Table 1. Level of Gender Integration In Operational Planning Process: Overall for all Regions

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration[1]			Some or Moderate Level of Gender Integration[2]			Strong Level of Gender Integration[3]		
		n	%	95% CI	n	%	95% CI	n	%	95% CI
All WHO Staff	131	45	34.4	26.3 - 43.2	37	28.2	20.7 - 36.8	49	37.4	29.1 - 46.3
By Sex										
Female Staff	46	12	26.1	14.3 - 41.1	14	30.4	17.7 - 45.8	20	43.5	28.9 - 58.9
Male Staff	85	33	38.8	28.4 - 50.0	23	27.1	18.0 - 37.8	29	34.1	24.2 - 45.2
p-value		0.3281								
By Grade										
D	31	7	22.6	9.6 - 41.1	9	29.0	14.2 - 48.0	15	48.4	30.2 - 66.9
P	99	38	38.4	28.8 - 48.7	28	28.3	19.7 - 38.2	33	33.3	24.2 - 43.5
G	1	0	0.0	--	0	0.0	--	1	100.0	--
p-value[4]		0.2063								
By WHO Level										
Headquarters	22	7	31.8	13.9 - 54.9	8	36.4	17.2 - 59.3	7	31.8	13.9 - 54.9
Regional Office	93	33	35.5	25.8 - 46.1	26	28.0	19.1 - 38.2	34	36.6	26.8 - 47.2
Country Offices	16	5	31.3	11.0 - 58.7	3	18.8	4.1 - 45.7	8	50.0	24.7 - 75.4
p-value		0.7307								
By WHO Region										
AMRO/PAHO	18	4	22.2	6.4 - 47.6	7	38.9	17.3 - 64.3	7	38.9	17.3 - 64.3
WPRO	18	1	5.6	0.1 - 27.3	7	38.9	17.3 - 64.3	10	55.6	30.8 - 78.5
SEARO	8	6	75.0	34.9 - 96.8	0	0.0	--	2	25.0	3.2 - 65.1
AFRO	20	12	60.0	36.1 - 80.9	2	10.0	1.2 - 31.7	6	30.0	11.9 - 54.3
EMRO	14	2	14.3	1.8 - 42.8	7	50.0	23.0 - 77.0	5	35.7	12.8 - 64.9
EURO	15	8	53.3	26.6 - 78.7	3	20.0	4.3 - 48.1	4	26.7	7.8 - 55.1
Headquarters	38	12	31.6	17.5 - 48.7	11	29.0	15.4 - 45.9	15	39.5	24.0 - 56.6
p-value		0.0063								
By Collaboration with GWHN										
Yes	69	18	26.1	16.3 - 38.1	18	26.1	16.3 - 38.1	33	47.8	35.7 - 60.2
No / Don't Know	62	27	43.6	31.0 - 56.7	19	30.6	19.6 - 43.7	16	25.8	15.5 - 38.5
p-value		0.0251								

[1] Score of 0-3 on questions 11 to 18
[2] Score of 4-6 on questions 11 to 18
[3] Score of 7 or 8 on questions 11 to 18
[4] p-value excluding "G"

Table 2. Level of Gender Integration In Operational Planning Process: AMRO/PAHO

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All AMRO/PAHO Staff	18	4	22.2	7	38.9	7	38.9
By Sex							
Female Staff	5	0	0.0	3	60.0	2	40.0
Male Staff	13	4	30.8	4	30.8	5	38.4
By Grade							
D	5	1	20.0	1	20.0	3	60.0
P	13	3	23.1	6	46.2	4	30.8
By Collaboration with GWHN							
Yes	10	2	20.0	3	30.0	5	50.0
No / Don't Know	8	2	25.0	4	50.0	2	25.0

Table 3. Level of Gender Integration In Operational Planning Process: WPRO

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All WPRO Staff	18	1	5.6	7	38.9	10	55.6
By Sex							
Female Staff	5	1	20.0	1	20.0	3	60.0
Male Staff	13	0	0.0	6	46.2	7	53.8
By Grade							
D	4	0	0.0	1	25.0	3	75.0
P	14	1	7.1	6	42.9	7	50.0
By Collaboration with GWHN							
Yes	9	1	11.1	2	22.2	6	66.7
No / Don't Know	9	0	0.0	5	55.6	4	44.4

Table 4. Level of Gender Integration In Operational Planning Process: SEARO

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All SEARO Staff	8	6	75.0	0	0.0	2	25.0
By Sex							
Female Staff	2	1	50.0	0	0.0	1	50.0
Male Staff	6	5	83.3	0	0.0	1	16.7
By Grade							
D	0	0	0.0	0	0.0	0	0.0
P	8	6	75.0	0	0.0	2	25.0
By Collaboration with GWHN							
Yes	1	1	100.0	0	0.0	0	0.0
No / Don't Know	7	5	71.4	0	0.0	2	28.6

Table 5. Level of Gender Integration In Operational Planning Process: AFRO

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All AFRO Staff	20	12	60.0	2	10.0	6	30.0
By Sex							
Female Staff	5	1	20.0	1	20.0	3	60.0
Male Staff	15	11	73.3	1	6.7	3	20.0
By Grade							
D	4	2	50.0	0	0.0	2	50.0
P	16	10	62.5	2	12.5	4	25.0
By Collaboration with GWHN							
Yes	8	2	25.0	1	12.5	5	62.5
No / Don't Know	12	10	83.3	1	8.3	1	8.3

Table 6. Level of Gender Integration In Operational Planning Process: EMRO

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All EMRO Staff	14	2	14.3	7	50.0	5	35.7
By Sex							
Female Staff	4	1	25.0	2	50.0	1	25.0
Male Staff	10	1	10.0	5	50.0	4	40.0
By Grade							
D	1	0	0.0	1	100.0	0	0.0
P	13	2	15.4	6	46.2	5	38.5
By Collaboration with GWHN							
Yes	8	0	0.0	3	37.5	5	62.5
No / Don't Know	6	2	33.3	4	66.7	0	0.0

Table 7. Level of Gender Integration In Operational Planning Process: EURO

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All EURO Staff	15	8	53.3	3	20.0	4	26.7
By Sex							
Female Staff	9	4	44.4	3	33.3	2	22.2
Male Staff	6	4	66.7	0	0.0	2	33.3
By Grade							
D	1	0	0.0	0	0.0	1	100.0
P	14	8	57.1	3	21.4	3	21.4
By Collaboration with GWHN							
Yes	7	3	42.9	1	14.3	3	42.9
No / Don't Know	8	5	62.5	2	25.0	1	12.5

Table 8. Level of Gender Integration In Operational Planning Process: Headquarters

Level of Gender Integration in Operational Planning	N	None or Weak Level of Gender Integration		Some or Moderate Level of Gender Integration		Strong Level of Gender Integration	
		n	%	n	%	n	%
All Headquarters Staff	38	12	31.6	11	28.9	15	39.5
By Sex							
Female Staff	16	4	25.0	4	25.0	8	50.0
Male Staff	22	8	36.4	7	31.8	7	31.8
By Grade							
D	16	4	25.0	6	37.5	6	37.5
P	21	8	38.1	5	23.8	8	38.1
G	1	0	0.0	0	0.0	1	100.0
By Collaboration with GWHN							
Yes	26	9	34.6	8	30.8	9	34.6
No / Don't Know	12	3	25.0	3	25.0	6	50.0

Table 9. Challenges to gender integration in operational planning

- **AMRO/PAHO**

All staff coming to understand what gender mainstreaming means for their particular field of work-- All staff coming to understand how to conduct this process or strategy from the beginning-- All staff internalizing the how to" respective knowledge a
Corresponding SO, RERs and OSERs were given and gender was not explicitly integrated in them. Only in the indicators you can integrate gender. The following observations refer to the activities in which gender was integrated
Ensuring that the analysis process be based on the specific needs of women and men-- Identifying and making explicit the situations of inequality and injustice between women and men-- based on the diagnosis, To decide what type of interventions are most effective To reduce inequalities
Gender blindness, rather than gender resistance.--Professionals in this area of work (Disaster relief) are mostly men and they tend to overlook gender issues--Overemphasis on women receiving the impacts of disasters. Men's side of the problem is not giv
Lack of Information about health conditions are affected by inequality--Insufficient awareness of inequality issues--in sufficient analysis
Lack of Information on differential access To relevant services. - Lack of specific indicators- Very little dialogue between thematic areas (highlighting GE) about specific concerns
Lack of resources, financial and human -People's knowledge gaps about gender: lack of understanding, even resistance to the subject-Lack of relevant information, not only statistical but policy-related.
Lack of shared conceptual frameworks
Limitation of financial, human and time resources
Multiplicity of managerial levels: difficulty of coordinating among them- Competing resources- Information on conceptual development in gender is not available. We do not know where We are in the process of evolving from a focus on women- the general umbrella of inequities where gender was inscribed disappeared as a WHO/PAHO work line
People still not being aware of the difference gender makes in the results of a project- People not knowing how To integrate gender in the process- top-down, instead of a bottom-up approach To gender mainstreaming
The same challenges faced by all six PAHO mainstreaming issues. They become secondary to the primary work theme.Each one is an added burden in programming, an added layer of thinking
There were no obstacles because gender equality is a goal and a direction that has been long time supported. It is not a new concept
To have the PAHO Gender Equality Policy known by all members of the Organization --To show the interaction between gender, poverty and other social determinants of health--To bring down gender concepts from theory to practice. Particular importance meri
To identify available knowledge/ evidence regarding the impact of gender inequalities on the problem at hand and from different dimensions: population, health workers, and services (i.e., demand and supply).--To sensitize planners and keep the gender t
gender was not considered a structuring factor in the definition of objectives.- gender was considered a demographic variable outsiday of an Equity logic.
need for a clearer understanding-- at the managerial but also, at general levels-- of gender equality concepts applied To specific areas of work. this would demand a generalized training effort implemented with the Support of the internal Office of human resources, as well as small Group seminars.
the need To have tools validated by gender experts. the tools provided were presented by a non- gender expert-the tendency To have gender as a cosmetic addition, not To integrate it in the work-the top-down instead of a bottom-up approach To gender integration - the need To be persistent in the face of the slow process that goes from mandates To operations- gender is not treated seriously in situational analysis, it is not seen as a determinant.-Competing interests for resources directed To PAHO six mainstreaming issues

- **WPRO**

1.Country Offices-should be sensitive advocates for GM.Ideally gender should be integrated into planning from the bottom up.Thus Office Specific Results should be generated by countries.2 Men's health needs should be incorporated into programs e.g NCD and Food and nutrition -men in Solomon Islands have lower life expectancy,more obesityand more cardio vascular disease and than women because their wives (who are regarded as having a lower status than them)feed them the choice cuts .3 GM experts need to be aware of the whole picture and be sensitive to specific program's perspective.4 Attitudes-Consideration of GM by specific programs can be regarded as a bother by them.
Culture-no one will disagree with concept of GM but staff don't want to be distracted by gender.Need for concrete tools for assessment and monitoringVocal advocacy to MS-WHO staff need to be prepared /equipped to raise issues to a point of discomfort with member states.Generally if you have the evidence and some policy options to present the MS are quite open. WHO staff should not be shy about raising and repeatedly following up issues with MS. Some other agencies take a tick box" apporach to GM .They document GM in planning instruments etc but don't take practical action including interacting with governments.WHO has not done a good job at communicating importance of gender and that something can be done to redress gender inequities"
GM has not been optimised in WHOTop management-Gender is not very important to themBig variation in countries on GBAGeneral paucity of SDD and GBA
Introduction of SOs lack of time for gender analysis.Focus was on ensuring you got your program included under new SO model.Lack of analytical framework for gender..eg gender inequality in access to DOTS.Need to check why/if not patient continued treatmentalthough staff in area included women and they were asked first they did not want to work on gender issues.So project is being done by men
Lack of evidence and data to test if gender disparity exists in delivery of services for children under 5.Addressing gender is not built into workplan
Resources available for evidence gathering limited.Prioritise by most serious. Gender analysis(GA) secondary consideration.Have to make a judgement as to need to put resources into SDD or GA.Limited financial resources for immunisation so choices made eg PV injection for women costs $100 per shot
Resources-Lack of practical tools to assist MS in planning.Current Info sheets need to go further to be of use on the ground. (e.g simple 1 page checklist for prgramme area eg AIDS)Resources for more in depth analysisNeed to identify and pinpoint where gender analsis should be done and programme developed or shaped.Need for clearer articulation of fact that gender applies to men and women
SOs lack of cultural and structural change accompaning introduction of SOs.e.g budget centres still rule.There is still vertical progamming.This completely counters push for integration.lack of evidence base-can't say with rigour what outcome will be;quality of information available-need for material to be presented from perspective of the line area e.g gender and NCDs.Broad generic material is not enoughlack of senior management commitment;One country office said there are no gender issues here""
gender analysis is taken to be about girls and women .This can lead to not addressing problems for boys eg teenage anaemia;micronutrients;obesity
identifying realistic straegies to encourage recruitment of women
lack of basic SDD
lack of resources for evidence gatheringlack of evidence of inequities to convince decision makerslack of awareness and capacity to do gender analysislack of SDDlack of training in how to incorporate gender into regional/county planning
limitations of WHO eg not dealing with social determinantsunderlying values of organisationGender is cross cutting issue difficult to handle in that wayreliance on easy formula rather than formulating direct effective approach
recruitment of female fixed term staff
recruitment of women to higher level positions in regional office- work for spouse,local conditions such as climate ,personal safety affect decision to apply for positionsretention of female staff -local conditions such as climate ,personal safety affect decision to stay
strategic objective require truemainstreaming-not a paragraph stuck on the endneed for GRA to be more broadly identified beyond reproductive health
varying degrees of awareness of gender inequality issues amongst units 3 day GA training program offered by HQ is too long.Needs to be shorter and tailored to specific needs of SO/program areaslack of formal training in GA in region

- **SEARO**

For adolescent health and development the vulnerabilities are due to the age (10-19 years). Firstly, the focus was on the age group and within that differentials and inequalities were addressed. Therefore, the challenges was to create 'space' for adolesc
Lack of Policy- Lack of clear understanding of gender
Lack of resources- Lack of capacity- difficulty in reaching out To affected populations
No clear policy.- Lack of clear understanding about links between rights in health care outcomes.
No resources - No capacity
Planning directed by Country priorities and involvement of women in Planning and in response areas limited.- No system for disaggregation of data.
Programming limited largely to specific activities.- No clear policy directives.-
There is no clear policy framework or directives to ensure that operational planning takes into account addressing inequalities between women and men. The implications of not addressing inequalities are beginning to emerge but there is very limited capacity to address this.

- **AFRO**

Access to adolescent friendly services is poor for both female and male; needs of adolescents seem not to be a priority on national agendad
Addressing inequalities between women and men is not yet entrenched in our minds
Lack of awareness at country level; WHO vertical intervention approach (instead of horizontal and cross-cutting and); Gender treated as a program at HQ, RO and counrty levels; Not enough community, NGO and church involvement; Budget limitations
Lack of disaggregated data and evidence; Resistance and culture in the different countries to include the needy with most needy being women; Difficulties to integrate objective, target population, resources and activities plus interest in inequalities between women and men
Lack of gender awareness among staff and at region and sub-region; Gender not considered priority among the many priorities; gender seen as abstract; Resistance; Lack of budget allotment
Lack systematic approach and framework how to address inequalities; No elaborated methodologies to do this; lack of capacity
Levl of poverty, few resources; plans have to be based on existing emvelope of budget and budget ceiling
NONE
Never thought abut it; lack of relevant knowledge how to do it
No gender inequalities during poutbreaks so no need to have such a focus
No personnel focusing on gender
None
Scarcity of Sex disaggregated data, scarcity of financial resources, scarcity of human resources with gender awareness and knowledge
Scarcity of relevant and sex disaggregated data as some countries have not heeded regional discussions that started in Maputo 2005
Scarcity of sex diaggregated data; Scarcity of financial resources for surveys to collect such data; lack of agreed indicators common to all countries and regions
The linkage has not been made in the unit
Very difficult to identify suitable women candidates
diseases we work with affect everyone
none

- **EMRO**

1) Awareness of everyone regarding gender mainstreaming, from senior management to country level. 2) We have a big challenge at the country level. In some countries, the poor status of women hinders our work. 3) We (WHO and development actors in general) have a history of isolating women and approaching this sensitive matter in inappropriate ways. This old notion of women in development, this approach failed, but the idea still persists. We need to scrutinize our approaches carefully and address gender in health in a comprehensive manner. We need to regain credibility among communities concerning our approach to gender. 4) We have to expand and improve our gender analysis. Sometimes we do more harm than development. For example, as a result of an income generation project in Sudan, gender based violence increased. Why? Because the women were in the shops all day and came home late, the husbands were frustrated and began to beat their wives. Proper gender analysis can help prevent these things. 5) T
1) I would not qualify them as challenges, but as areas that need more evidence in order to for us to work. In the areas where we have evidence, it was not a challenge to plan, but we need additional evidence (in terms of number of countries providing data and number of topic areas addressed) to assist us in mainstreaming gender. For example, on the topic of women affected by sexual violence and access to victim services, we have evidence in 3 countries, but we lacked it in other countries. We found it very difficult to convince the decision-makers in the remaining countries to conduct such a study for cultural reasons. Another example, on the topic of prevalence and causes of road accidents we have good data from some countries. But for other countries, there are disparities in the data -- the data provided to us from hospitals data does not match the data from the traffic police. 2) More tools are needed for planning multi-sectoral and coordinated responses and programming.
1) Identifying the real causes of inequalities. For example in Afghanistan, the rates of TB between men and women are the opposite of those in the rest of the world. Usually, about 70% of the cases are men and 30% are women. In neighboring countries of Pakistan and Iran the rates are about 50% men and 50% women. There are a various ideas and explanations for the differences in the rates but we don't have the answer. We are planning to conduct operational research. Without understanding the real cause we can't identify the effective actions to address inequalities. 2) Identifying the effective actions to address inequalities.
1) Speaking about programming at the country level, one of the biggest challenges is that we lack SDD data, and evidence of the health benefits of reducing gender inequalities. We need to be evidence-based in our approaches; this strengthens our position in communicating with countries. We work in a situation of scarce resources, and we need to provide evidence that helps us to identify programming priorities. 2) Other challenges include low capacity of staff in this area, lack of tools, and lack of solid technical support. The argument for gender is accepted on a moral ground but we need increased technical skills in developing appropriate programming. We must help answer the question "How can gender be reflected in national programming?" We need a lens and tools, to see how to develop appropriate programming. How can we help national staff to do this? Such changes are costly. These changes require training, new research methodologies and other resources. We can't just throw it at them. If we do,
1) The basic challenge is to make others understand what we are talking about. We have to make the concept of gender clear to staff before it can be incorporated into their work. If we deliver the right message, and then staff can understand it in their own language. The application of gender mainstreaming is different for administrators, for logisticians and for the various medical professionals. 2) Staff have to be equipped to utilize information about gender in their planning. Necessary tools. Example, staff are using the WHO system; this system should be set up to help planners to address inequalities between men and women. For example, a reminder message could be set up: "Have you addressed differences between women and men?" It's a simple thing. 3) Context analysis and problem identification is critical. Even if our staff recognize a problem, they may not know how to analyze it and incorporate it into the performance based management system. 4) Keeping in mind the high rate of turnover among
1) We experience no challenges if we include gender and sex in any of our projects. We don't have to fight to talk about gender issues. 2) One challenge to do more in terms of integrating gender in our work is the limited time we have to invest in it. For example, our project to develop a component on gender in our regional training manual – we set aside time to do this. We don't always take the time to examine the issues in-depth, unless it's an urgent priority. We miss some opportunities. The GHD is also busy and we miss some opportunities to work with them. More gender integration would be better, but it's not a high priority.
1) We haven't faced any problems so far, because we still in the stage of training national staff. 2) Lack of adequate resources that can create pressure and create the change required for gender equality.
1. Gender is a cross-cutting issue, and no resources are allocated at the unit or country level. There is a separate gender unit. 2. In EMRO in general the issue of gender is not clear enough, so we couldn't plan activities; although, in my unit's work gender is well represented. 3. We lack information and research on gender issues at the country level. 4. Gender is not on the agenda during planning meetings and at the results level, although we discuss the issue and take it into consideration during technical meetings. 5. Insufficient number of gender focal points at the country level.
In my opinion, which is believe is shared commonly among managers, if you really want to mainstream gender in planning, your tools, guidelines, and standard operating procedures must be gender sensitive. If you want to mainstream gender (or another issue such as human rights) you have to pick it up in the accountability framework of the whole organization, at all levels of the organization and at all stages of program management – planning, implementation, and evaluation. WHO has acceptable tools and applications for gender mainstreaming in terms of situational analysis and planning. Here it is a matter of enforcement; addressing gender inequalities should not be a matter of choice. It should be mandatory and there should be milestones. People have to show it, through a compliance check.The most important element of planning is formulation of results and their respective performance indicators. How should we incorporate gender in these two places? This is key.Our accountability framework is defined by
Lack of awareness. So many issues affect women more than men. For example, malaria affects pregnant women. Another example is that leishmanais disease causes scarring which is a significant stigma and may even decrease a woman's marriageability. We haven't been able to address these issues because of the lack of awareness within WHO. We need advocacy for gender issues within the organization and then outside in the areas where we work.
No challenges. The issue was never discussed.
No particular challenges.
There is negligence. We can't say that we've encountered challenges because the work on gender has not yet begun. There is no relevant Strategic Objective or OWER which addresses gender either directly or implicitly. Gender should not be under a single OWER but incorporated across them all. The same can be said for human rights more broadly.
We worked on this issue for 2 countries and there were no challenges there. The issue was that male vaccinators cannot vaccinate women.

- **EURO**

1) Competition of topics that have to be addressed all at the same time. We tend to be generic in our products in order not to miss anything. It's a question of how to balance your priorities. We are not prevented by management to explore this issue. 2) we are sometimes limited by the availability of data.
1) Even though our planning frameworks and processes change regularly and emphasize new issues, our basic practice doesn't change. We do the same work; we just report it and describe it differently every year. 2) We look at health system issues for the whole region, for example, financing of health care. This broad topic includes so many issues. We should be looking at each issue in terms of gender, but we don't. There is the perception that these policy issues are gender neutral, but they are not. Gender is not a priority; it does not seem important enough within these broader policy issues. As an organization, we think in terms of functions, and gender is not a function. 3) The policy makers, the researchers, and the research leadership are predominantly male and their awareness is generally low on gender and how it is relevant to health systems and policies. It doesn't come up for them as a priority issue. When we bring up the issue of gender, the first question is "Who will lead this research?" B
1) Gender is connected to the broader concept of inequality, but it's only one of the inequalities that we are addressing. I recognize that gender is important, and we address it, but within a broader agenda. For example, we are currently mapping mental health care in EURO region; the purpose is not to address gender inequalities, but it's an important sub-component. There are sometimes very specific contexts in which gender is a priority and other situations in which gender is a subsidiary issue. I mean that in some instances, gender is linked to the health issue, but it's not where you start. For example, in addressing mental health and education -- girls may not have equal access to education, but you start by addressing the link between mental and health and education in general.2) The absence of gender as a priority. To date, gender has been to date insufficiently prioritized. If there's a clear message from the top all the way down, then it can be done! There's many steps between DG down to my l
1) In the planning process, we had a much broader number of people than those which who are directly and regularly involved in gender, and their awareness is not as high. Their concept of gender is feminism. We had to explain a lot what gender means. Also, if people understand the broad concepts, they may lack a more practical understanding of the term in relation to health, the European context and our work. They may think that gender is only an issue in Africa where the differences between men and women are striking. This lower level of awareness and these misconceptions are common in Eastern Europe and the Russian speaking countries. 2) Europe gender does always mean women's health. Sometimes we must address men's health issues, such as sexual and reproductive health for young men and boys and the involvement of men in family planning. One challenge is to remind people that it is not women only.
1) Our job is to build the capacity of countries to address gender inequalities. Our region is very heterogeneous in terms of recording SDD. Some countries do not collect this data. 2) In those countries that have SDD, sex disaggregation is not enough. In my opinion, male/female is an oversimplification. There are many inequities within gender categories. For instance, there are many differences within the male population and the female population, such as inequalities due to socioeconomic factors. Sometimes the differences are greater between the social classes than between the genders. 3) WHO should audit for gender integration in country programming. 4) Many medical professionals who are very competent in their technical areas, lack an understanding of the basic social issues and socioeconomic factors affecting health. This lack of basic social information affects our ability to plan, and this, in turn, results in poorer health outcomes. We have to be more daring and more sophisticated with th
1) Still this issue is not recognized, and because of the amount of work and the amount of other priorities, its importance in planning SOs and activities is underestimated. It's not discussed frequently. 2) The process of planning is a two way process. Planning is like a bridge between member states and WHO where we discuss and debate priorities for collaboration. The countries come to the table with emergencies like epidemics, disasters, and health financing. They never present an issue like gender as a priority for their ministries. The ministers are men and the deputies are men, and they do not think about it. Our role is to define interventions that address their needs. The issue should be better promoted from our side. 3) [Cultural barriers to discussing gender within the organization.] I'm from Russia and gender issues are not discussed in our culture. Gender is a very cultural thing, and when we work in multicultural teams, people are used to accepting the roles they have their cultural ba
1) The issues are reasonably well-identified within our technical area, but to take the next step and determine how to operationalize it becomes more complicated, or at least, it is more complicated to show it in our work plans. 2) In some instances, we are addressing these issues, but probably not communicating explicitly how our work incorporates the gender approach. In the planning process, we are told to reduce the numbers of activities and results, so we condense everything and then it's more difficult to explicitly address gender. Our administrative system constrains us in this.
1) The lack of budget for gender and the lack of information concerning gender in our technical are interconnected. We have some data but it's inadequate, so we are selling this issue to the member states without sufficient data. At least a third of the region doesn't have the MIS to collect even basic data in our technical area, and we don't have the money or the expertise to assist them in this. We don't have enough expertise in this area. We don't have the funds to collect the data and without the buy-in of the member states we can't raise the funds to collect the data. 2) There is one GFP for the whole region and that's not enough. When she is not available, we go to one of the member states, such as Sweden, who has an expert. 3) Lack of recognition among the member states. It's only one or two countries that are pushing for gender specific studies and publications. The others don't feel that it's really relevant. There's not enough requests from the member states themselves, so it's difficult
1) The main challenges are related to lack of understanding by program managers on how to include this gender in their work. 2) As an organization we are responding to country defined priorities, and the gender issue is not often identified as a priority by member states. We want to be responsive, so we might not find it in our work. We try to engage member states in a consultative process and put this issue on the table, but they don't always take it up.
1) There were no challenges. We discussed the differences between women and men, we collect SDD data on the populations, and we address vulnerable groups in our activities, one of which is lactating women. But when we are planning we don't make a distinction between population groups, for men or women. We didn't put gender specified groups into the products and services explicitly, so there were no challenges. They are not our target groups. When we have certain activities, say in a school, we provide services to both boys and girls, but in reporting on those activities, we would disaggregate the data by sex and age. 2) If WHO would like us to address this in a better way, then teams need more information on how we should address these issues our work, more guidance and instruction on defining indicators, and how to include gender in the expected results and OSERS. Hardly anyone is doing it. If they really want us to do this, then there should be clearer instructions.
I did not experience challenges in addressing gender because of the technical area in which I work. Our work concerns empowering nurses, and 90% of nurses are women. Research shows that empowering nurses, empowers their patients. This is especially relevant in midwifery, which we also address, because the patients are female. Within health systems, the nursing profession is generally considered less valuable, than physicians.

EURO (cont.)

The challenge is the prioritization of issues within the context of each country. The gender is one issue among many others. Some countries give it a priority, in others inequalities in general are not at the top of the agenda.
The planning process was so challenging in itself, that there was not enough time or opportunity to address issues like gender. The administrative and financial part of the planning was difficult, hectic and confusing. We had to reduce and reduce and lump things together. So there was not enough time for critical reflection on the content of the technical deliverables.
They way you ask the question, you imply that this issue was addressed explicitly. Challenges don't refer to a ghost. These issues were not in our mind during planning. If someone, an advocate for gender, had been there during planning, and reminded us "How about women's health?", but otherwise, we did not consider it. Those of us who have been here long enough to understand the organization's values, if you asked me to list the organization's values, I wouldn't say gender. Gender is not one of the top values of the organization, but equity is. When we deal with equity, we look at the socioeconomic dimensions, and gender and other social determinants of health. When we address equity, then women's health comes up, but it's a different pathway. The specificity of actions that are gender sensitive, this not clearly spelled out as in our minds if we are not a specialist in this area. We recognize that there are differences for women and men, but beyond the concepts, colleagues are not sure what it means
We did not experience any major challenges. We are preparing for a ministerial conference on environmental health and gender was identified as a priority issue. We are giving specific attention to gender, for example, with regard to water safety, and with regard to injury and violence, in these areas there is a strong bias in terms of gender. The evidence clearly shows that men and women's experiences are different in these areas.

- **Headquarters**

1) For most of our planning, the focus is with our partner, the Ministry of Health. There is a ministry of women's development, and we give them support, but they are not our direct partner. Most of our work is involved in technical issues, so we are left with little resources to deal with issues as such gender.
1) One of the challenges is the identification of the priorities by the government. Gender is not a separate priority for the government, but they agree to integrate it into activities. 2) In some programs there is a clear understanding that gender is relevant and is closely linked. But in other program areas gender is not as closely linked. It is not clear to many technical units how gender is relevant. 3) The national health policy document states that gender is important; this is a statement of political commitment, but it's not operational. Although there is a political commitment, there are no clear operational mechanisms for carrying it out. [this statement contains both a challenge – no operational mechanisms – and a facilitating factor – political commitment. So it's in both 19 and 20.]
Carrying policies from the HQ to the Regional and then country office level, countries greatly vary in their capacity, it is more obvious at the regional level where policies can be more easily implemented.Need to be able to identify where weaknesses exist in implementation and the reasons why.Some partners are more commited than others to integrating gender.Although resources may be available it may be that the capacity on the ground is weak to carry out projects as intended.
Challenge is to really integrate well in the operational planning levelGender is a critical aspect of th substance abuse, as gender pervasive the department does not feel it is necessary to do separate product on gender as the focus though not completely on gender includes genderIn the examination of the substance abuse and alcoholism gender plays an important role as men and women drink for different reasonsIf you look strictly at the operational planning it is not apparent that gender is considered but it is very much considered, as gender has been far more incoporated than what is apparent.
How to address all the organizational goals with the context of work plan is very difficultNot enough time.The prioritization of the ADG, SO has to make gender an important issue
Implementation is difficult because often global plan do not translate easily to the local level.It is difficult to identify the response mechanisms that are and are not in place to respond to problems.The evironment in which we are trying to work makes it difficult to address social problems as social stratificiation will affect the response.
In the line of Neglected Tropical Diseases WHO is not very far in being able to control the disease let alone arrange for data to be recorded. There is not the human resources in the field to collect the data as many neglected diseases appear in such remote areas that dispensarie often only consist of a person who is only manning the desk for a short period of time and there is rarely any medicine to sufficiently respond to the need. Having this level of support makes it very difficult for people to pay attention to gender.
Ineffective Regional program- No clear guidance
It is not clear: What is the role of the Country Office in promoting gender; human rights and gender are cross cutting issues that must be embedded in everything we do, we need a paradigm shift, while the CCS guidelines promote gender there are numerous players to comply and doing so can be difficultWork needs to be done on how gender integration is applied to different departments.
Lack of gender awareness within the counry office; Cultural issues and resistances
Large amount of funds but few people in countires are able to produce proposals that pass the criteria for counter-marketing of tobacco, it is difficult to demonstrate that the proposal will be cost-effetive and evidence that it will do what the proposals say they will. As a result, the inclusion of gender in the counter-advertising is challenging, most of the time people want to focus on women and empowerment, but when it comes to tobacco the focus has to be on -why do women want to smoke and how to give the message that they should not. A counter marketing strategy is needed to focus on gender and tobacco control, as the number of women smoking is growing.There just as is no capacity to write proposals.
Little money; Human Resources limited; Need to mainstream gender in all programs; Commitment from Ministry of Health as we archived only one meeting in one year for the working groupon gender; To make the process more global UN rather than WHO only in the context of One UN joint program
MOH's program is not designed in ways to directly address gender: National Health Plan-- Need to address gender from various perspectives, underscoring that of empowerment -- Having to face up huge social problems with how women are regarded, among them
Men do worse on treatment because they do not have the same health/help seeking behaviour that women have, pregnant women are also a challenge because they do not always try to access the care available
Nature of the work is about processes, gender does not play a role in Fianance and ITT, people are not always interested, people do not understand how gender should be considered.
No Major challenges
No big challenges
No capacity- No staff(Gender Focal Point but only 7% of the time dedicated to gender work)
No real challenges, the biggest challenge when it comes to gender is that in some countries there is a preference to having girls vaccinated and in other countries to having boys vaccinated which are cultural issues.
Reaching agreements on the subject with the MOH coleagues. They not only lack gender sensitivity but have a very medicalized vision of health: health as individual rather than collective process.
Regular budget very small-competing priorities SO 7 gets left out-have to chase extra-budgetary funding
SO 12 does not go into details on gender
Some areas do not produce very much gender data i.e. neglected tropical disesases, this is largely due to the lack of human resources available to collect data.
The challenge is in moving from principles and guidance to technical program producing the work plan.Gender can be more explicity stated as a requirement to be addressed in the work plan.
The office is concerned with the Right to Health but it is not clear whether the actual policy of WHO is fully supportive of it.Difficult to get country ministries to support the collection of SDD, WHO does not have enough staff on the ground to ensure the collection of SDD.Budget ceilings create an impediment as office is asked to cut back by 10% of its activities and yet it is expected to do more.
There are a number of subgroups that are looked at and there are only so many human resources available, as a result when you are looking at young children boys and girls are treated much the same but once they reach adolescents the importance of dividing according to sex becomes more relevant.
There are difficulties in operationalizing gender equality in th work as the results are in specific helath products which reflect the product but not necessarily gender.People do not see the relationship between what they are doing and gender.

Headquarters (cont.)

There are women health workers but in some countries the attitude is to keep women at home, culturally women have to be released from having to stay home.In certain countries physician positions are dominated by men, culturally it can be very hard for women to b promoted into men's positions
There is the issue of the gender and TB stigma which makes it hard to focus on one gender because you do not want to deepen the stigma.Efforts are made to take into account the male/female equity, it matter is of maintaining the awareness while being focused on the work itself as the priority.As soon as the study of a project begins it has to look at the gender of the subjects and maintain gender sensitivity.Obtaining the information at a country level is sometimes very difficult.
This area of work has never really been analyzed through the lens of men and women inequalities.Only beginning to realize that there are more gender issues with regard to Food SafetyThere are human resources limitations to being able to promote some issues on gender.No support given to facilitate.
We face no challenges in addressing gender and that's why there are not so many products explicitly targeting gender. Gender has been integrated as a cross-cutting issue in our objectives.
lack of practical planning tools developed with help of gender experts.There are no shortcuts to gender mainstreamingcountry level technical competence;need for country level capacity buildingtools need to be developed issue by issueWHO planning templates need to build in gender ,SDD ;need for training short enough for program staff to attend -1 day
nonesome vaccines are gender sensitive as they address issues specific to gender
not easy to get good best practice examples-need expert help;understanding of staff on gender -not clear in country office;concern re use of term inequalities" in questions-gender issues are not necssarily about inequalities but about vulnerable groups eg when we are helping mobile populations we are not tackling "mobility" itself.Same applies with women's equality.We look at gender not inequalities.Both men and women have access to services but we use different approaches.The questions in the survey don't really open up to gender mainstreaming responses because of use of term"inequalities""
not enough woman as planners, Managers and service providers- health uses human resources inputs from education Sector and hence cannot initiate a complete change
not enough women as planners and service providers
resources-difficult getting money to do gender situational analysisfinding good people to do workat country level including GA in planning has to pushed
where To locate gender in the Planning instrument-- MOH is not gender-sensitized and their gender skills are Very weak. in fairness, however, MOH technical capacities in general are Very Weak --gender is still largely seen as a FCH theme

Table 10. Facilitating factors to gender integration in operational planning (Question 20)

- **AMRO/PAHO**

- Advocacy by the Gender Unit` Progress in understanding the relevance of gender
- The work of this team is framed by the MDGs -- MDG 3 within them-- and community participation.----Seeing work on gender not as an extra activity but as an strengthening factor of each action
Collaboration with the Gender Unit. Members of the Gender Unit actively participated in the area planning process
Commitment with donors to incorporate gender and ethnicity considerations in a workshop. Thus, gender was incorporated in this action but the interviwee still has difficulty perceiving the relevance of this concept beyond the demographic realm.
Conscience in the Organization and the health services about the existence of unjust differences between women and men in terms of access To resources. this recognition within the Organization is Very important
Director's and AD's push
Growing understanding about the theme being a political priority at the institutional level--Planning guidelines included gender equality as one of six institutional cross-cutting issues --PAHO gender equality Policy
PAHO Director's commitment to gender equality-- Having a gender unit in the House
Partnership with the PAHO Gender Unit for the determination of relevant indicators
The definition of six institutional mainstreaming issues , gender equality being one of them
The dialogue with GE was very important for him to start thinking about gender in his specific area of work. However much more of this dialogue is needed to arrive at gender-sensitive practice
The most senior management is very aware and supportive of this goal.
To have professionals that combine a solid training in public health and gender within the team- To have women professionals in the team- To be exposed To good mainstreaming practices in the countries - Availability of human and financial resources (mainly from external funding)
To have staff with experience in the subject both globally and regionally - SDE has many professionals from social sciences and WHO are women
external consultants on gender-- Realization that energency aid had not been appropriately distributed because women did not participate in the decisions about it-- Consciousness about the differential problems of women and men in emergency situations. Emphasis should be on differences not on inequalities
having the Equity framework-- Opportunity To think about how gender can contribute To work more efficiently, for instance, how To emphasize traditional gender roles that are good for family and community
the gender Unit advocating for the theme-- Managers have it as an agenda item, as a priority theme
work history of the PAHO gender Unit -gender equality movement -Support of PAHO Director and PAHO Governing Bodies

- **WPRO**

1 Attitudes -GM has been around for a long time and it is now normal natural to incorporated into data collection and surveillance.eg tobacco,ageing2.donor conditions can help e.g 2-1-22 Pacific NCD Progarmme Implementation Plan (2008-2011) states interalia .. The program will aim to ensure that all policies ,activities and evaluations address gender inequality issues...criteria for grants funding will require applicants to identify how men and women will benefit from the proposed intervention..Gender will also be a consideration where the program assists countries to develop new national NCD policies3 GM is now built into SOs and articulated in strategic approaches
Evidence of tobacco related gender issues in China eg Wives of smokers have a 40%-50% chance of breast cancer and cardiovascular disease;awareness that low rate (3%)of women smokers (as compared with 70% men)is a potential market for tobacco companies.
Evidence of gender differences in risk factors for adolescent health is available
HQ gender and technical publications eg gender and violence;indoor air pollution and women
RD commitmentShame game -the fact that comparative data by region is published by WHO
SOs articulates gender and increases awareness3 day GM training in SaltzburgDonor pressure insisting on gender component
SOs help to create a long term strategy of integrating gender into work.But introduction needs to be gradual
discussion of gender in a human rights context helps to gender analysis to draw out equity dimensionhaving identified technical gender expertise within the division -over and above the designated GRA mainstreaming into National Health Plan
management supportaffirmative action in recruitment
personal consciousness of genderbroad cultural mix of WPRO office with staff recruited from WPRO countries and other regions good balance of men and women in unit
recognition that gender analysis applies to women and mencase by case analysis
strengthening of gender focal points in region
strong evidence basebroad messages in training packages
the countries with strong integrationextra resources at WPRO for genderAdaptation of WHO training down from 3 weeks to 1 week.Done 3 years in a row in Malaysia for maternal and child health-built capacity
the existence of SOswhich are supposed to facilitate cross portfolio work.
training and specific studies

- **SEARO**

Availability of strategic information which had been accumulated during 2006-07 by AHD helped in operational planning process.
Have had informal discussions with GRA but nothing formalised.
Initiated cross consultation and discussions at personal level with GRH.
NA
Part time human resource To Support programming.

- **AFRO**

Availability of good evidence from research and implementation that is important to address inequalities; Joint planning with DRH/GWH; Peer review process
DG priorities for women in Africa
Document on social determinants of food security
Existence of evidence of inequalities between men and women in epidemics in Africa;Accessibility of care and treatment; Good collaborations between unit, division and DRH especially GWH unit/ focal person, and partners e.g. Global Fund; More countries willing to include gender
Gender awareness of some staff
Growing interest in gender because of work by Commission on Social determinants which highlighted the importance of gender
My personal interest in addressing gender inequalities; my training that included awareness and skils in gender - during my post-graduate studies my supervisor was very strict on this so I llearned a lot; WHO organisational orientation especially SO 7; AFRO having a gender focal person with whom we interacted and collaborated
NONE
Orientation of Reginal Director to insist on including at least one woman per 3 shortlisted candidatesDG Directive on gender equality
Planning together with another divison/unit
Regional strategy for adolescent health and regional advisor for adolescent health both gender aware
Working with SOs because gender cuts across all; Women's health and gender has become a priority of DG; Adoption of gender strategy to guide WHO work; Wide consultations asking divisions to include gender in their work
none
none as never intended to address

- **EMRO**

1) Data!! Sex and age disaggregated data. Present the data and you don't have to argue. For example, data on the level of education between women and men. 2) We need to find credible models of what is working. We should gather information on tested best case practices and share that with countries and communities. 3) Advocacy is important. On behalf of both men and women. Drop-out rates are higher for boys than for girls because they are pulled to work and support their families. In this case, I will advocate on behalf of boys for drop-out from schools.
1) Gender is core to my positions as Facilitator of SO4, the Coordinator of Community Health, and being responsible for women's and reproductive health. 2) The newly introduced Medium Term Planning Strategic Planning process which ensures synergy across programs. 3) Close working relations with the GHD unit.
1) In recent years, several World Reports were published on topics relevant to my work. In those reports WHO was mandated to undertake specific actions in relevant programming areas. In addition, two resolutions were passed in the World Health Assembly and three UN resolutions were also passed. The WHO resolutions are legally-binding for the Secretariat. These resolutions and reports took place before the MTSP and generated a lot of debate and motivated a lot of support for programming in these areas. They served as good advocacy tools and helped to create a congenial enabling environment. The supportive enabling environment helped us to work cross-departmentally at both HQ, regional and country level to address these issues. We undertook joint planning and this reinforced our planning process. 2) Flexible, yet clear planning guidelines. 3) We experienced no impediments from the region or HQ.
1) PME workshops: His unit delivered a full round of training to country offices, and EMRO staff including RAs and others. 2) Adapting the planning guidelines to incorporate gender and disseminating them widely.
1) Presence of qualified officer (Gender FP) at the regional level who supported and promoted the idea during the planning stage of SO7; 2) HQ supports and guidelines used as evidence at CO level.
1) Since the establishment of the regional gender unit, we have become more aware of important gender issues related to my unit's work. 2) Opportunities for consultation with the gender unit. 3) The gender unit website. I learned more about the relevance of gender to my unit's work by reading the information on the website.
1) The burden of disease is a helpful tool. It's costly, but it's a scientific tool and we should return to it and introduce gender into it and use it. We have to make use of the country's acceptance of the burden of disease tool, and use it as a gender analysis tool. 2) Awareness of the issue of population growth and the central role of women. This issue is recognized by countries. We need to rephrase the inequality discussion and women talk about women as an important asset. The message that women are poor and marginalized focuses on the lack of choices and resources of women. 3) Upsurge of local NGOs which deal with women's issues and gender. Working with NGOs has helped our work.
1. Designation of gender focal point/gender unit at the regional level. 2. Mutual planning and collaboration between my unit and the gender unit. 3. Presence of some gender focal points at the country level. 4. Information sharing
Addressing gender is a commonly accepted approach in HIV/AIDs programming. There's nothing that you have to defend.
Burden of diseases. And raise the awareness of this issue in the countries concerned: You will never achieve MDG4 without increasing the vaccination levels of women.
Evidence concerning inequalities between women and men. For example, evidence that women are more vulnerable to mental health problems, such as suicide and depression. In the EMRO region women are more vulnerable to suicide and depression unlike in Europe where its more prevalent among men.
It's easy for me to get funding from HQ if a project addresses women. Then I use the regular office budget to address men's issues.
Quantitative data (detailed data disaggregated by sex and age) on inequalities between women and men.
The existing tools and guiding principles in some program areas (such as sexually transmitted diseases). But this is not in all program areas. There are gender sensitive trainings and other initiatives in some program areas.

- **EURO**

1) Having a focal point for sure. When we came to planning, she guided us on what kind of issues to look at, and what data to collect and what kind of recommendations to make to member states. Also, she advised us how to present an argument to the countries and she reviewed our publications. It's a very difficult area to address. Our understanding was at a certain level and she helped to build on that. 2) There's a mandate from HQ. We hear from Dr Chan that she wants to see more in terms of gender, so we make the extra effort, but it's not part of our routine.
1) In some countries in the region, the level of awareness concerning gender and inequalities more broadly is actually high. The government is very aware and they make it a priority. 2) On the one hand, in some countries, there are still gaps and we move the issue forward where it's needed.
1) Maybe it depends who is conducting the strategic planning. When it's led by men, the issue of gender does not receive much support. And when it's a woman leading the planning, gender does not always get attention either. In some cases, the female population within the organization are helping to address inequities. 2) Studies and surveys facilitate the planning process because they help us to think about the issue. In our everyday we accept our work roles. We do not think about it. Gender can help improve overall health outcomes. 3) Its always important to have leadership to facilitate discussion of this issue. Usually, it's women that bring up the questions.
1) None. 2) Well, I'd like to add something -- Margaret Chan mentioned gender as a priority in her speech, so that message could have been in the back of our minds, but in the planning process that got lost. But messages like that are important reminders.
1) Research and evidence. For example, we can demonstrate a correlation between the lower the number of nurses in a hospital unit, and higher mortality rates. Or when we can show that the majority of the new generation of physicians are female, but the responsible positions in health care systems and universities are disproportionately male. Evidence and research helps us to advocate for our work. 2) Debate, discussion, and disseminating evidence-based information.
1) SDD and research findings on the impact of gender inequalities on health outcomes. The more evidence there is, the easier it is to bring this issue to the attention of both internal and external stakeholders. 2) Having strategic documents and resolutions help a lot in convincing stakeholders. 3) UN initiatives that aim to strengthen gender mainstreaming within the UN system are a serious asset in promoting the issue with member states. For example, the discussions on creating a UN Office on Gender Equality sensitized member states on this issue. 4) Our own strategy is a useful instrument to increase visibility and action both internally and among members states.
1) The operation planning process is quite open and leaves a good deal of flexibility to individuals. The environment is quite enabling and if people choose, they can address this issue. 2) Gender specific analysis is a standard in our technical area; we are sometimes limited by the availability of data, but addressing gender is a standard procedure in terms of analysis.
1) We have SDD on the relevant topics. An evidence-based approach is the best way to discuss with colleagues during planning. 2) These dialogues [during planning] were constructive, and it was helpful to have a forum for discussing gender issues. The planning process took almost one year.
1) We have a designated GFP in the office. People say that gender is everybody's business, but then it tends to become nobody's issue. Having a GFP helps to build the capacity of staff to integrate it into our work. Then it really will become everybody's business. This is a critical factor in mainstreaming the issue. 2) An SO that specifically addresses gender. 3) Gender has become very important for certain countries and for the EU, and this creates an environment that is more conducive for taking up these issues. There is increasing political awareness of gender, but also, finally, a number of countries are taking action in this area.
1) When partners bring it up that helps. People are generally aware of the issue and positive about it; that helps. It just doesn't help very much. It doesn't materialize into anything. 2) We tend to collaborate with colleagues who are sitting next to us. That's why it's important to have colleagues who are gender sensitive throughout the organization. The GFP used to sit in our office and we would discuss matters, even informally. Although we didn't carry out specific activities related to gender, the presence of the GFP kept the issue in our minds.
Gender inequalities are on the radar screen. We are aware of the importance of the issue. We have this draft gender strategy which outlines the important areas of our work in relation to gender, but it didn't go forward.
Information. SDD provides evidence of inequalities and strengthens our case with governments in demonstrating the challenge. Inequalities between men and women is an area in which ideology plays an important role, so efforts to address it must be backed up with data. 2) Recommended interventions. There's no point in bringing up the problem if you don't have a solution; SDD needs to be linked to interventions. That's when it's powerful. And we don't lack for effective solutions interventions that could be applied.
Not Applicable
The fact that we were able to use SDD indicators and we were able to show how particular health issues affect women and men differently. It was easy to identify issues within my work that are relevant for gender. Violence and injury prevention is one striking example.
The flip side of above. Advocacy for gender, information and incentives, these are things that are taking place now, but not in a systematic way. If we strengthen them, it will go a long way towards mainstreaming gender. One needs to be strategic here, and we are embarking on a planning process and we have to deliver, if there these three inputs at that time that would be more effective. 1) Advocacy, we need to proactively encourage consideration of gender at appropriate times, during the planning process. 2) To provide information that would spell out what needs to be done, in other words, the practical implications for integrating gender in our work. 3) To provide incentives, to reward, to encourage to WHO staff and partners for addressing gender and women's issues.

- **Headquarters**

1) 70% of the WHO country office staff have been trained on gender issues so they understand its relevance to health. 2) The government has a clear understanding of gender issues and they have established a commission. 3) The national health policy document states that gender is important; this is a statement of political commitment, but it's not operational.
1) Helpful factors include the existing legislation and the constitution which protect the right to health and promote equal rights between women and men. That's been in existence for over 50 year, so the country has a history of addressing inequalities between women and men. The current challenges for the country are related to the emerging diseases of the 21st century, especially non communicable diseases, and to adapting the health system to address these diseases. Another current challenge is the changes in the age composition of the population, the "graying" of the population. New gender issues will emerge with these population changes. 2) The availability of SDD makes the gender differences clearly visible.
Age is a facilitating factor in determining at which stage the distinction between males and females become important.The funding is currently adequate but could have better funding than what currently exists. there is a need for the funding to be flexible so that research can be done on specific areas i.e. HIV/AIDS
Awareness of the importance of issue
Best practices guidelines with a focus on women and children.Having clear guidance, being clear on what is being looked at.Gender is seen as a subset of the equation when examining something, it involves separating out the data
Better information as to how the health workers were distributed, which in turn helps operational planning.
Countires Forum has a Pacific Platform for action on Advancement of WomenGM very high on UN agenda .Therefore UNDAF integrates it well.
DG's clear focus on gender issuesThe support of the gender team's staff members.
Gaining access to data to inform researchers where trouble areas lie helps to address them better.Identifying the decision makers and convincing them to participate in a vaccination programme helps.At the country level a lot of the implementation is done by UNICEF so it is with another agency.
Global fund has a strong gender orientation, the development of gender sensitive criteria and indicators ensured the inclusion of the guidelines for the global fund. The availability of gender experts has also helped.Activists have provided support to provide data analysisThe office has been able to harness the support of other offices such as FCHInformation sharing with other unites and close working links with othersThe presence of regional networks has also helped to give support.
Good and active counterparts.
Having Gender Strategy calls attention to the need to consider gender.
Having gender institutionalized
Health rights training has been effective in also helping the gender component, but direct help for gender groups has not happened.
It is already designated in the SO that work will be done on gender and there are resources being made available
Key facilitating factor is the engagement of the Senior management, that the ADG have a committed interest in promoting through their leadership, this makes it more clear to everyon in the org. that they want to take gender seriously.
NA
None
Official commitment to address gender, champions of promoting gender, if the GSM carries a gender code it will be easier to monitor.
Openness of Ministry of Health which has designated a gender focal person; Gender awareness of UN agencies; Interest of other health partners
PAHO staff sensitized about gender--UN Interagency Group on Gender--Alliance and Partnership with INAM (Women's Affairs Ministry) which has a very dynamic Minister--Interest on the subject on the part of the new Minister of Health --The National Plan of
Policy recommendationsresourcestechnical support, commitments from WHO
The Gender Strategy helps to promote gender integration and obtain resourcescommunication briefs
The UN framework for development in Guyana favors interagency work to address this problem.-- The Minister of Health (a man) is an advocate for women's equality, women's health and women's empowerment, without disacknowledging men's disadvantage in ter
The motivation and dedication of department staff can make a difference.
There are policies in the country and there is an office of Population and Family Health which has the technical capacity to carry out its work. In fact, it is a huge institution and they have made a big impact on the lives of women in the country. We are working with them on violence against women. There is also an active local NGO sector.
UNIFEM office is useful in training and finding good consultants
WHO's own policy for gender equality in health- The host Govt. concerned about ruling out inequalities at planning and implementation in health
Willingness and interest of staff to participate; It was included in the workplan provided an opportunity for awareness and to create knowledge
You need to have champion of the issue to advocate for looking at inequalities, need people who are able to promote gender.
awareness of issue in WHO UN and society in general;UN bilateral partners;donor agencies
gender environment in Bhutan
gender focal point in the Country Office--Country Office staff gender trained, PWR included--Exchange with and Support received from the gender Unit in PAHO/HQ --PAHO gender equality Policy, available and reader-friendly
none
research developmentintroduction of a project that is gender sensitive

Table 11. Level of Gender Integration In Programme Implementation: Overall for all Regions

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]			Some or Moderate Level of Gender Integration[2]			Strong Level of Gender Integration[3]		
		n	%	95% CI	n	%	95% CI	n	%	95% CI
All WHO Staff	127*	47	37.0	28.6 - 46.0	73	57.5	48.4 - 66.2	7	5.5	2.2 - 11.0
By Sex										
Female Staff	44	12	27.3	15.0 - 42.8	29	65.9	50.1 - 79.5	3	6.8	1.4 - 18.7
Male Staff	83	35	42.2	31.4 - 53.5	44	53.0	41.7 - 64.1	4	4.8	1.3 - 11.9
p-value		0.2510								
By Grade										
D	30	5	16.7	5.6 - 34.7	22	73.3	54.1 - 87.7	3	10.0	2.1 - 26.5
P	96	42	43.8	33.6 - 54.3	51	53.1	42.7 - 63.4	3	3.1	0.7 - 8.7
G	1	0	0.0	--	0	0.0	--	1	100.0	2.5 - 100.0
p-value[4]		0.0152								
By WHO Level										
Headquarters	21	4	19.1	5.5 - 41.9	15	71.4	47.8 - 88.7	2	9.5	1.2 - 30.4
Regional Office	90	39	43.3	32.9 - 54.2	48	53.3	42.5 - 63.9	3	3.3	0.7 - 9.4
Country Offices	16	4	25.0	7.3 - 52.4	10	62.5	35.4 - 84.8	2	12.5	1.6 - 38.4
p-value		0.1217								
By WHO Region										
AMRO/PAHO	17	6	35.3	14.2 - 61.7	11	64.7	38.3 - 85.8	0	0.0	--
WPRO	17	2	11.8	1.5 - 36.4	15	88.2	63.6 - 98.5	0	0.0	--
SAERO	8	6	75.0	34.9 - 96.8	2	25.0	3.2 - 65.1	0	0.0	--
AFRO	20	11	55.0	31.5 - 76.9	8	40.0	19.1 - 64.0	1	5.0	0.1 - 24.9
EMRO	13	8	61.5	31.6 - 86.1	4	30.8	9.1 - 61.4	1	7.7	0.2 - 36.0
EURO	15	6	40.0	16.3 - 67.7	8	53.3	26.6 - 78.7	1	6.7	0.2 - 32.0
Headquarters	37	8	21.6	9.8 - 38.2	25	67.6	50.2 - 82.0	4	10.8	3.0 - 25.4
p-value		0.0175								
By Collaboration with GWHN										
Yes	66	13	19.7	10.9 - 31.3	46	69.7	57.2 - 80.4	7	10.6	4.4 - 20.6
No / Don't Know	61	34	55.7	42.5 - 68.5	27	44.3	31.6 - 57.6	0	0.0	--
p-value		< 0.0001								

[1] Score of 0-4 on questions 21 to 25
[2] Score of 5-9 on questions 21 to 25
[3] Score of 10-12 on questions 21 to 25
[4] p-value excluding "G"
* 4 participants with missing values (don't know in question 25)

Table 12. Level of Gender Integration In Programme Implementation: AMRO/PAHO

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All AMRO/PAHO Staff	17	6	35.3	11	64.7	0	0.0
By Sex							
Female Staff	5	1	20.0	4	80.0	0	0.0
Male Staff	12	5	41.7	7	58.3	0	0.0
By Grade							
D	4	1	25.0	3	75.0	0	0.0
P	13	5	38.5	8	61.5	0	0.0
By Collaboration with GWHN							
Yes	10	1	10.0	9	90.0	0	0.0
No / Don't Know	7	5	71.4	2	28.6	0	0.0

Table 13. Level of Gender Integration In Programme Implementation: WPRO

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All WPRO Staff	17	2	11.8	15	88.2	0	0.0
By Sex							
Female Staff	5	1	20.0	4	80.0	0	0.0
Male Staff	12	1	8.3	11	91.7	0	0.0
By Grade							
D	4	0	0.0	4	100.0	0	0.0
P	13	2	15.4	11	84.6	0	0.0
By Collaboration with GWHN							
Yes	8	0	0.0	8	100.0	0	0.0
No / Don't Know	9	2	22.2	7	77.8	0	0.0

Table 14. Level of Gender Integration In Programme Implementation: SEARO

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All SEARO Staff	8	6	75.0	2	25.0	0	0.0
By Sex							
Female Staff	2	1	50.0	1	50.0	0	0.0
Male Staff	6	5	83.3	1	16.7	0	0.0
By Grade							
D	0	--	--	--	--	--	--
P	2	6	75.0	2	25.0	0	0.0
By Collaboration with GWHN							
Yes	1	1	100.0	0	0.0	0	0.0
No / Don't Know	7	5	71.4	2	28.6	0	0.0

Table 15. Level of Gender Integration In Programme Implementation: AFRO

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All AFRO Staff	20	11	55.0	8	40.0	1	5.0
By Sex							
Female Staff	5	2	40.0	2	40.0	1	20.0
Male Staff	15	9	60.0	6	40.0	0	0.0
By Grade							
D	4	2	50.0	1	25.0	1	25.0
P	16	9	56.3	7	43.8	0	0.0
By Collaboration with GWHN							
Yes	8	2	25.0	5	62.5	1	12.5
No / Don't Know	12	9	75.0	3	25.0	0	0.0

Table 16. Level of Gender Integration In Programme Implementation: EMRO

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All EMRO Staff	13	8	61.5	4	30.8	1	7.7
By Sex							
Female Staff	3	1	33.3	2	66.7	0	0.0
Male Staff	10	7	70.0	2	20.0	1	10.0
By Grade							
D	1	0	0.0	1	100.0	0	0.0
P	12	8	66.7	3	25.0	1	8.3
By Collaboration with GWHN							
Yes	7	3	42.9	3	42.9	1	14.3
No / Don't Know	6	5	83.3	1	16.7	0	0.0

Table 17. Level of Gender Integration In Programme Implementation: EURO

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All EURO Staff	15	6	40.0	8	53.3	1	6.7
By Sex							
Female Staff	9	4	44.4	5	55.6	0	0.0
Male Staff	6	2	33.3	3	50.0	1	16.7
By Grade							
D	1	0	0.0	1	100.0	0	0.0
P	14	6	42.9	7	50.0	1	7.1
By Collaboration with GWHN							
Yes	7	1	14.3	5	71.4	1	14.3
No / Don't Know	8	5	62.5	3	37.5	0	0.0

Table 18. Level of Gender Integration In Programme Implementation: Headquarters

Level of Gender Integration in Programme Implementation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All Headquarters Staff	37	8	21.6	25	67.6	4	10.8
By Sex							
Female Staff	15	2	13.3	11	73.3	2	13.3
Male Staff	22	6	27.3	14	63.6	2	9.1
By Grade							
D	16	2	12.5	12	75.0	2	12.5
P	20	6	30.0	13	65.0	1	5.0
G	1	0	0.0	0	0.0	1	100.0
By Collaboration with GWHN							
Yes	25	5	20.0	16	64.0	4	16.0
No / Don't Know	12	3	25.0	9	75.0	0	0.0

Table 19. What challenges affected the implementation of 2006-2007 biennial work plans in terms of addressing inequalities between women and men? (Question 26)

- **AMRO/PAHO**

- Limited resources- PAHO Country Representatives' reaction: priority is given to medical issues- Gender is not a priority in terms of evaluation
-Attitude of Country Representatives: Gender is seen as a soft issue , not hard public health. They question investment in the subject.-Lack of clarity regarding Gender counterparts in Ministries of Health-Perception that gender equality issues are not PA
Addrerssing gender inequalities was not a primary focus in programming
Does not know. He was not working with PAHO at that time
Don't know
Gender was not an element in planning, hence it was not in the implementation either.
Getting a mind-set change in the entire organization. Everyone will have to be aware and supportive of these goals --> Broadening awareness
Lack of a seen association between the gender approach and the work being done-- Lack of understanding of the scope of the gender approach-- the Planning instruments were not oriented in that direction: the indicator structure was not conducive
Lack of clarity --or practical knowledge-- regarding appropriate lines of action -- Lack of knowledge derived from impact evaluation in specific areas of work-- Over Emphasis on women
Lack of human resources within the Organization To devote To this project. need To have a full-time professional working on gender focused projects within the team. external consultants were hired at different stages but that is not enough for continuity purposes- Few opportunities for exchanging ideas between programs - Lack of sufficient financial resources
Lack of knowledge and clarity about gender among People responsible To implement-Inconsistency between political mandates at the national and local levels-Lack of Information and research filling the knowledge gaps
Lack of operational tools provided by the gender Unit
People agreed with the need for gender integration but lacked the know how.--the gender Unit should have been present in the discussion of the work plan
The work of this area did not facilitate that integration. The area was transitioning both managerially and substantively during that period.
There was not conscience of the importance of gender as a structuring factor
There was not enough time between the approval of the Gender Equality Policy (September 30, 2005) and the formulation of the work plan 06-07 (October-November 2005).-- Tools were not available-- Policy was not widely disseminated
countries did not always have the required level of sex-disaggregation --There was not adequate analysis of this disaggregated Information To produce relevant knowledge that would guide the developoment of strategies and programs (To pass from Information To action)-- No fora were organized on the subject at the Regional level
financial resources for hiring gender experts- Availability of human resources with expertise in both gender and their specific technical area - Limitation of time

- **WPRO**

1.Getting gender into mainstream programs-need for clear strategies focussed on implementation.Time should be made available for collaboration between progam areas gender focal points. eg safe water program.As water carriers, women's health benefits in multiple ways from safe water. 2.Attitudes Willingness to implement GM is expressed but something like a macho attitude is holding the region back3 Motivation of female staff-need for more recognition women's capacity to to implement programs;care needs to be taken that in performance appraisal bias undervaluing the work women do on gender related issues does not occur4. Six monthly review of workplans -need to introduce standard question asking for assessment as to whether inequalities between women and men were addressed in any of the products or activities or services.5. Rules and procedures for regions-need to review these to eliminate sexist language e.g references to RD as he"6.Evidence base-level of evidence required in technical advice is now so
Countries and areas in the Western Pacific Region are making steady progress towards the global goal of the elimination by 2020 of lymphatic filariasis(more commonly known as elephantiasis) . Samoa has completed six rounds of mass treatment and is at the critical stage of confirming that prevalence has dropped to below the 1% target level. The routine blood testing revealed that a significant number of men in Samoa did not swallow the tablets. When investigated it was found that many men were not treated because they were inaccessible, .(e.g out working in the fields, out socialising with their mates). Local women are often the distributors of the drugs to their community.One of the researcher's hunch is that perhaps the men do not take the drugs because the men may have undermined the integrity of the local women as being capable of giving medicines to the members of the community when they do not have any recognised health / medical background. As well men traditionally do not wear shirts and are usual
Lack of issue specific tools to identify if there are gender inequalitiesLack of tools to measure level of gender inequalities that are found.Lack of program models to address inequalities found
Making gender part of broader equity agenda could help in gaining support for gender. Equity is the middle ground with gender as a component of it.Combination of GM and mainstreaming is likely to be most effective.MS communication -Bottom line is effectiveness- no matter how incremental your approach is it must progress identifying issues and solutions. Gather evidence and sharing analysis including gender with MS.Refine message to fit with culture you are in eg Some MS accept a message couched in terms of access and equity rater than human rights.Need to adjust message to be heard in particular MS. This is a training issue-
None
SDD still not always available when it should bePlanning roles in WHO still male dominated esp in countriesLack of area specific materials on gender where it is needed eg model gender analysis tools for communicable diseases
There are no specific gender analytical tools for effective interventions approprite to communicable diseases .These tools need to be applicable at successive levels eg recovery.need for development of these.Difficult to find experts in field with gender expertise as well.
funding for nutrition generally is inadequate and this affects resources problems identified for women and girls.last thing to invest in ;low priority
gathering robust evidence to go to boss to get resourcescountries-level of motivation variesTop management-Gender is not very important to themBig variation in countries on GBAGeneral paucity of SDD and GBA
lack of WHO carriage of issue;fragmentation of approach;WHO under resourced;lack of instruments to produce the evidence baselearning from provisional programmes not scaled up to comprehensive intervention
lack of availability of SDD from countries even though spreadsheet designed for this
lack of basic SDD
not enough resources to do capacity buildinglack of practical manuals for people working in the field.What ia available if often at higher level.Good for researchers but not on the ground operatives.Need for simpler easier to understand version.
recruitment of women to higher level positions in regional officeretention of female staff
reliance on other agencies for fundingMore cases of male neonatal tetanus reported than female cases, so that it is suspected that some female cases were missed or not detected. GA needed on why fewer girls. Difficult to get resources to follow through on anecdotal evidence of disparity
time-limited resources;budget implications
zero regular budget,reliance on extra-budgetary resourcesNational level-lack of technical capacity; gender desks very patchy coverage;lack of technical tools.eg $USD5.2m earmarked for emerging diseases.$170k earmarked for gender but MS does not know how to use money

- **SEARO**

Lack of Policy directives- No dedicated efforts To promote gender in the system
Lack of resources- Lack of capacity- difficulty in reaching out To affected populations
Limited human resources-No dedicated resources
Limited resources- No clear Policy directives
No capacity.
No focus in such areas
WHO POA is still largely dependent and directed by priorities of Memeber States.
non Availability of age and sex disaggregated data for many variables at national level.

- **AFRO**

Budgetry constraints at both region and sub-region; Orientation and training on gender lacking; Lack of human resources at country level
Difficulty to identify suitably qualified women candidates
Gender inequalities not taken into account because we are servicing community members equally
Gender perspective not articulated in the workplan so it is addressed only as implied and ad hoc; Limited human resources - one person for the whole region as gender advoisor is
Human Resource c, technical and financialapacity for assessing inequalities is lacking; Lack of awareness; challenge to match focus oof unit with focus on inequalities as we assume these inequalities belong elsewhere
Human and financial resources limited
Lack of adequate disaggregated data
Lack of disaggregated data; Lack of human resources trained in gender awareness
Lack of funds
Lack of human resources dealing with gender; awareness about importance of gender equality lacking; not considered in planning
Lack of sex disaggregated data
No explicit plan to address inequalities
Not considered as part of this department's area of work because of fragmentation; low awareness; Low numbers of women staff, far fewer women than men
Scarcity of human resource capacity, funding; Lack of collaboration between units and at country level; lack of data; weak systems
These issues were dealt with not specifically but as part of general approach
integration of sensitivity to inequalities between men and women in the different areas; finance - plan had budget but sometimes no actual funding
none
none as no effort made

- **EMRO**

1) Evidence & tools; 2) Lack of human resources; there are almost no or very few people skilled in this area, especially at country level. 3) Financial resources
1) Identifying the real causes of inequalities. 2) Identifying the effective actions to address inequalities.
1) Lack of political commitment; 2) Traditional and wrong beliefs at both the community and policy making level; 3) Severe poverty & complex emergencies; 4) Inadequate community leadership/ownership; 5) Inefficiencies of the health care system in relation to accessibility, efficiency, sustainability & accountability; 6) Low literacy rate & awareness on health particularly among female; 7) Inadequate coordination between major stakeholders and donors; 8) Insufficient resources (human, financial); 9) Lack of reliable/ consistent data and weak monitoring, supervision & information system, including lack of SDD; 10) Lack of essential health system research.
1) Main challenge is that WHO forgot about women during the last biennium. The department of Women, Gender and Health in Geneva changed its name and the word "women" vanished. Because my unit is named Women and Reproductive Health, I lost the TA and funds. Now this support is diverted and goes only to Gender Health and Development without specific attention to women's health. People can argue about this, but for my department losing the word "women" has had real budget implications. And we have lost the ability to design results (OWERs, RERs, and OSERs) for women's health. This is a great problem for us. 2) The issues related to gender, and inequalities between men and women need to be addressed at the national level where we face many cultural sensitivities concerning this issue. Issues can be easily misunderstood.
1) The WHO monitoring and assessment tools are not gender sensitive enough. 2) In countries like Saudi Arabia, in drafting the Country Cooperation Strategies WHO staff cannot express the gender issues in the language as they would like. [same as 19] 3) The basic challenge is to make others understand what we are talking about. We have to make the concept of gender clear to staff before it can be incorporated into their work. If we deliver the right message, and then staff can understand it in their own language. The application of gender mainstreaming is different for administrators, for logisticians and for the various medical professionals. 4) Staff have to be equipped to utilize information about gender in their planning. Necessary tools. Example, staff are using the WHO system; this system should be set up to help planners to address inequalities between men and women. For example, a reminder message could be set up: "Have you addressed differences between women and men?" It's a simple thing. 5
1) we are deficient in human resources at both regional, but especially country level. It has improved in 2008/09. 2) Despite the enabling environment resulting from the recent major reports and resolutions, when we consider the distribution of resource allocations, it does not match the burden of disease distribution of some of these conditions related to gender. In addition, public sector funds frequently follow the pattern of WHO funding distribution patterns, therefore, the lack of funds at WHO is mirrored at the country level.
In the countries where we operate (such as Pakistan), the poor security situation and cultural issues related to gender combine to make implementation difficult. For example, in Pakistan the EPI strategy for very remote areas is based on mobile teams which travel 2-3 days away from home to provide vaccination services. Male members of the mobile teams are not allowed to enter the house to vaccinate the women. And we cannot hire local female vaccinators because they are not allowed to travel for 2-3 days away from home as required. So we have difficulties vaccinating women and the children too.
Lack of awareness and lack of resources.
Lack of funds and human resources
Lack of resources -- time, human resources, and financial resources. It's a competition for resources, and to make progress in this area we have to give priority to this work in addition to all the other issues.
Limited funds and lack of human resources. Integrating gender increases the amount of work, so you need more people. Generic programs, ones that fit all groups, are a tendency if you are limited in funds. We do some activities directed to mothers, but women should not only be considered as mothers. We need to expand our focus beyond mothers.
None. It's not discussed if it's not included directly in staff work plans.
The main challenge is that in this region in terms of AIDs there are so many basics to be addressed, such as a clean blood supply, etc. The priority now is to put the basics in place. The one exception for gender integration is in testing and counseling because this is very obvious. For treatment, there may also be a need to integrate gender, but we haven't addressed it yet. It is coming up now that experience in service delivery is increasing.
We collaborate a lot with the gender unit; but we need human resources within the department to incorporate gender throughout the work of the department.

- **EURO**

1) Lack of SDD data. 2) Competition of topics. If the organization made a commitment to address gender both implicitly and explicitly in all its activities and products, this would be a help. For example, if you publish a report on a topic, gender should be one of the aspects that is addressed for any health related topic, like risk factors and social determinants.
1) The GFP was not always a full-time position. 2) Not all program managers know how to translate gender into action across OWERS. 3) Interest is not always high and we have to work to maintain it. 4) Uneven interest and progress across countries. Some countries have made good progress and others less so. There are some good examples, but it requires a lot of investment to maintain a high profile for gender.
1) The amount of resources is not adequate. 2) We are too few people for so much work.
1) The work plan did not address gender inequalities. 2) When I took the position, the work plan was already developed and half of the biennium was already gone so I was so busy just implementing my work plan. There was no time and resources to address extra issues like gender.
1) There were not major challenges. 2) Our external consultant, who is a well-respect researcher and recognized throughout Central Asia in gender rights area, does not speak English. I speak Russian, but the GFP does not and the language was a big challenge for conducting joint activities. But we managed. 3) One other challenge was to convince Margaret Chan to write an editorial in our magazine, Entre Nous (on sexual and reproductive health). She's such a busy person, it was very challenging to convince her to make the time to write this piece for us.
1) We need to have more information; the data is still very weak. There's not much active research in my technical area with regard to gender. 2) At the national level, the counterparts tend to be male. In my experience, the gender of the national counterparts had impact on the implementation of our work plans. Women staff tended to be harder working, more motivated, and more responsive than their male counterparts. Maybe that's because I'm a female and we try to support each other.
After the member states agreed that it's a priority, we prepared and presented a paper on gender-specific findings related to the environment and outlining recommendations. At that point they realized what were asking them to do, and how much work it required, and they said that they are not ready for it yet. They realized that it would be extremely difficult to operationalize, and they felt they lack the human resources and funds for it. It's a challenge to keep gender inequalities as a priority on the agenda of the member states. Some countries, especially the eastern countries and some of the Balkans states, have very basic priorities, so gender and the environment is very low on their list. They don't realize it should be part of their daily work, and they think of gender as an expensive specialization. In a place like Sweden, its part of what they do.
Gender was not been explicitly considered or formulated or included. I can't tell you the answer, because no one asked this question before. I'd need to investigate this answer, talk to partners and others who have done work on men's and women's health.
I don't know.
It is difficult to answer a question about implementation. When it comes to OSERS and expected results you wouldn't find gender, but we do address it in our work. It is standard for us to collect and report data that is sex disaggregated, but our activities such as surveillance, or monitoring child growth standards are not targeting one gender group over the other. Women are often more vulnerable groups, but our activities don't specify women as targets. We don't forget the men. In our objectives we are working at a higher, more general level. It's only at the micro level that target groups like women can be specified, and we cannot define down to the micro level in our projects. If we found striking differences between genders, we would advise the government that they need to address these disparities, but you wouldn't find that in our work plan.
Lack of resources. I only have 2 staff and such a big work plan, so some of these specific challenges just get drowned. It's a matter of competition of priority areas. There are so many demands that you cannot tackle all of them.
One difficulty that is not often mentioned is the lack of priority given to gender at the country level, especially the ministries in Eastern Europe. When developing the cooperative plan, we ask countries what their priorities are. Gender issue does not come up as a priority. They are not against it, but it's not a stated priority. When we propose developing information systems for monitoring consumption of medicines, we propose that the data is disaggregated by sex. Designing a system that provides SDD is an easy thing to do, but it's generally not recognized as a priority. Regarding the political awareness of gender issues, there is room to improve.
The main challenge is the lack of political momentum and commitment on the ministry side. Very often the issue of gender issue is not a top priority for governments, and I don't see many gender health policies developed. In the organization we have one staff working 75% of the time; that's an indicator of how much priority the issue is given by member states.
WHO has tools, for example, a gender audit, to measure whether health services are gender sensitive, but these tools should be totally integrated into the work that we do. It's not effective to approach gender as a special project; it should be included as a component of health care quality with other components we normally assess. If staff can continue to do their same work, this is more effective.
We didn't build it into our planning, so there were no activities to carry out.

- **Headquarters**

1) No challenges. 2) Well, let me add that there is a difficulty in translating the term “gender” in English into Bulgarian. There is no equivalent term in Bulgarian. It is generally translated as “equality between men and women.” Although there is a history of valuing gender equality, it’s more difficult to explain the specific term “gender” in our language. This makes it somewhat difficult to communicate the international program related to gender.
Distracted by other priorities.Unless gender issue is of importance to someone it will not be addressed
Gender sensitivity is not widespread. This is a pending task--Facing cultural norms regarding women's role in society--Women's groups are not active concerning women's health issues other than Gender-Based Violence
Gender sensitization of human resources--Knowledge on HOW TO integrate gender--Difficulties associated with a learning process, better established for the 08-09 biennium --Need to build capacity among ALL staff (very important)
Human Resources scare; Financial resources constraints in partnerships; People refuse concepts of gender - there is need to clarify that it is not just activism;
I think one of the things is that we don’t have concrete products from WHO to add to the work on gender. Aside from this study on women’s health which we accessed, we don’t have enough tools or capacity. The country itself is quite advanced in this area, so it is very hard for us to lead in this area.
In most cases food bourne diseases will afect males and females, the exception is perhaps hysteria affecting pregnant women.
Ineffective Regional program- No clear guidance
Lack of financial resources, plans cannot be fully implemented without the funds
Lack of funds
Lack of resources, lack of specificity, lack of ideas in gender department
Lack of time and funds,
Limitation in resources (human and finances)- Difficult To reach
Limited resources - Lack of human resource- political transition and change in the system.
No challenges
No challenges, not operational
No focus in terms of promoting gender- No Support in terms of dedicated human resource.
No real challenges, once products produced, but this creates a challenge for the Ministry of Health to address violence in the work place, discrimination, and how to address and make changes. The problem is moving from policy to implementation.
None
On the research side, having appropriate gender balance to work on projects it is difficult to identifywomen to be on committees who are qualified to do the work. There has been an effort to promote womenNeed to have good meaningful indicators.
Permission to vaccinate kidsWeaknesses in capacity to address issues, it is largely the partnersiph between UNICEF and WHO that addresses issues and there is the dependency on how well the communication is between the two in different countries.Under vaccination of people leads to the carry on of the disease.
Political commitment is high, but the level of understanding among mid-level managers in the ministry of health is low.
Regular budget very small-competing priorities SO 7 gets left out-have to chase extra-budgetary fundingUnderstaffing
Same as above
Scaling up of work, lack of technical capacity, planning for country level work and its challenges
The Department of GWH is under staffed, overwhelmed and not able to provide much technical support. There has not been any Director since May 2006. There seems to be a lack of capacity as to how gender mainstreaming is institutionalized. It is incorrect to think that one size fits all Departments in coming up with a gender strategy what is needed is a strategy that allows for diversity.
The funding quotaHow best to address gender at the national level given the existing realities on the ground.No one specifically working on gender issues.There are some products that indirectly address inequalites.Looking at the OSERs it is not readily apparent that we are doing anything to address inequalities but we are.We have tried to mainstream and worked with GWH.No products specifically addressing inequalities.
There has been no specific direction given beyond the guidelines to put gender into work.Whether PRP should play a more systematic role is open for discussion.
This question presupposes a certain modus of operation - instead of the focus being on the issues that have men and women in them, the question makes having men and women more important than the issue we are trying to address. In our work adolescent boys and girls are not always unequal because of the dependence on maturity. The language of this question is not necessarily right for all departments.
TimeHuman resourcescommitment
lack of good practice examples
lack of practical planning tools developed with help of gender experts.There are no shortcuts to gender mainstreaming;we don't have monitoring tools for gender analysis;country level technical competence;need for country level capacity building
lack of resources
nothing to report
same as above
the public health Subsystem is fragmented, and so are their Information system and interventions. this fragmentation constitutes a difficulty for achieving integrated and comprehensive interventions.

Table 20. What factors helped in the implementation of the 2006-2007 biennial work plans in terms of addressing inequalities between women and men? (Question 27)

- **AMRO/PAHO**

Availability of human and financial resources-Support of progressive donors-Exposure of staff To positive practices or experiences in the countries. Exposure To statistical data is important but it is far from enough. You need the roundnes and the emotion
Collaborative work with the Gender Unit
Country PWR Support even in the absence of gender focal points-Pressure from the Inter American and the UN Systems
Decision-makers commited to gender equality
Does not know. He was not working with PAHO at that time
Don't know
Donor pressure
None (3 participants)
Policy-- enough senior women that will make harder not To align To directives-- Director leading by example
Regional Director's support- Good working relationships with PAHO Gender team
To have a full-fledged project on gender and national accounts- To have GE as a partner in the project- To have financial resources obtained from related projects- Leadership of Unit's coordinators that gave seed money to the development of this project
To have had a gender expert in the larger organizational area with whom consulting
clarity regarding what is possible To accomplish: knowing that gender-sensitive actions can make a difference is a motivation, an incentive for action. --Exchange and collaboration with the gender Unit
collaboration by the gender Unit-- Very gender-conscious professionals within the area
good relationship with the gender Unit-- Willingness of People To integrate gender if They only knew how
the US Center for Disease Control (CDC) organized an international Conference on gender and Communicable Diseases in which the Director participated, lending visibility and attracting interest To the subject-- Donor Support, by having the theme as a prio

- **WPRO**

Existence of WPRO Poverty Gender and Human rights position which is not part of reproductive health.Good working relationships and influence ,very nascent demand for technical support
HQ gender and technical publications eg gender and violence;indoor air pollution and women
RD commitmentShame game -the fact that comparative data by region is published by WHO
additional resources for gender in WPRO
better understanding of epidemic leads to gender analysis;regional framework
external donors;fundraising
high level of commitment eg hiring recruitment policyNeed for greater focus on gener aspects of program delivery
monitoring frameworks advocate that countries collect SDD
recognition that gender analysis applies to women and mencase by case analysis
recruitment of female fixed term P staff
some access to specific guidance on gender aspects
the countries with strong integrationextra resources at WPRO for gender
translation of workshop materialtraining modules developed so far
use of international networks to find employment for spouses in region

- **SEARO**

Increasing awareness about rights in general and it's impact in terms of larger acceptance of health and rights.
NA (5 participants)

- **AFRO**

Existence of evidence of inequalities between men and women in epidemics in Africa; Accessibility of care and treatment; Good collaborations between unit, division and DRH especially GWH unit/ focal person, and partners e.g. Global Fund; More countries wi
Focus on gender difference was important already then although not as focused as 2008/2009 planning and implementation processes
Gender and women health was an area of work in the division; Collaboration with partners including other divisions and agencies
Move by WHO to develop strategy raised awareness; reminder constantly by governing bodies for WHO to improve on addressing gender inequalities; Colleagues play active roles in raising awareness
Orientation of Reginal Director to insist on including at least one woman per 3 shortlisted candidatesDG Directive on gender equality
Partnerships; bilateral funding; Development of some guidelines; Human resource capacity in unit and with counterparts in SRH
Priority on malaria for use of infecticide to service pregnant women
Recruitment of inter-country team staff
Reports from countries that were aware of inequalities, which pushed us (the unit) to consider that aspect; Collaborations at country level
Some resources spent on orientation on adolescent health; some countries are aware of these inequalities
Willingness of staff, unit manager, AFRO management
none (9 participants)

- **EMRO**

1) A much better and more receptive political atmosphere resulting from the recent major reports and resolutions gave us the leverage to act. In fact, countries were approaching us to request assistance. 2) Recent increasing awareness of gender disparit
1) Determination. It was an EMRO initiative to sensitize the planning package; this idea did not come from the Secretariat. And because we have so many challenging deadlines to meet, we had to be very determined. 2) I had the support of my management.
1) Quantitative data (detailed data disaggregated by sex and age) on inequalities between women and men. 2) Donor and country office support.
1) The concept of social determinants of health has helped us to conceptualize gender in relation to programming and created awareness among ministries. 2) The awareness population growth as a health concern. 3) The burden of disease.
1. His unit's awareness of gender issues & the relevance of gender to the unit's work. His programs are very sensitive to gender. 2. The regional gender unit.
Available resources (funds and staff time), increased awareness, better utilization of tools and skills. Political will to do the work. A shared belief among the staff in my unit in addressing gender.
Good informed managers and policy makers
Have a group of dedicated colleagues in NGOs and universities. We have hired some of these colleagues through an APW to produce work plan products.
I'm not sure there were any.
None
None. It's not discussed if it's not included directly in staff work plans.
There are few helping factors. 1) The main factor is the technical and financial support provided by Gender and Rights unit under the Reproductive Health and Research in Geneva. 2) At the national level, developing a new strategy for GHD was considered
There is no major objection within the WHO regional office, or within the country offices to address the issues of gender. Because it is generally accepted, it is not difficult to integrate it and use the funds for this work.
Working collaboratively within my own division brings everyone on board. My own professional background as a gender trainer earlier in my career.

- **EURO**

1) Close collaboration with GFP was crucial. This allowed us to integrate gender from the beginning of the planning and implementation process and not add it in at the end of the process. We had questions about how to do it in the best way, and with the
1) I don't know. 2) SDD.
1) The GFP 2) The collection, documentation and dissemination of examples that demonstrate the relevance of gender in delivering high quality health services, in reducing health inequities, and in reducing health care costs.
1) The fact that there is a commitment in our work plans on equity issues. We had specific products we have to deliver. In the current biennium there's less emphasis on equity issues even though there's less emphasis than previously. Now it's streamlin
1) The insistence of the lead country of Sweden, who kept bringing it up over and over again at every opportunity, and inserting it into the language. 2) Internally, it was for us Dr Chan's request and mandate. Without Dr Chan's message, we might have g
1) We had some good SDD data readily accessible. Because of our technical knowledge, we were aware of the importance of discussing these issues. 2) Even though resources are limited, where there are issues where it is very clear, we are able to say some
Gender was not been explicitly considered or formulated or included. I can't tell you the answer, because no one asked this question before. I'd need to investigate this answer, talk to partners and others who have done work on men's and women's health.
I do not know.
I don't know.
None.
Not applicable. We didn't build it into our planning, so there were no activities to carry out.
Putting forward this issue among colleagues in a variety of forums and during operational planning. The more opportunities we have to discuss this and present evidence the more progress we make. WHO strategy 2007 has bee a useful instrument in increasin
There is a growing interest in gender issues and this is reflected in a growing number of inquiries concerning gender and requests for SDD.
There's a trickle down effect. We're dealing with health care system reforms on a very large scale, and when we make some higher level changes, that should affect some of these specific challenges, such as gender. One recent example: We began the proces
Within the program we are aware of its importance, and we've identified some specific activities in which we can incorporate gender. For example, in our work with countries to develop therapeutic guidelines, we ensure that they include specific issues re

- **Headquarters**

1) The Gender program supported the country with technical assistance to develop a reproductive health strategy covering 2006-2010. 2) A good set of national experts.
1) The high level of understanding of the national authorities of the needs of the different population groups, 2) The availability of SDD which makes gender differences clearly visible.
Although there are not visible fruits yet, these factors were: -- Internally, working with a lyfe cycle approach .-- In general, the collaboration with the Ministry of Women regarding a Plan of Action for the development and empowerment of women-- In gene
Appointmnet of junior professional on Human Rights including Gender
Awareness helps
Champions
Commitment at highest level of Govt.- Close collaboration betweeen WHO and the health Sector
Commitment at the highest level of Govt.- Close collaboration between health and WHO
Commitment if Ministry of Health to address gender inequalities; Strong women's organisations in the contry and their role in ensuring that gender inequalities are addressed
DG's gender strategyFeedback from the field which helps to see the utility of the gender strategy.
Data on vaccination rates, the probability of people being takent to vaccination centres.
Good coordination within the departmentGWH contributed to CCO
Good funding support
Having a PAHO national gender focal point-- Support from PAHO HQ/Gender Unit-- UN interagency collaboration on gender-- Partners outside UN, in the Public Sector, such as the Women's Affairs Ministry-- International Cooperation Agencies, such as the Sw
Having gender awareness helps but it would be more helpful to have greater equity on the committees. as having a gender policy alone is not sufficient.
In HIV/AIDS pressure from external consultants has led to a response.
In the work that they do they have to consistently look at the affects on men and women
Ministry of HealthFRIENDS group on Domestic Violence
NA (2 participants)
No factors that helped
None (3 participants)
Partnerships with in agencies and government sectors--resources mobilized for safe motherhood issues and around these, education, Information and empowerment of young girls before pregnancy
Presence of PartnersLong time relations with consultantsGWHRaising awareness, conference of partners interested in raising awarenessActive engagement
Reminder from DG speechesHealth workers to bring in a gender consciousnessBulletins, Directives, at the HQ level management has to be conscious as to how information is filtered down to the regional and country level.
Same as other facilitating factors.
Sensitivity
The UN Special Rapporter outside of WHO presence, and reporting in leading journals like the LancetNGOs
This comes more broadly in the issue of equity. Here there are policies, and a ministry for women, and NGOs who are active on this issue. Others are taking the leadership in the area of gender. We don't have the technical capacity or the resources. In
awareness of issue in WHO UN and society in general;UN bilateral partners;donor agencies
extra budgetary fundscommitment of staff in country
nothing
nothing to report
same as above (2 participants)

Table 21. Level of Gender Integration In Programme Monitoring and Evaluation: Overall for all Regions

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]			Some or Moderate Level of Gender Integration[2]			Strong Level of Gender Integration[3]		
		n	%	95% CI	n	%	95% CI	n	%	95% CI
All WHO Staff	127*	87	68.5	59.7 - 76.5	38	29.9	22.1 - 38.7	2	1.6	0.2 - 5.6
By Sex										
Female Staff	45	29	64.4	48.8 - 78.1	16	35.6	21.9 - 51.2	0	0.0	--
Male Staff	82	58	70.7	59.7 - 80.3	22	26.8	17.6 - 37.8	2	2.4	0.3 - 8.5
p-value		0.3670								
By Grade										
D	30	17	56.7	37.4 - 74.5	13	43.3	25.5 - 62.6	0	0.0	--
P	96	7	72.9	62.9 - 81.5	24	25.0	16.7 - 34.9	2	2.1	0.3 - 7.3
G	1	0	0.0	--	1	100.0	2.5 - 100.0	0	0.0	--
p-value[4]		0.1278								
By WHO Level										
Headquarters	21	14	66.7	43.0 - 85.4	7	33.3	14.6 - 57.0	0	0.0	--
Regional Office	90	62	68.9	58.3 - 78.2	26	28.9	19.8 - 39.4	2	2.2	0.3 - 7.8
Country Offices	16	11	68.8	41.3 - 89.0	5	31.3	11.0 - 58.7	0	0.0	--
p-value		0.9161								
By WHO Region										
AMRO/PAHO	16	13	81.3	54.4 - 96.0	3	18.7	4.1 - 45.7	0	0.0	--
WPRO	18	6	33.3	13.3 - 59.0	11	61.1	35.8 - 82.7	1	5.6	0.1 - 27.3
SAERO	8	8	100.0	63.1 - 100.0	0	0.0	--	0	0.0	--
AFRO	19	14	73.7	48.8 - 90.9	5	26.3	9.2 - 51.2	0	0.0	--
EMRO	14	9	64.3	35.1 - 87.2	4	28.6	8.4 - 58.1	1	7.1	0.2 - 33.9
EURO	15	12	80.0	51.9 - 95.7	3	20.0	4.3 - 48.1	0	0.0	--
Headquarters	37	25	67.6	52.0 - 82.0	12	32.4	18.0 - 49.8	0	0.0	--
p-value		0.0529								
By Collaboration with GWHN										
Yes	67	39	58.2	45.5 - 70.2	26	38.8	27.1 - 51.5	2	3.0	0.4 - 10.4
No / Don't Know	60	48	80.0	67.7 - 89.2	12	20.0	10.8 - 32.3	0	0.0	--
p-value		0.0210								

[1] Score of 0-8 on questions 28 to 33
[2] Score of 9-18 on questions 28 to 33
[3] Score of 19-25 on questions 28 to 3
[4] p-value excluding "G"
* 4 participants with missing values (don't know in question 28-29)

Table 22. Level of Gender Integration In Programme Monitoring and Evaluation: AMRO/PAHO

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All AMRO/PAHO Staff	16	13	81.3	3	18.7	0	0.0
By Sex							
Female Staff	5	2	40.0	3	60.0	0	0.0
Male Staff	11	11	100.0	0	0.0	0	0.0
By Grade							
D	4	2	50.0	2	50.0	0	0.0
P	12	11	91.7	1	8.3	0	0.0
By Collaboration with GWHN							
Yes	10	8	80.0	2	20.0	0	0.0
No / Don't Know	6	5	83.3	1	16.7	0	0.0

Table 23. Level of Gender Integration In Programme Monitoring and Evaluation: WPRO

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All WPRO Staff	18	6	33.3	11	61.1	1	5.6
By Sex							
Female Staff	5	2	40.0	3	60.0	0	0.0
Male Staff	13	4	30.8	8	61.5	1	7.7
By Grade							
D	4	1	25.0	3	75.0	0	0.0
P	14	5	35.7	8	57.1	1	7.1
By Collaboration with GWHN							
Yes	9	4	44.4	5	55.6	0	0.0
No / Don't Know	9	2	22.2	6	66.7	1	11.1

Table 24. Level of Gender Integration In Programme Monitoring and Evaluation: SEARO

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All SEARO Staff	8	8	100.0	0	0.0	0	0.0
By Sex							
Female Staff	2	2	100.0	0	0.0	0	0.0
Male Staff	6	6	100.0	0	0.0	0	0.0
By Grade							
D	0	0	0.0	0	0.0	0	0.0
P	8	8	100.0	0	0.0	0	0.0
By Collaboration with GWHN							
Yes	1	1	100.0	0	0.0	0	0.0
No / Don't Know	7	7	100.0	0	0.0	0	0.0

Table 25. Level of Gender Integration In Programme Monitoring and Evaluation: AFRO

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All AFRO Staff	19	14	73.7	5	26.3	0	0.0
By Sex							
Female Staff	5	2	40.0	3	60.0	0	0.0
Male Staff	14	12	85.7	2	14.3	0	0.0
By Grade							
D	4	3	75.0	1	25.0	0	0.0
P	15	11	73.3	4	26.7	0	0.0
By Collaboration with GWHN							
Yes	7	3	42.9	4	57.1	0	0.0
No / Don't Know	12	11	91.7	1	8.3	0	0.0

Table 26. Level of Gender Integration In Programme Monitoring and Evaluation: EMRO

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All EMRO Staff	14	9	64.3	4	28.6	1	7.1
By Sex							
Female Staff	4	3	75.0	1	25.0	0	0.0
Male Staff	10	6	60.0	3	30.0	1	10.0
By Grade							
D	1	0	0.0	1	100.0	0	0.0
P	13	9	69.2	3	23.1	1	7.7
By Collaboration with GWHN							
Yes	8	5	62.5	2	25.0	1	12.5
No / Don't Know	6	4	66.7	2	33.3	0	0.0

Table 27. Level of Gender Integration In Programme Monitoring and Evaluation: EURO

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All EURO Staff	15	12	80.0	3	20.0	0	0.0
By Sex							
Female Staff	9	7	77.8	2	22.2	0	0.0
Male Staff	6	5	83.3	1	16.7	0	0.0
By Grade							
D	1	1	100.0	0	0.0	0	0.0
P	14	11	78.6	3	21.4	0	0.0
By Collaboration with GWHN							
Yes	7	4	57.1	3	42.9	0	0.0
No / Don't Know	8	8	100.0	0	0.0	0	0.0

Table 28. Level of Gender Integration In Programme Monitoring and Evaluation: Headquarters

Level of Gender Integration in Programme Monitoring and Evaluation	N	None or Weak Level of Gender Integration[1]		Some or Moderate Level of Gender Integration[2]		Strong Level of Gender Integration[3]	
		n	%	n	%	n	%
All Headquarters Staff	37	25	67.6	12	32.4	0	0.0
By Sex							
Female Staff	15	11	73.3	4	26.7	0	0.0
Male Staff	22	14	63.6	8	36.4	0	0.0
By Grade							
D	16	10	62.5	6	37.5	0	0.0
P	20	15	75.0	5	25.0	0	0.0
G	1	0	0.0	1	100.0	0	0.0
By Collaboration with GWHN							
Yes	25	16	64.0	9	36.0	0	0.0
No / Don't Know	12	9	75.0	3	25.0	0	0.0

Table 29. Challenges to gender integration in programme monitoring and evaluation (Question 34)

- **AMRO/PAHO**

Addressing gender inequalities was not an evaluation criteria
Does not know. He was not working with PAHO at that time
Gender equality was not incorporated in planning, hence it was not part of the monitoring process
Information--Sensitization
It was not a priority theme in programming, hence not object of evaluation.The corporate process of evaluation was not designed with that purpose in consideration.
It was not an evaluation criterion
Lack of a technical team in the area to address the subject
Lack of gender tools and Criteria--work plan elaborated too soon after the gender Policy approval. not enough time To digest it.
Lack of information & evidence on the relation of gender and specific problems (Gender as determinant)-- Tools are needed--
Lack of proper evaluation tools, in general--gender was not integrated in evaluation tools --Weak capacity for monitoring and evaluation, in general
None of the technical units responsible" for the six mainstreaming themes, gender equality among them have not contributed with criteria for design and evaluation. Since there were not gender indicators and criteria for planning there were not either in
Not understanding the nature of objectives related to gender equity- Not understanding this work in the context of PAHO's mission- Not having relevant information disaggregated by sex
There was not a formal gendered evaluation
There were no gender criteria for the evaluation
There were not gender-related criteria in the evaluation
This was not a planning criterion
data was not collected in a way that allows To see many relevant aspects, for instance, fields of work, score cards for Managers, change of attitudes toward women
the evaluation framework was too general: gender-specific indicators were lacking

- **WPRO**

Can't really test own programme effectiveness on gender because indicators do not capture genderCurrent workplan does not include activities that can be monitored for gender
Mixed quality of data sent by MS for use in evaluations lack of data
More cases of male neonatal tetanus reported than female cases, so that it is suspected that some female cases were missed or not detected. GA needed on why fewer girls.Difficult to get resources to follow through on anecdotal evidence of disparitylack
PMDS is not designed to encourage gender analysis eg targets.Assumption when you are recruited that you can do WHO planning and monitoring is wrongNo systematic way of ensuring people here have training.No tools to help people learn to do planning and
as per planning and implementation
high level gender sensitive program indicators need to be developed;donor agency requirements can be a faciliatating factor but capacity for gender analysis needs to be strengthened via WHO internal culture;should be more than a tick box" attitude and res
lack of agreed set of gender sensitive indicatorsPaucity of SDDlack of consistency amongst regions in terms of organisational arrangementseg gender focal points location/level of resourcing
lack of funds to monitor progressno finalised set of gender sensitive indicators to use
local climate ,difficult to find employment for spouses affects women taking up posns ,
no data,no awareness,no institutional culture,blinding indifference eg Planning system enables GM to be integrated but this is not taken up adequately.Opportunity presesented by mid term review not taken up.lack of technical tools.
similar to planning and implementation
some specific issues require gender analysis
staff time;resources
under resourcing to gather information

- **SEARO**

Lack of Policy directives
Lack of Policy directives- No dedicated efforts To promote gender in the system
Lack of capacity and focus.- not clearly defined programme indicators
Lack of capacity.
Lack of clear directives.-Lack of capacity.
Lack of directives- Lack of resources-No clear understanding
Limited resources- No clear Policy directives
non-Availability of data in HMIS in countries which is age and sex disaggregated.

- **AFRO**

Continuing to ensure that data includes gender; scarcity of appropriate tools
Difficult to get data; Lack of indicators that cut across from country to region and lack of coherence thereof; Weakness of monitoring system itself
Have only one woman in the division; no relevant indicators
Lack of disaggregated data ; Lack of collaboration; Planning only within unit and division and not jointly with others
Lack of support; lack of evidence based tooolss and indicators
Lack of tools, capacity and methodologies
No specific planning to address inequalities
None
There was no specific obligation or focus at the beginning of the biennium on inequalities between women and men; underfunded SO 7
Tools not designed to monitor inequalities between wmen and men
Tools not specificOrganisation has not been looking at these issues in this way
Was not in work plan
never thought of
none (6 participants)
workplan not geared towards addressing inequalities between men and women

- **EMRO**

1) Currently, the monitoring of programs and the monitoring of our own organizational culture are not sufficient for addressing either gender issues within the organization or in the populations that we serve. 2) In general, indicators are not gender se
1) Few performance indicators are gender sensitive. 2) Assessment reports (the global assessment from HQ) cannot help staff to extract gender information. 3) There's little analysis to look at gender information that may be found in reports. 4) Most st
1) Identifying the real causes of inequalities. 2) Identifying the effective actions to address inequalities In our case concerning the higher rates of TB among women over men in Afghanistan, even after our research, we can't find the final answer; this
1) The low degree of ownership by ministry of health staff on this issue. We need to work on that at the country level. 2) The weak capacity at CO level. Everywhere in this region we don't have the capacity to monitor gender, to disaggregate data, and
1) We didn't analyze date in light of inequalities between men and women. There is no awareness of the need to do this analysis. 2) At country level the data is not available to do this analysis; health information systems are not adequate. Proper info
1) We rely on existing national mechanisms to provide data. The data is not provided very frequently and the quality of the data is not adequate. There are a myriad of reasons for this. Sometimes it's not being recorded, or data is not being managed pr
1) When it comes to monitoring and assessment, we (WHO) are not strong enough, we don't have enough capacity to capture aspects of gender mainstreaming in our monitoring and reports. I don't advise adding another layer of reporting to our current mandato
1. No proper planning regarding indicators. 2. Lack of budget and human resources
Country reporting system doesn't provide information on gender. These are complex systems and making changes in them requires increased funds and capacity.
For his work, monitoring and evaluation for impact is scheduled to take place during the next biennium. At this point, he has only been monitoring deliverables. His predictions about what challenges he will encounter when he begins to undertake monitori
Lack of financial support. Funds were available only for training, and we accepted this because we didn't want to sacrifice even those limited resources.
No monitoring related to gender inequalities took place. I don't think we will encounter major obstacles. In the future, we may encounter some cultural barriers to collecting data on certain indicators.
None. There nothing stopping it and nothing promoting it. It's all up to individual initiative.
We didn't have gender specific outcomes of our direct work plan. Our work is to assist countries in developing guidelines and policies and things like that. There's nothing in our work plan for developing women-specific products, for example, women's tr

- **EURO**

1) Definition of indicators has been one big challenge. We had low capacity during the planning phase for this. It was difficult to define accurate, relevant and measurable indicators. It was also difficult to establish baselines, and this makes it ver
1) Gender is discussed, but not incorporated into the work plan. The language of the work plan is very condensed and this prevents us from mentioning gender specifically. It will be difficult to include gender in every product; a better way to do it may
1) Lack of awareness. 2) Lack of requests by WHO at any level. Gender was not specified and singled out. The outcomes of work plan could be made quite easily gender specific, but it's not the way that we look at it. If we wanted to, we could offer it,
1) There are no gender-specific indicators in our area, but being conscious of gender issues, we are working on the data we do have to look for inequalities and to promote collection of SDD at the country level. 2) There's a challenge in monitoring gende
Data is not consistently available.
In most countries SDD is available, but not all. 2) Analyzing data only according male and female. Without data that is stratified both in terms of gender and socioeconomic categories, we are relying only on averages of men and averages of women. I nee
It was not included in the work plan.
It was not required by my supervisor, so it wasn't a challenge. This is the status quo.
Lack of SDD data or non-comparable SDD. We didn't always receive SDD from member states, or the SDD that was available was not comparable because the age categories were not comparable. This is a significant on-going challenge that we have tried to addr
Not having explicitly defined gender in the products and activities of the work plan makes it quite difficult to monitor.
The lack of focus and discussion on this issue.
These questions are not easy. Some of our indicators aren't disaggregated, so we don't see the inequalities between women and men as such, and so we don't know whether we are addressing the issue or not. Looking at the work plan, we did disaggregate by
This is the nature of my unit's work: The level of planning is very high level and too aggregated to address specific issues. It's difficult to specify an issue such as gender. We are helping countries to develop policies, and these policies are genera
We did not plan it and we did not implement activities to address inequalities, so there was no impediment to my monitoring. I'm speculating, but I think there would be resistance to monitoring. [No monitoring took place]To my thinking there are two imp
We never did it, so we couldn't monitor it.

- **Headquarters**

1) No real challenges, except the translation issue. 2) But there are several ways that gender may be included but not visible and this may make monitoring it more difficult. For instance, it may integrated at the activity level, but not included in the
Cannot track changes with the indicators that are not used.There have not been any indicators used over a substantial amount of time.
Deficit of data in previous bienniumHave to move beyond the general-level to tap into women's groups
Distractions, all relative to different issues emerging in emergencies.
Do not do monitoring, work with gender unit only began in 2008
Do not really have gender specific indicators. The focal point deals with examining barriers t having women vaccinated. The recruitment of females to be on a team to address issues, in some countries thare is strong opposition to having women on a team.
Fiancial impediment to implementation
Formulating gender sensitive indicators for other technical SOs e.g. communicable diseases
Ineffective Regional program- No clear guidance
Information is not adequate.- Information system and management requires strengthening
Lack of Information - Lack of qualified human resources.
N/A
Need for tools to check gender mainstreaming throughout
Needed qualified professional who was originally not available; lack of human resources; Lack of financial resources; Late receipt of relevant funds
No big obstacles
No challenges
No focus in terms of promoting gender- No Support in terms of dedicated human resource
No indicators makes it difficult to monitor
No one is asking them to include them.
No time to go into monitoringOffice is told not to growchild adolescent healthnot even permitted to fund raise for, the office is dependent on 63% specified funding while only 15-20% is unspecifiedthey have a 5 year programme that does not leave room to m
None
Nothing
Quality of data
Same as above
Technical strategies.
The challenges already mentioned regarding implementation: social and cultural norms regarding women's role in society-- The gender dimension was not specifically mentioned in the planning stage, neither as a specific theme (except for gender-based viole
We do not monitor necessarily at that level.
We have a problem in monitoring & evaluating our work, because we as WHO are catalytic only, we provide TA only. The nationals are delivering the programs, so there is some ambiguity in evaluating. How can I measure the impact of my input on gender? We
When we go to experts and ask how we can get indicator for gender, it is difficult to pull out. The best response is to be descriptive where indicators tend to be qualitative making the research difficult. It is difficult to pull gender out of the researc
gender was explicitly addressed in certain specific results but No in all --monitoring indicators were too general. There was not specificity regarding gender. They require revision. They should reflect cross-cutting issues.
lack of gender sensitive indicators and monitoring tools
lack of good data on women and men
no awareness unlessasked and prompted.Not consisitently addressed
no monitoring efforts
same challenges as above
the PAHO Planning system (AMPES) does not facilitate this type of evaluation -- the task is not easy for the gender Unit To cross all programs -- it has not been possible To permeate all professionals (staff and consultants) in the Office-- resources are

Table 30. Facilitating factors to gender integration in programme monitoring and evaluation (Question 35)

- **AMRO/PAHO**

Availability of data that permits To identify detailed levels of inequality
Awareness of the association between gender, poverty and discrimination--The MDG framework--Objectives of Health Develoopment--PAHO Gender Equality Policy
Does not know. He was not working with PAHO at that time
It is easy to reduce the mainstreaming strategy to sex-disaggregation. But, to make a difference, training and in-depth knowledge are required
None
None for the work plan 06-07. But an instructive was given for the 08-09 evaluation that includes the consideration of all PAHO six mainstreaming issues, gender equality among them
None this time, In the future, the fact that gender equality will be one of the institutional cross-cutting themes.
The presence of gender conscious- professionals in the area
There was not a formal gendered evaluation

- **WPRO**

It is part of my work.Gender is integrated through whole planning implementation and monitoring cycle.Just some specific issues require gender analysis
Planning WHO paying more attention to M&E e.g MPS
Regional Child Survival 2005 endorsed by member states. 5 yearly coverage indicators are available from participating countries.As well lower level more frequent proxy measures have been developed(eg antibiotics treatment for childhood pneumonia,care seek
SOs emphasis on negelected, underserved, marginalised populations will help achieve equity for women
Staff's broad cultural mix in WPRO boosts equity awarenessAchieving good male/ female balance in staffing taken very seriously in region
The lesson from public health is projects are much more likely to succeed if women in charge of delivering them at the community level.This lesson should be incorporated into WHO policyand promulgated via activity planning templates etc
UN system pressure.Beijing Platform but these are so remote
as per planning and implementation
donor agenciesSOs building awareness and encouraging cultural change
including men in IWD functionsRecruitment of staff procedures requiring inclusion of women candidatesdesign of M&E spreadsheet to gendersupportive organisation culture
new WHO monitoring frameworktools and standards making
similar to planning and implementation
some SDD available but there is room for improvementGWHN and other regions(eg EMRO) and Gender Health Equity Network(UK based)are helpful
supervisors and management support for equal employment opportunity policies
workplan based on SDDevidence base

- **SEARO**

Collaborations with other departments/units e.g. HPE, TFI, NHD, RHR, Mental Health to include age and sex disaggregation of data.
NA (5 participants)

- **AFRO**

Appropriate tools; Fact that activities indlude gender consideration of inequalities
Available data and tools
Dedicated full-time staff; Commited activists - including the gender focal point who was also an activist; Peer review in the division; Rules of WHO require attention to inequalities between women and men; Whole DRH division involved in issues that oblige
Own interest; OWER 1 to 3 directly under me; SO7 though appears underfunded
Peer review process. See Q27
Tradition of disaggregating some of the data
Willingness of staff, unit coordinator, and AFRO management
never thought of
none (12 participants)

- **EMRO**

1) Currently, it depends on the interest of individual staff. The facilitating factor is staff attitude. We need to make it part of all WHO work. 2) When a country expresses a need in the area of gender, that provides an opportunity for us to address i
1) Existing knowledge and awareness. We shouldn't underestimate our staff; there is quite a lot of experience and understanding in certain program areas of the organization. 2) Also, in public health we deal with inequity, our profession has a basis for
1) Giving opportunities for women. 2) Sex disaggregated data is very important and we need to use it at every opportunity. 3) We are improving. The gender focal point has helped.
1) MTSP itself provides an opportunity for more cross-fertilization between programs. The previous planning process tended to encourage vertical programming and silos. The MTSP promotes mutually reinforcing programming. 2) The improved political environ
1. Joint planning with the gender focal point regarding indicators and their analysis.
No facilitating factors.
No monitoring related to gender inequalities took place. Potential facilitating factors include: 1) Proper planning; 2) Orientation of policy makers, mangers, data collectors and community; 3) Timely feedback to the source of information (community); 4)
None
None.
None. There nothing stopping it and nothing promoting it. It's all up to individual initiative.
None. When it's not in your work plans, there no support to monitor gender issues.
Quantitative data (detailed data disaggregated by sex and age) on inequalities between women and men.
The only facilitating factor is if the unit or country office included gender sensitive indicators in their performance plan. I estimate that outside of the SOs explicitly addressing gender, less than 50% of the units or country offices include gender se
We didn't monitor progress in addressing women and men's equalities because, when we provide training or a service, gender is not addressed as a specific outcome although it may be integrated into the work. For example, if we provide training on collecti

- **EURO**

1) Improving awareness among staff. Progress on gender is not easy to measure and we have much more room for improvement. 2) Drafting indicators for internal deliverables was easier than for external deliverables.
1) In fact, we haven't done it explicitly, so it's difficult to monitor it. 2) Potentially, the flexibility of the planning process would facilitate the incorporation of this issue.
1) The availability of reliable data is critical for our organization. 2) Country champions. There are a couple of countries that are moving ahead and making progress and this influences other countries. Ministers of Health always ask if this has been
1) We have data that tells us whether there are inequalities between women and men. 2) It's standard in our technical area for countries to provide SDD; they see the value of that.
1) We were working with a lot of partners that share our understanding of the gender in health issues and its relevance. We are not the only players; we have partners like large NGOs and other UN agencies, and this greatly facilitated our progress becaus
General awareness of the issue. One next step could be for WHO to raise the awareness with countries during planning, and incorporate it into the BCAs. If it's not in the BCAs it's not likely to happen.
It was not included in the work plan. Margaret Chan's speech stimulated me to think about this, and the memo from the Deputy Regional Director, and my contact with the GFP. Before that I was not thinking about gender inequalities. I considered gender a
No incentives or facilitating factors. During planning, gender sensitive indicators were not agreed upon and included in the work plan, so there were no facilitating factors for measurement.
None. (3 participants)
Not applicable.
We did not plan it and we did not implement activities to address inequalities, so there was no impediment to my monitoring. [no monitoring took place]
We never did it, so we couldn't monitor it.
When SDD data is available it allows us to demonstrate the difference between men and women in relation to health and health care.

- **Headquarters**

1) The high level of understanding of the national authorities of the needs of the different population groups, 2) The availability of SDD which makes gender differences clearly visible.
Address the gender staff balance, the Strategy Department in the context of the work it does, does not apply to the work plan.
At country level working with other UN agencies where others push integration of gender
Champions make all the difference.
Close relationship between Ministry of health and WHO
Commitment of staff to the issue
Gender awareness, knowing that it is important to give consideration. On the ground institutional support.
Gender having been explictly incorporated in some results within the work plan-- The national PAHO gender focal point that is very attentive to these issues-- PAHO staff being gender-sensitized -- Change ocurring towards the inside of PAHO: Gender is r
Gender strategySupervisors who support doing gender
Have not monitored the progress.
Having women on teams leads to greater access to some households in some areas. Gender can be used ad hoc depending on the country in which a problem may exist.Line listed data and being able to collect data makes it easier to identify gender.
Information from partnersCollaboration with external agencies, GWH networkIn some countries the CCS includes both the gender and tobacco concerns.
Joint program of UN; Priorities of the country and of Ministry of Health; working group on gender which includes partners
N/A
NA (2 participants)
No facilitating factors (3 participants)
None (3 participants)
Nothing (2 participants)
Now that indicators are being developed there is hope that they will be able to use them to obtain better information.
PHE staff have tood field experience where inequalties are addressed.There are vulnerable populations which mixes women with other vulnerable groups.
SDD is becoming increasingly common health data collected.
Staff are open minded and receptive.
Support of UN as One UN in addressing gender inequalities; Gender is a priority issue for Eritrea as government, ruling party, Ministry of Health and Social Welfare
Technical factors of products that only benefit one sexHIV/AIDS need to take a gender sensitive approach
UN bilateral partners;donor agencies
UNDAF M&E GroupAnnual workshop organised by UNPositive attitudes to GMMaterials from WPRO and UN system
WHO's own policies and Govt.'s concern about gender issues
We did not do that kind of monitoring to start with that with except the SDD.
We have a UNDP Gender Program which builds the national staff capacity in the government. UN team group on gender, the participation of UN agencies on gender activites. UN joint program on gender.
none
same as above