
Generation of gender and health data	-identification of core indicators to assess gender-based health inequalities		
Analysis of gender-based health inequities	- Training workshops in gender analysis for producers and users of health data - Create coordination mechanism - Regional and national reports on-gender-based inequalities in health, with standardized format	- for training: consultants; funding (WHO and other partners) - for reports: standard methodology to guide format of national and regional reports (WHO and other partners)	- support TWG (National govt) Policy support (National govt)-NGOs: data analysis to influence-their own programmes and for advocacy
Data use for decision making	- Create mechanisms to institutionalize the process, such as TWG, regular forums on health research; quarterly meetings of health sector partners - Make data available on websites to academia		

China

- Women's health unit in dept of MCH in MOH collects data through routine reporting system and maternal and child mortality surveillance system: both are disaggregated by sex; and by (rural-to-urban) migrant status
- No national VAW survey
- Sex disaggregated data are available in MOH, but gender analysis not routinely conducted
- Suicides much higher in women; but sometimes attempted on impulse, without a history of depression

Philippines

- Philippines: GAD law, 5% of budget for GM, but weak implementation; NCRFW mandated to collate information on gender indicators from all Departments.
- National health statistics system, various agencies: disease programmes, health systems, hospitals. All are already disaggregated by age and sex
- Coordination meeting in collaboration to take stock of information available and generate list of core indicators to assess gender-based inequities in health (e.g., urban HEART domains: outcomes, governance, economic, political and social)
- Invite other agencies outside DOH into a TWG (NCRFW; edu; labor and employment, social welfare, NSO): to create list of core other health-related indicators
- Workshop to create a national plan of action and build capacity on gender analysis
- No budget constraints
- Weak capacity for gender analysis of information on health inequities

Malaysia

- Health data are disaggregated by sex
- National Social Council, chaired by Dy PM
- Ministry of Women and Family Devt does 6-monthly monitoring of 8 indicators in Gender and Development Information System (1 on health)
- Health equity analysis is conducted but there is lack of awareness and skills in gender analysis of health information
- Private sector is untapped as yet on gender issues in health
- Gender-based budgeting piloted (2008) in MOH and 5 other ministries

Viet Nam

- National Law on Gender Equality, natl action plan 2010-20.
- GSO is part of MPI: GSO is assigned to develop framework and clear indicators to monitor the gender equality law
- National statistical indicator system [NSIS] (300+ indicators) doesn't adequately capture gender
- GSO is trying to work with MOH to initiate sex disaggregation of routine and survey-based health data
- No budget constraint
- Needs coordination, agreement on methodology
- Weak capacity for gender analysis of information on health inequities

WPRO Regional Working Group: Actions to improve gender and health statistics

Key next steps and responsible partners:

1. Brief MOH policymakers (participants)

2. Capacity building

3. Generate a country profile on gender and health (MOH)

4.

5.

Annex C: C all to Action for better evidence to improve women's health through gender and health statistics

The participants in a global *Policy dialogue for better evidence to improve women's health through gender and health statistics* (Washington, DC, 25-27 October 2010), call upon all countries and partners to take action to improve gender and health statistics and reduce gender and health inequities.

Guiding principles to sustain national, subregional, regional and international efforts to reduce gender and health inequities

1. Political will is essential, and must be created and sustained.
2. Health ministries are responsible for leading the identification and reduction of gender-based health inequities.
3. Health information and national statistical systems are key partners in the production and strengthening of gender and health statistics.
4. Multiple stakeholders need to be involved at all stages of strengthening gender and health statistics. These stakeholders are diverse and include:
    i. different levels of the health sector (community, district, national, subregional, regional, international);
    ii. other sectors and/or line ministries;
    iii. civil society organizations (for women, human rights, ethics, etc.);
    iv. universities and health researchers;
    v. United Nations agencies, bilateral and multilateral partners.
5. Adherence to international, regional, subregional and national mandates, commitments and obligations is critical.
6. Women from diverse groups must be engaged and empowered at all stages of the process.

To strengthen the generation and analysis of gender and health data, we call for the following action

1. Establish consensus by means of continued dialogue between users and producers of gender and health data, particularly data on:
    i. common understandings, concepts and/or definitions related to gender, equity and health statistics;
    ii. key priorities and domains needed for gender-based analysis of health inequities, with particular emphasis on the following areas:

a) disaggregation of health information by sex and age;

b) information on key determinants of health (socioeconomic status, ethnicity, gender-based violence, urban/rural location, political participation, access to health services, access to and control over resources, etc.);

c) indicators for global, regional, subregional and national monitoring of gender-based health inequities;

iii. ethical considerations related to data collection, analysis and use.

2. Develop, adapt or strengthen tools to generate and analyse gender and health data.
3. Develop and/or strengthen sustainable institutional, group and individual capacity for data collection, sharing, analysis and use by:
   i. increasing gender awareness among producers and users of health data through various strategies, including curriculum revision for the training of health-care providers;
   ii. increasing the gender analysis skills of various producers and users of health data;
   iii. establishing mechanisms to support data collection, sharing, continued disaggregation and flow, using information and communication technology (ICT) and other means.
4. Procure and allocate adequate human and financial resources.
5. Promote data-sharing and interoperability across relevant information systems.
6. Empower individuals, groups (e.g. civil society organizations, health professionals, etc.) and communities to improve their capacity and skills to generate demand for gender and health data.

To use gender and health data effectively in policy actions, we call for the following action

1. Build and develop sustainable group and individual capacities to use data to inform health policies across a range of stakeholders by, for example:
   i. exchanging experiences among partners;
   ii. enhancing the gender awareness and gender planning/programming skills of decision-makers;
   iii. generating demand for data on gender and health for policy use.
2. Ensure data access for a range of stakeholders involved in advocacy and decision-making at all levels of a national health system.
3. Translate information for different stakeholders into proactive, simple messages in a diversity of formats, such as policy briefs, case-studies, etc.
4. Identify strategic venues for dissemination of gender and health data through policy forums, workshops, the Internet, etc.

5. Leverage partnerships with key actors, such as the media, in order to disseminate and share information on gender and health.
6. Monitor progress, establish accountability and evaluate impact of evidence-to-policy outcomes in gender and health through social monitoring and other strategies.

Annex D: List of Participants

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