Gender mainstreaming in WHO: what is next?

REPORT OF THE MIDTERM REVIEW OF WHO GENDER STRATEGY

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Abbreviations

AFR	African Region
AFRO	Regional Office for Africa
AMR	Region of the Americas
AMRO/PAHO	Regional Office for the Americas (Pan American Health Organization)
APOC	African Programme for Onchocerciasis Control
CCS	Country Cooperation Strategy
CO	Country Office
DG	Director-General
EMR	Eastern Mediterranean Region
EMRO	Regional Office for the Eastern Mediterranean
EUR	European Region
EURO	Regional Office for Europe
GA	Gender analysis
GMS	Gender mainstreaming
GSM	Global Management System
GWH	Department of Gender, Women and Health
GWHN	Gender, Women and Health Network
M&E	Monitoring and Evaluation
MTR	Midterm Review
OSER	Office-specific expected results
PMDS	Performance Management Development System
PoA	Plan of Action
RO	Regional office
SD	Strategic direction
SDD	Sex-disaggregated data
SEAR	South-East Asia Region
SEARO	Regional Office for South-East Asia
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNITAID	United Nations International Drug Purchase Facility
UG	Ungraded (post)
WPR	Western Pacific Region
WPRO	Regional Office for the Western Pacific

Executive Summary

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

WHO's Gender Strategy promotes its broader objectives of health equity and gender equality as well as the Millennium Development Goals. The strategy builds on the WHO gender policy adopted by the Secretariat in 2002, and is grounded in various international agreements and commitments on gender equality and health. The WHO Gender Strategy is being implemented through four strategic directions (SD):

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

In 2007, the Gender, Women and Health Network developed a monitoring and evaluation (M&E) framework built on actions and indicators identified in the WHO Plan of Action to support the implementation of the WHO Gender Strategy. Its first step was to conduct in 2008 a Baseline Assessment, followed in 2010 by a Midterm Review (MTR). This report presents the synthesis findings of the Midterm Review that was conducted to determine the progress towards achieving the four strategic directions set out in the Strategy.

Twelve indicators were selected, seven of which were covered in the baseline assessment. These seven indicators were measured using a similar sample size and methodology as in the baseline assessment, allowing for direct comparison with the Baseline Assessment findings.

For the first strategic direction (SD1), MTR examined institution-wide capacity for gender analysis and actions. A web-based questionnaire was sent to key informants in all countries, regions and HQ. It documented efforts to develop capacity through training activities. Given the introduction of the Global Management System (GSM) in four WHO regions, the GSM indicator of gender responsiveness in WHO products and services was used to assess the second strategic direction (SD2). Human resources data from 2009 were analyzed to examine the level of sex parity in staffing, and documents were reviewed to assess whether Country Cooperation Strategies (CCS) integrate gender. The third strategic direction (SD3) was measured by a content review of key WHO publications to determine the extent to which they promote and use sex disaggregated data (SDD) and gender analysis. The last strategic direction (SD4), measuring accountability for gender mainstreaming, was assessed through analyses of senior management speeches, and by a review of WHO resolutions and accountability functions at country and regional office level.

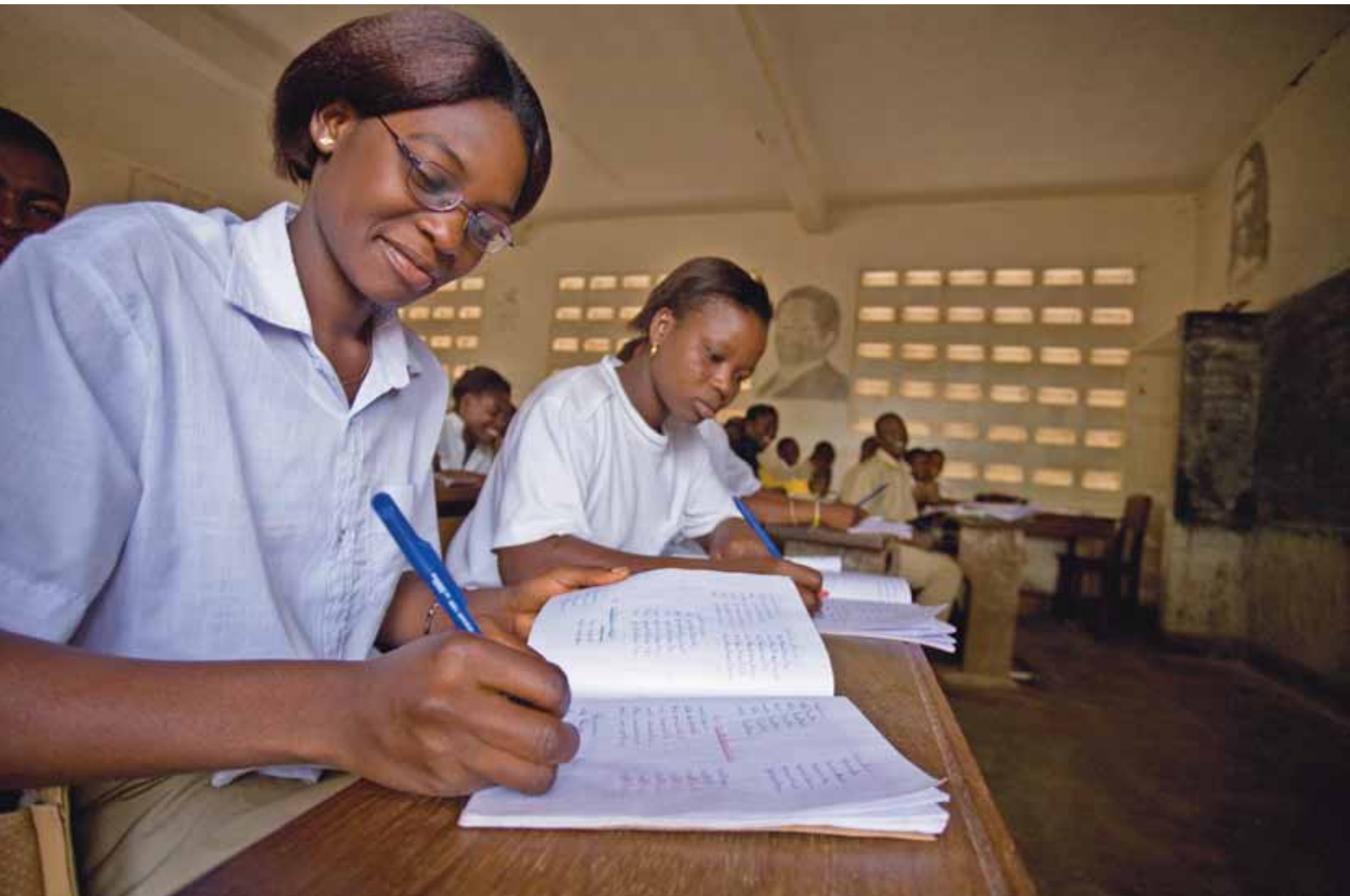
Results indicate little change in gender mainstreaming in WHO since the BA. Key findings are:

- Capacity development efforts have been systematically implemented, but not on the scale required. From Jan 2009 to July 2010, a total of 2675 people from forty-one Member States received training on gender. About one third of the training is for government and one quarter for WHO staff
- With respect to the Gender, Women and Health Network, progress includes an increase in the number of gender focal points in all WHO regions. Currently there are 112 such focal points.

- There was a modest improvement between 2008 and 2010 in the number of Country Cooperation Strategies that integrate gender. While there is a strong focus on maternal health within the Country Cooperation Strategies, gender issues are rarely raised when discussing specific diseases.
- Women continue to be underrepresented at higher professional grade levels.
- Between 25 and 50% of the sampled WHO publications promote or use gender analysis and sex disaggregated data; these show little progress since the baseline assessment in 2008.
- 38% of WHO countries and regional offices have at least one accountability function in place for gender mainstreaming: for example, a country office plan for gender mainstreaming or formal mechanisms for senior managers reporting on gender.

In conclusion, WHO has implemented a far-reaching gender mainstreaming program, but the impact on day-to-day work has been limited. Much of the mainstreaming focus has been on training and network development. This needs to be maintained but should now be supplemented by other strategies. These might include:

- More systematic capacity development, including assessment of capacity as recommended by the United Nations Development Group, in order to ensure that training is organized according to required competencies.
- Improved accountability mechanisms to integrate gender analysis and actions into WHO work.
- Gender Plan of Action targets within each Strategic Direction. These targets should be determined by the Gender, Women and Health Network and relevant WHO regional and country offices and departments.



1. Introduction

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

WHO's Gender Strategy[1] strengthens its pursuit of the broader objectives of health equity and gender equality as well as its work in achieving the Millennium Development Goals. The strategy builds on the WHO gender policy adopted by the Secretariat in 2002 and is grounded in various international agreements and commitments pertaining to gender equality and health.[2]

The goals and objectives of the Strategy are to enhance, expand and institutionalize WHO's capacity to carry out gender analysis and to monitor and address unfair gender-based disparities in health.[3] The primary target audience is WHO managers and staff, for it is they who can ensure that gender equality and health equity are incorporated into WHO guidelines, policies and programmes designed to improve health in Member States. The WHO Medium-term Strategic Plan (2008-2013) reinforces this Gender Strategy by articulating a specific organization-wide expected result, according to which gender analysis and responsive actions will be incorporated into WHO's normative work.

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

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

The entire WHO Secretariat, including headquarters, regional offices and country offices, are responsible for implementing the WHO Gender Strategy. The Gender, Women and Health Network[4] (GWHN) provides technical support.

Integrating Gender Analysis and Actions into the Work of WHO: The Plan of Action (WHO/FCH/GWH/06.2) seeks to integrate gender perspectives into all operational planning and reporting procedures of WHO, thereby strengthening WHO's ability to support Member States in addressing gender issues in health policies and programmes. For each of the four strategic directions of the WHO Strategy, the Plan of Action (PoA) identifies specific actions for integrating gender perspectives into WHO programmes (programmatic mainstreaming linked with organization-wide strategic objectives 1–9) and WHO mechanisms (institutional mainstreaming, primarily linked with organization-wide strategic objectives 10–13).

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1 *Strategy for integrating gender analysis and actions into the work of the World Health Organization* (EB 120/6. WHA 60.25).

2 World Health Organization. Integrating gender perspectives in the work of WHO: WHO gender policy. Geneva, 2002.

3 *Strategy for integrating gender analysis and actions into the work of the World Health Organization* (EB 120/6. WHA 60.25).

4 The Gender, Women and Health Network (GWHN) includes the Department of Gender, Women and Health at headquarters, the Gender Regional Advisers and/or Gender Units in the regional offices, and the gender focal points in country offices.

In 2007, the Gender, Women and Health Network developed a monitoring and evaluation (M&E) framework built on actions and indicators identified in the WHO Plan of Action to support the implementation of the WHO Gender Strategy.

FIGURE 1 The WHO Gender Strategy monitoring and evaluation framework

The first step in the M&E framework was to conduct a Baseline Assessment (BA) in 2008[1] followed in 2010 by a Midterm Review. This report presents the synthesis findings of the Midterm Review that was conducted to determine the progress towards achieving the four strategic directions set out in the Strategy. WHO is the first UN agency, with the exception of WFP, to develop and track a baseline in such a detailed fashion.

The main findings of the Baseline Assessment (BA) can be summarized as follows:

- For Strategic Direction 1, a majority of WHO staff had a basic understanding of gender and health, but only one third of staff was at least moderately applying gender analysis and actions in their work, and only a third reported institutional support for integrating gender into their work.
- For Strategic Direction 2, gender was strongly integrated into WHO's operational planning and programme cycle, but planning focal points report only "moderate" levels of gender integration in operational planning, programme implementation and monitoring and evaluation; and there was also limited mainstreaming in Country Cooperation Strategies (CCS) and country workplans. With respect to sex parity in staffing, women were under represented, particularly at the higher professional grade levels (P4 and above) in all parts of the Organization.
- For Strategic Direction 3, less than a quarter of the sampled WHO publications promoted or used sex-disaggregated data, and roughly half of them promoted or used gender analysis.
- For Strategic Direction 4, 14 out of the 40 speeches sampled made by Regional Directors and the Director-General included a reference to gender.

1.1 Purpose

The purpose of the Midterm Review is twofold: to determine the progress on the implementation of the WHO Gender Strategy in relation to the four strategic directions since the Baseline Assessment, and to identify what mid-course corrections need to be made in WHO to reach the objectives in the plan of action vis-à-vis gender mainstreaming.

The Midterm Review results reported here supported the Director General in her second progress report on resolution WHA60.25 to the Executive Board in October 2010, and to the World Health Assembly in May 2011. The MTR report is aimed at facilitating internal reporting, and also provides the benchmarks against achievements in the implementation of the WHO Gender Strategy, which will be measured again in the final evaluation to be undertaken in 2013.

[1] WHO (2010) *Gender mainstreaming in WHO. Where are we now? Report of the Baseline Assessment of the WHO Gender Strategy*. Geneva: World Health Organization.

Under the definitions of the M&E framework developed in 2007, the MTR will serve as an internal and lesson learning process to track progress and assess any challenges that have arisen in gender mainstreaming.

1.2 Objectives

The specific objectives of the baseline assessment are to assess

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

2. Methodology

The MTR used a standard review methodology[1] whose main data sources were WHO documentation, the WHO global management system and a web-based questionnaire. Because of resource and time constraints, face-to-face interviews with WHO staff were not held. The MTR was planned as an efficient exercise, focusing on only a selected number of strategic indicators from the BA. While the BA was quite comprehensive, it was also resource and time consuming. In addition, it was not thought necessary at the midterm stage to get as comprehensive a picture of progress on gender mainstreaming as with the BA. Issues of causality (that is, why WHO has achieved its current level of gender mainstreaming) were not directly addressed, as these would need a more intensive study.

In consultation with WHO staff and the MTR consultant, indicators covered in the MTR were selected to balance the following:

- Areas that may be of particular concern or where progress might have been expected given the findings of the BA.
- Resources available, i.e. one short-term consultancy of 25 days and input from HQ and the Regions. Thus, for example, it was not thought feasible to carry out a questionnaire survey covering all WHO staff as in the BA.
- Easy access to data.

Twelve indicators were selected, six of which were covered in the BA. Indicators covered in the BA were as follows (with the corresponding Strategic Direction in parentheses):

- Percentage of new CCSs sampled that strongly integrate gender (SD2)
- Percentage of all professional and administrative long-term and temporary posts by sex, and grade-level until Dec 31 2009 (SD2)
- Percentage of all long-term and temporary new appointments in 2009 by sex and WHO category (Professional, National Professional Officers and General Service) (SD2)
- Percentage of new WHO publications that promote and/or use sex disaggregated data (SD3)
- Percentage of new WHO publications that promote and/or use gender analysis (SD3)
- Percentage of speeches by the DG and the Regional Directors that include at least one reference to gender (SD4)

These indicators were measured using a similar sample size and methodology as those of the BA (see Annex 1), thus allowing for direct comparison with the BA findings.

A web-based questionnaire (see Annex 2) submitted to 200 selected budget centres was used to measure capacity development and existence of accountability functions (see Annex 1). The methodology for selecting budget centres for this questionnaire involved taking the total number of WHO budget centres generated by the Global Management System and removing those that belong to management offices, including finance and administration, UNAIDS, Computer Centres, APOC, and UNITAID. This left 200 budget centres reviewed for the biennium 2010–2011. A list of these budget centres can be found in Annex 3.

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[1] Shaw et al (2007) *Sage Handbook of Evaluation*. London: Sage Publication; Patton, M. (2009). *Utilization-Focused Evaluation*. London: Sage Publication.

At each budget centre key informants were selected on their knowledge of gender mainstreaming activities in their respective departments, regional or country offices. Altogether 112 gender focal points were included in the sample, one per budget centre. Where there was no gender focal point available, the Director of the department or the WHO Country Representative was invited to respond or to appoint an officer to respond to the questionnaire on behalf of the budget centre.

There were 72 responses, yielding a 36% response rate. Not all respondents answered all questions, and actual numbers who responded are given in parentheses in the text. Geographical responses were reasonably well distributed and can be seen in Box 1.

BOX 1 PERCENTAGE OF RESPONSES TO MTR QUESTIONNAIRE BY REGION

Total	AFR	AMR	EMR	EUR	HQ	SEAR	WPR
72	14%	11%	18%	11%	22%	7%	17%

The questionnaire referenced three indicators of gender analysis and planning:

- Number of gender mainstreaming trainings supported by WHO (SD1)
- Number of people who participated in gender mainstreaming trainings (SD1)
- Number of Member States supported by gender mainstreaming trainings (SD1)

In May 2009 WHO integrated a "gender classification" into WHO's Global Management System (GSM). GSM asks WHO staff involved in the preparation of workplans to indicate if their products and services are gender responsive. Given the introduction of the GSM gender classification in WHO as a means of supporting data organization and reporting on gender, it was thought relevant to introduce one gender indicator into planning:

- Number of budget centre workplans including at least one product or service classified as gender responsive as a percentage of the total number of budget centres (SD2)

With regard to SD 4 (establishing accountability), while the indicator used for the BA, "Percentage of speeches by the DG and the Regional Directors that include at least one reference to gender," was useful, a more comprehensive attempt to capture the existence of WHO accountability mechanisms was needed. Therefore, two further indicators were added :

- Percentage of WHO resolutions that integrate/refer to gender analysis and actions (SD4)
- Percentage of WHO Offices with at least one accountability function in place (SD4)

Accountability functions were measured by considering country office plans for gender mainstreaming and/or formal mechanisms for senior managers reporting on gender. The MTR also took into account progress in developing UN system-wide accountability mechanisms since the BA, in particular the UN Country Team Performance Indicators for Gender Equality introduced in August 2008,[1] and the draft indicators for the System-Wide Policy and Strategy on Gender Equality and the Empowerment of Women.

It was decided to undertake a straightforward numerical analysis of data rather than a statistical analysis. There were two reasons for this. First, statistical analysis was not undertaken in the Baseline Assessment, and the intention for the MTR was to make it directly comparable to the Baseline Assessment. Second, much of the analysis is qualitative in nature and did not lend itself to statistical analysis, particularly given small sample sizes. Lack of statistical analysis is acknowledged as a limitation of the MTR.

For more details on the methodology, including sample sizes and data analysis, see Annex 1.

[1] http://www.undg.org/index.cfm?P=222

3. Main findings and conclusions

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

Three questions on capacity development were asked in the web-based questionnaire. While it is recognised that capacity development extends beyond training, it was thought appropriate to ask a question related to training, as most country offices would be involved in this activity; moreover, the scope of the MTR did not allow for more detailed analysis of capacity development activities. Two additional questions were included on development of a capacity assessment plan, based on UNDG guidance.[1] The three questions are as follows:

- Was there any training for staff and/or counterparts (e.g. government) on gender mainstreaming or promotion of equal health outcomes between men and women undertaken in your country/office during the period Jan 2009 to July 2010?
- If training was offered by WHO, was there a prior assessment of the capacity of trainees?
- Is there a capacity building plan for gender mainstreaming (for WHO staff/or counterparts), with measurable targets, developed by your department or country office or region?

3.1.1 Number of gender mainstreaming trainings supported by WHO

Of the 70 respondents to the questionnaire in this area, 49% responded affirmatively. They reported a total of 76 separate training activities. Most countries noted more than one training. Because only 37% of budget centres responded to the questionnaire, this does not capture all WHO training, but rather gives an indication of the extent of training. In future analysis, e.g. during the final evaluation of the Gender Strategy, it will be possible to use this figure as a baseline as long as the proportional response rate is taken into account.[2]

3.1.2 Number of people who participated in gender mainstreaming trainings

In total 2,675 people participated in training activities, with Indonesia, reporting 525 trainees, or some 20% of the total. Respondents were asked to list the number of trainees by organizational affiliation. A percentage breakdown of these affiliations is given in Box 2.

BOX 2 ORGANIZATIONAL AFFILIATION OF TRAINEES

Organization	Government	NGOs	UN (non WHO)	WHO	Other
% of training	35	13	17	26	9

[1] http://www.undg.org/index.cfm?P=225

[2] The breakdown of response by region is as follows (figures are rounded): AFRO: 13%; AMRO: 10%; EMRO: 19%; EURO: 12%; HQ: 22%; SEARO: 7%; WPRO: 17%.

3.1.3 Number of Member States supported by gender mainstreaming training

Forty-one Member States reported that they had receiving training: Afghanistan, Albania, Bangladesh, Bolivia, Burkina Faso, Chile, Colombia, Ecuador, El Salvador, Ethiopia, Fiji, Gambia, Ghana, Guatemala, Iran, Iraq, Jordan, Kyrgyzstan, Liberia, Lithuania, Maldives, Mexico, Myanmar, Nigeria, Norway, Pakistan, Peru, Republic of Moldovia, Sierra Leone, Slovenia, Somalia, Spain, Tajikistan, Turkmenistan, The Former Yugoslav Republic of Macedonia, Tanzania, Vanuatu, Venezuela, Viet Nam, Yemen, Zimbabwe.

Afghanistan reported the most of trainings (5), while several countries held three . It is not possible to draw conclusions about the geographical spread of training because not all budget centres responded to the questionnaire.

As to whether assessment of capacity had been carried out prior to training, 35% (19 out of 54 respondents) responded affirmatively. And as for developing a capacity building plan, 40% (26 out of 65 respondents) responded affirmatively.

There have been important efforts and investments on trainings throughout WHO regions. However, most of these efforts are not coordinated, and probably not sustained or evaluated.

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

3.2.1 Percentage of budget centre workplans including at least one product or service classified as gender responsive

In July 2008 WHO introduced its Global Management System (GSM) to support results-based management using unified and simplified tools based on common rules and procedures for planning, operating and monitoring the work of WHO. The GSM is also meant to provide an integrated and consolidated view of programme delivery and achievements at each level of the Organization, and of the Organization as a whole. To date the system has been rolled out at HQ, WPRO, SEARO, EURO, and EMRO.

In April 2009, a "gender classification" was introduced into GSM to enable WHO to monitor and track progress on Resolution WHA 60.25. The gender classification reads:

Is this product (top task[1]) gender responsive? (Y/N)

While not mandatory, use of the gender classification is strongly encouraged. To qualify as a gender responsive top task in GSM, products should consider gender norms, roles and relations and should perform the following :

- Promote use of age and sex disaggregated data and gender analysis
- Address specific health needs, situation, access and control over health resources, and contribution to health of women and men

The GSM was introduced after the BA and therefore not assessed during that exercise, but as the GSM is the central organizing software for WHO, and a gender classification has been introduced, it was thought important to include a review of the GSM gender classification during this MTR. One indicator was included:

- Percentage of budget centre workplans including at least one product or service classified as gender responsive.

The methodology involved taking the total number of budget centres and removing those that belong to management offices, including finance and administration, UNAIDS, Computer Centres, APOC, and UNITAID. This left 200 budget centres whose gender classification was reviewed for the biennium 2010–2011. The percentage of budget centres with at least one product/service classified as gender responsive can be seen in Table 1.

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[1] In GSM, a work plan is a "project". Planning elements are called "tasks". Products and services are "top tasks". Activities are "sub-tasks" (or "middle" or "lowest tasks").

TABLE 1 **Percentage of budget centres with at least one product/service classified as gender responsive**

Office	HQ	WPRO	SEARO	EURO	EMRO	Total
Budget centre with at least one product/ service classified as gender responsive	15	13	5	31	21	85
Total number of budget centres	65	37	24	43	31	200
Indicator value (%)	23	35	21	72	68	43

The range between a high of 72% and a low of 21% establishes that there is considerable variation in reporting on gender responsive products across WHO. Validity and quality checks are necessary to determine to what extent this data reflect the reality of gender integration within WHO workplans. This assessment establishes a baseline against which future progress can be measured. Data from PAHO/AMRO and AFRO are not reported here because at the time data were collected they still were not in the GSM system.

The quality of data in the GSM system

It is likely that it will take some time before the gender classification is fully and adequately reported on. In the web-based questionnaire, 39% of respondents (28/72) reported that they had heard about the GSM. A further question was asked: "Does the Head of Office encourage use of the GSM gender classification?" Twenty nine % of respondents replied positively (20/69), 26% negatively (18/69), and 45% said that this was not applicable (31/69), because the GSM has not yet been introduced in their region. This is consistent with the BA finding where only a third of questionnaire respondents reported institutional support for integrating gender into their work. These findings suggest that more could be done to publicize the gender classification, and senior managers could do more to promote it.

A review carried out by PAHO[1] found inappropriate use of the gender classification as well as a lack of understanding of how to use it. For example, any products and services involving data collection were coded as gender responsive on the assumption that all data would be disaggregated by sex; however, this does not include gender analysis, which, as set out above, is one of the areas required for positive coding. Also, any activity that mentioned the terms "strategy," "policy," "plan," or "norms" was coded for gender, on the assumption that PAHO has a gender integration policy and therefore any other policy would mainstream gender.

These findings and the variation in gender coding noted across regions suggest that WHO needs to take a more proactive approach to promoting the GSM gender classification. The issue of whether the gender classification is correctly understood and applied by budget centres needs to be clarified.

3.2.2 Number of post-2008 sampled Country Cooperation Strategies that strongly integrate gender[2]

Content review of 10 Country Cooperation Strategies (CCS) was undertaken to measure this indicator. The same methodology as in the BA was used. A list of all CCSs completed post-2008 was provided to WHO regional advisers, who were asked to identify which CCSs had been completed with GWHN support. One CCS which had been completed with and one without GWHN support were then randomly selected for review per region. This dual selection was made so that it could be determined whether the GWHN input would have an effect on the integration of gender within CCSs.

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[1] A summary of this review was provided for the MTR.

[2] The MTR originally planned to assess workplans, as in the BA. However, because the format for workplans had changed since the BA and a comparative assessment was not possible, assessment of workplans was not included.

It had originally been intended to select 12 CCS for the BA, but only 9 were chosen. This is because no CCSs were available from AFR, and only one was available from WPR.[1] The MTR review is equivalent, with 10 CCSs, and no CCSs included from AFR. The CCSs selected for review in the MTR can be found below. Further details on the methodology can be found in Annex 1.

BOX 3

	WPR	SEAR	EMR	AFR	EUR[a]	PAH
CCS	Mongolia[b]	Bangladesh[b]	Sudan[b]	None	Moldova[b]	Paraguay[b]
Cambodia	Myanmar	Syria		Turkey	Brazil	

[a] Biennial Collaborative Agreements rather than CCSs were reviewed.
[b] Received input from GWHN

On the basis of a content analysis in seven areas (Table 2 and Annex 1), CCSs were assessed as strongly, moderately or weakly integrating gender The results are summarized as follows (BA findings in parentheses):

- Number of post-2008 CCSs that "strongly" integrate gender: 1/10 (1/9)
- Number of post-2008 CCSs that "moderately" integrate gender: 5/10 (3/9)
- Number of post-2008 CCSs that "weakly" integrate gender: 4/10 (5/9)

As can be seen, there is a modest improvement in CCSs that moderately integrate gender. The total rating for all MTR CCSs in the seven areas assessed was slightly below moderate.

TABLE 2 Content analysis of CCSs[a]

Area for content analysis of CCS	Rating
1. Is there one or more statement/reference to gender equality or gender equity?	8/10
2. Does the document mention consultation/partnerships with women's groups?	0/8
3. Does the document refer to consultation/ partnerships with Ministry of Women's Affairs/ Gender?	2/8
4. Does the document recommend use of sex disaggregated data?	1/8
5. Does the document use sex disaggregated data?	10/18
6. Does the document analyse/interpret the differences between women's and men's outcomes (i.e. gender analysis of sex disaggregated data)?	8/20
7. Does the document specify actions to address gender?	9/10

[a] For areas 1–4 and 7, rating was 0 or 1; for areas 5 and 6 rating was 0, 1 or 2. A "not applicable" category was also included

As can be seen from the Table 2, CCSs were much stronger in terms of references to gender equality/equity and of specifying actions to address gender issues. While there is a strong focus on maternal health in the CCSs, gender issues are rarely raised in discussions about disease. Consultation/partnership with women's groups is never mentioned, and only one CCS recommended use of sex-disaggregated data. There is a sense that the authors of the CCSs are uncertain as to how to integrate gender issues apart from maternal health. This may be a result of the emphasis on maternal health in the Programme Budget 2010–2011, which would have been discussed when the CCSs reviewed were being formulated. There were a number of missed opportunities vis-à-vis inclusion of gender issues, for example in relation to poverty and universal access. In some CCSs women are not even included in listings of "vulnerable" groups, where they usually appear.

[1] CCSs were reviewed for the following countries in the BA: China, India, Bhutan, Occupied Palestinian Territories, Saudi Arabia, Czech Republic, Tajikistan, Trinidad and Tobago, Honduras, and Saudi Arabia.

In the BA, the four CCSs rated as moderate or strong. These four CCS were produced in country offices where there has been input from the GWHN. For the MTR, the one CCS that rated as strong (Paraguay) and three of the five CCSs rated as moderate (Mongolia, Bangladesh, and Sudan) were in country offices where there has been GWHN involvement. The other two CCCs rating moderate were Myanmar and Brazil. As in the BA, this finding suggests that mainstreaming of gender is higher in countries where there has been GWHN input.

3.2.3 Percentage of all professional and administrative long-term and temporary posts by sex and grade-level (cumulative) until 31 December 2009

3.2.4 Percentage of all long-term and temporary new appointments in 2009 by sex and WHO category (Professional, National Professional Officers and General Service)

The purpose of these indicators is to determine how far WHO is meeting its mandate of sex parity in staffing. WHO (2003: 1)[1] sets out WHO's commitment: "In 1997 the Health Assembly, by resolution WHA50.16 decided to raise the target to 50% [for the proportion of women in professional and higher-graded posts in WHO's established offices], and added the target of 50% for new appointments of women to professional posts by 2002."[2]

A comparison of the distribution by sex within the three staff categories as of 31 December 2007 and 2009 is shown in Table 3.

TABLE 3 Percentage of all long-term and temporary posts by sex and staff category (professional, general service and national professional officers), 2007 and 2009

2007			2009		
	F (%)	M (%)		F (%)	M (%)
Professional	38	62	Professional	40	60
National Professional Officer	37	63	National Professional Officer	35	65
General Service	58	42	General Service	55	45
Overall WHO Staff	49	51	Overall WHO Staff	46	54

Note: figures in this and all other tables have been rounded.

As can be seen in Table 3, the overall percentage of women has decreased since 2007, but this masks shifts within the categories. There has been a 2% increase in the number of women in the professional category since 2007,[3] and a 2% decrease in the number of women in the national professional officer (NPO) category. There is a decreased imbalance in staffing in the general service category, with the number of men having increased by 3% since 2007. WHO is still some way from achieving its 1997 commitment to have 50% women in professional and higher graded posts. The 2010 *Human Resources Report* (p. 2)[4] notes: "The representation of women in the professional and higher categories has increased by nearly 10% during the past 11 years, rising from 29.9% in December 1999 to 39.5% in December 2009."

Figure 2 illustrates that the percentage of women in professional long-term posts (P4 to UG) has increased in all categories between 2007 and 2009.[5]

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1 *Human Resources Annual Report: Gender Balance. Report by the Secretariat.* A56/39

2 Figures for PAHO, which are recorded separately by WHO, have been included in calculations as relevant.

3 By comparison, in the UN Secretariat in 2009 38% of all staff in the professional and higher categories with appointments of one year or more were women. (http://www.un.org/womenwatch/osagi/ianwge/Factsheet%20as%20of%20FEB%202010.pdf)

4 *Human Resources Annual Report.* A63/40.

5 By comparison, as of 30 June 2009, women in the UN Secretariat constituted
- 27.3% (180 out of 660) of all staff at the D-1 level and above
- 39.3% (2,713 out of 6,903) of all staff at the P level

Gender balance has only been achieved at the P-1(50%) and P-2 levels (51.5%).

FIGURE 2 **Percentage of women in long-term professional posts, 2007 and 2009**

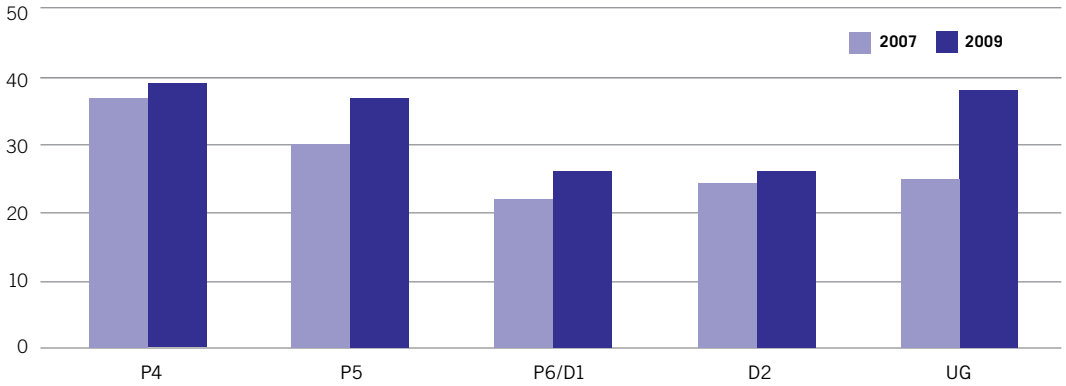


FIGURE 3 **Percentage of women recruited in 2007, 2008 and 2009**

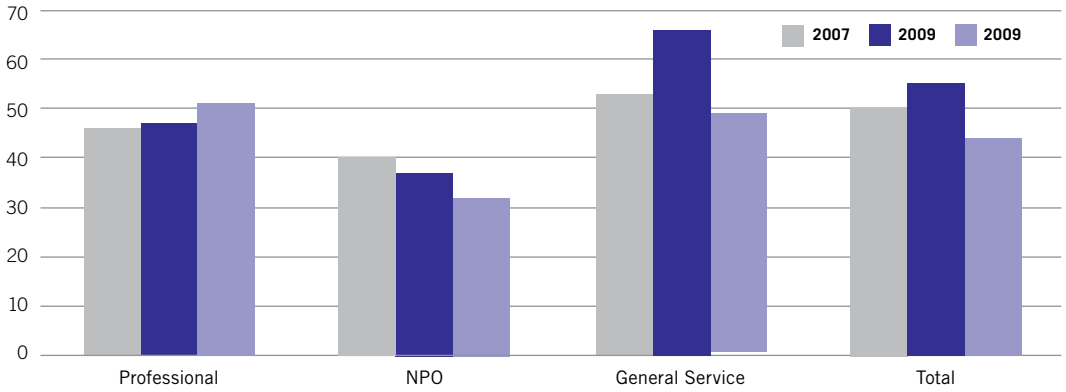


Figure 3 illustrates that recruitment has increased at the professional level to almost par; but since the Baseline assessment it has decreased by 8% for NPOs, 5% for general service staff.

Since sex-disaggregated data are not available for appointments by grade-level, it is difficult to assess whether gender balance in staffing, through increased representation of women at higher grades (i.e. P4-P6/D1, D2 and UG), will be achieved in the near future. An important measure to take into account when assessing when WHO is likely to achieve its target is the higher percentage of women in the younger age categories: 56% in the 30–39 category, and 45% in the 40–49 category. Given that Human Resources has estimated total retirement in the Professional category will be 921 by 2019, or some 115 per year, total retirement would be about 575 by the end of 2015. Of those in the above 50 age category, 70% are male. Currently there are 1403 male and 936 female professional staff. If 70% of men retire by the end of 2015, which is consistent with their representation in the over 50 age category, the number or men retiring by the end of 2015 would be 403, as opposed to 172 women. This would leave a remainder of 1000 men and 764 women, or 43% women, at current levels of staffing. So in order to achieve 50% women in professional posts by the end of 2015, presuming the professional staffing number stays constant, it would be necessary to hire 169 men and 405 women; in other words, there would need to be 71% women hired each year between 2011 and 2015 to achieve gender balance. However, if staffing levels increase or decrease, these projections will change.

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

Twenty seven publications,[1] four from each of the six WHO regions and three from HQ, were randomly selected from the 2009 publications list covering four categories: a) seminal institution wide documents (e.g. World Health Report); b) policy/governing body documents; c) evidence type documents; and d) tools/normative guidelines.

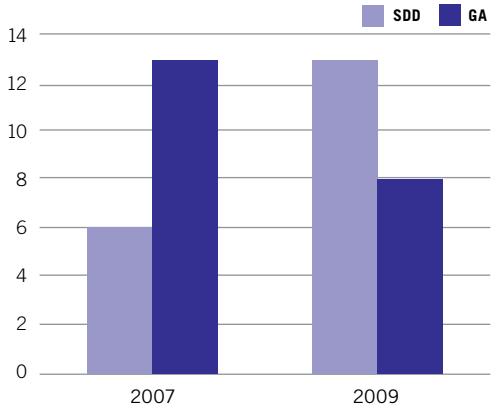
The midterm values for this strategic direction are summarized by two indicators:

- Number of new WHO publications that promote or use sex-disaggregated data: 13/27
- Number of new WHO publications that "strongly" promote and/or use gender analysis in health: 8/27

Figure 4 provides a comparison between the Baseline Assessment and MTR in terms of these two indicators.

The main point here is that in terms of these indicators, WHO publications are rated at between 25 and 50%. This is a poor result for an agency committed to gender mainstreaming.

FIGURE 4 Number of new WHO publications that promote or use sex-disaggregated data and gender analysis in 2007 and 2009



In terms of overall strengths and weaknesses across the assessment categories,[2] publications reviewed were strongest in relation to "implicit" references to gender equality (17/27) and in using neutral language (21/27), and were weakest in interpreting the difference in outcomes between women and men (6/27). Highest rating reports were the HQ report "Promoting sexual and reproductive health for persons with disabilities" and the EURO report "The European Health Report 2009: Health and health systems." Among the four categories, evidence type publications achieved the highest rating at 75%, and policy/governing body documents the lowest rating at 43%, suggesting that there should be greater focus on improved mainstreaming in the latter.

3.4 **Strategic Direction 4:** Establishing accountability

3.4.1 Percentage of sampled speeches by the Director General and the Regional Directors that include at least one reference to gender

The BA methodology and indicator were also used in the MTR. Twenty-eight randomly selected speeches, four from each region and HQ, were analyzed for at least one reference to gender issues.

Box 4 contains the comparative findings between the BA and MTR; percentages have been included because of the different sample sizes between the two years.

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[1] In the Baseline Assessment, 28 publications were selected, but in the MTR only 3 publications were found for AFRO.

[2] See Annex 2 for details of the assessment criteria.

BOX 4 PERCENTAGE OF DIRECTOR GENERAL AND REGIONAL DIRECTOR SPEECHES INCLUDING AT LEAST ONE REFERENCE TO GENDER	
Speeches including at least one reference to gender: Baseline Assessment (%)	Speeches including at least one reference to gender: Mid-Term Review (%)
35	36

Overall there is the same reflection of gender issues in the MTR, with 10 out of 27 speeches making one or more references to gender. In total, sixteen references were included in the speeches, of which nine referred to differential or specific health needs/outcomes of women and/or men. There was one reference to gender equality and two references to women's rights, suggesting that senior manager speeches are focusing less on gender equality as a rights issue and more on differential health outcomes as a "technical" issue. WHO could set as an intermediate target that at least 50% of senior manager speeches include at least one reference to gender issues.

3.4.2 Percentage of WHO resolutions that integrate/refer to gender analysis and actions[1]

Thirty five resolutions from across WHO were assessed using a four point scale against five criteria: gender analysis, language, expert and stakeholder participation, gender relevance, and monitoring and evaluation of the resolution. Details of the resolutions reviewed and the criteria employed for review can be found in Annex 1. Results are shown in Table 4.

TABLE 4 Percentage of WHO resolutions that integrate/refer to gender analysis and actions

Number of resolutions assessed (n)	High adherence	Moderate adherence	Low adherence	No adherence
35	11% (n = 4)	9% (n = 3)	57% (n = 20)	23% (n = 8)

It can be seen from the table that 80% of WHO resolutions have low or no adherence to the gender mainstreaming strategy, suggesting there is considerable room for improvement.

AFRO and PAHO are the only regions that have passed highly adherent resolutions; PAHO and WPRO are the only regions with no resolutions showing apparent adherence to the Gender Mainstreaming Strategy. For both EMRO and SEARO, three of four resolutions analyzed were found to have low adherence and one was not adherent in each region. The EURO region had similar adherence rates: four of five resolutions analyzed were found to have low adherence with only one non-adherent resolution. Regional committees generally reflect the performance of WHA resolutions, with five of nine WHA resolutions revealing low adherence, one found to be moderately adherent and three non-adherent. Most resolutions miss opportunities to acknowledge or address gender in areas where doing so would improve the ability of Member States to meet specific goals in their resolutions.

3.4.3 Percentage of WHO offices with at least one accountability function in place

Questions in the web-based questionnaire covered accountability functions, or areas that can be taken as proxies for accountability. Responses provide the first systematic evidence of the state of accountability for gender mainstreaming in WHO, as outlined in Table 5.

[1] This Section is based on a background paper by Jenny Knoester, who also developed the methodology for the review of resolutions, included as Annex 7.

TABLE 5 **Accountability mechanisms for gender mainstreaming in WHO**

QUESTION IN WEB-BASED QUESTIONNAIRE	RESPONSE – SHOWN IN PER CENT FOLLOWED IN PARENTHESES BY ACTUAL VS TOTAL NUMBER OF RESPONSES	
Does your office have a plan for implementation of the WHO Gender Strategy or similar?	Yes 32 (23/71)	No 68 (48/71)
If yes, does this include: Time-frame? Resources required for implementation? Accountability of staff (from senior management down)? A monitoring and evaluation framework? Targets and timelines for achievements?	Yes 70 (16/23) 70 (16/23) 56 (13/23) 56 (13/23) 61 (14/23)	No 30 (7/23) 30 (7/23) 44 (10/23) 44 (10/23) 39 (9/23)
Is a gender focal point in place?	Yes 78 (56/72)	No 22 (16/72)
Does the gender focal point regularly attend senior management meetings?	Yes 44 (28/64)	No 56 (36/64)
Do senior managers (e.g. heads of office and/or high level professional staff) report on gender mainstreaming?	Yes 38 (26/66)	No 62 (40/66)

Responses show that only about one fourth of the WHO offices that responded to the questionnaire have at least one accountability function in place. We considered two indicators as measures of an accountability function: existence of a plan or similar for the implementation of WHO Gender Strategy, and senior managers reporting on gender mainstreaming.

One third of country and regional offices and HQ departments have an implementation plan for the WHO Gender Strategy, and one half of these plans include details on accountability of staff and a monitoring and evaluation framework. Respondents submitted 11 plans along with their questionnaire responses. These ranged from workplans at the country level (e.g. Afghanistan, Myanmar), to programme related performance frameworks covering gender and other areas (e.g. The Special Programme for Research and Training in Tropical Diseases; Food Safety, Zoonoses and Foodborne Diseases), to a detailed plan of action for implementing PAHO's gender equality policy. There were thus some positive initiatives taken by individual units or country offices, but there was no consistency in plans of action to implement the Gender Strategy.

Respondents to the questionnaire were asked if senior managers (e.g. heads of office and/or high-level professional staff) are expected to report on gender mainstreaming. 38% (25/66) responded affirmatively. Respondents were also asked to indicate the type of reporting format and frequency of reporting used. There were 22 responses in this area, with 10 respondents noting reporting on "activities", nine noting reporting through the Performance Management Development System (PMDS), and a further three noting the GSM.

Respondents were also asked if there were any other accountability functions in place for promoting gender mainstreaming. 27% (17/63) said yes. Eighteen examples of accountability functions were provided. Of these eighteen, eleven related to reporting, some of which was regular reporting on programmes that also included reporting on gender mainstreaming. One example related to speeches by the Regional Director and other senior managers, and a further example to staff performance assessment. The remaining five examples related to a variety of accountability functions.

The overall conclusion is that the majority of WHO offices do not have accountability functions in place. There is little consistency across the accountability functions that do exist. Reporting by senior managers on gender mainstreaming is not systematic and could be improved. An accountability framework, tied to minimum standards and performance assessment, and overseen by an intra-agency committee to ensure gender mainstreaming, would help promote accountability.

4. Limitations of the review

The review did not test any hypothesis or predict causal and effect relationships, hence statistical analysis of the numerical data was not undertaken.

Three areas could not be adequately addressed in the Midterm Review. The effect of the training on the improvement of staff knowledge on gender concepts could not be measured, and the reliability of GSM data could not be assessed. Furthermore face-to-face interviews with WHO staff were not held due to resource and time constraints, The MTR was planned as an efficient exercise, focusing on only a selected number of strategic indicators from the Baseline Assessment.

Limitations also included the low number of WHO documents reviewed. A more robust sample size would improve reliability of the findings.

For the web-based questionnaires, although the sampling frame and the response rate were adequate, the results might not be generalized, for example, it is not possible to draw conclusions about the geographical spread of training, because not all budget centres responded to the questionnaire. In future analysis, e.g. during the final evaluation of the Gender Strategy, it will be possible to use this figure as a baseline as long as the proportional response rate is taken into account.[1]

[1] The breakdown of response by region is as follows (figures are rounded): AFRO: 13%; AMRO: 10%; EMRO: 19%; EURO: 12%; HQ: 22%; SEARO: 7%; WPRO: 17%.

5. Recommendations

It would be inappropriate to conclude this report without making reference to the question "what is next?" What follows is a list of key recommendations that have emerged from the findings of the Midterm Review. We hope that this can be taken forward by key stakeholders in order that WHO can effectively mainstream gender across the organization. The recommendations are presented for each strategic direction as follows:

SD1: Building WHO capacity for gender analysis and planning

- WHO should follow-up the recommendations in the BA to see which have been completed as planned.
- WHO should continue the implementation of its monitoring and evaluation framework for the gender strategy. The responsibility for the oversight and implementation of the M&E framework must rely on a technical unit/department with core mandate on gender equality defined by the WHO Director-General.
- The WHO Unit/ Department that retains core expertise on gender should carry out systematic capacity development related to gender mainstreaming in order to ensure that training is organised according to required competencies.
- The WHO unit/department responsible for capacity development on gender needs to roll out trainings in accordance with a long-term strategy, channelling resources and targeting countries in which there are gaps. Furthermore, these efforts must be accurately monitored and evaluated.
- Gender equality should be integrated within staff training and guidelines of the WHO Planning, Resource and Coordination Department (PRP).

SD2: Bringing gender into the mainstream of WHO's programme management

- The current Plan of Action for the WHO Gender Strategy is outdated and does not reflect an organization-wide commitment. WHO needs to identify and to appoint one lead cluster to coordinate the review and update of the PoA. This review is an organization-wide effort in which budget centres across clusters, regions, countries and at WHO HQ must be identified for focused interventions. The plan of action must be timed to end in 2013. Resources must be allocated by each budget centre within their respective 2012–2013 budget work plans to implement what was planned.
- WHO Director-General to appoint a cross-cluster Gender Mainstreaming Committee consisting of six or seven Executive Directors with the overall responsibility of implementing the WHO Gender Strategy and joint planning for gender across WHO.
- PRP should take a more proactive approach to promoting the GSM gender classification. GSM gender classification should be formally introduced within WHO through induction trainings and seminars. Resources should be made available for the required validity and quality checks of the data available within GSM.

- The WHO Department of Human Resources should calculate how long it will take at the current rate to meet WHO's mandate in gender balance in staffing, and in association with GWHN set a date by which the agreed targets should be met.

SD3: Promoting the use of sex-disaggregated data and gender analysis

- In terms of gender mainstreaming in publications, greatest emphasis should be placed on policy/governing body documents which achieved the lowest rating among the four types of documents reviewed.

SD4: Establishing accountability

- WHO should develop minimum standards for gender mainstreaming in all key functions. These minimum standards can be based on the criteria developed for the BA and this MTR. WHO should examine the ILO experience with setting minimum standards for gender mainstreaming, and draw on work already carried out by the UN Development Group Task Team on Gender Equality and the Empowerment of Women, and UN Women in relation to the Chief Executives Board Policy and Strategy on Gender Equality and the Empowerment of Women.
- Related to minimum standards, WHO should develop targets in relation to the Strategic Directions in its Gender Strategy and for the indicators in its Plan of Action. These targets should be set by the GWHN and relevant WHO Departments. Accountability for meeting the targets should rest at the level of the Assistant Director-General or equivalent through inclusion of the targets in their reporting requirements to the Director General and in their performance assessment.[1] An example of a target would be 75% of CCSs adequately integrating gender by 2012, and 100% by 2014.

[1] The WHO Gender Policy (2002) notes: "Senior management will take the necessary steps to ensure the policy is translated into action in both technical and management aspects of WHO programmes. They will transmit the policy to technical and administrative staff and monitor its consistent and effective application throughout the work for which they are responsible. They will be accountable to the Director General for successful incorporation of gender considerations in their work." The Gender Strategy (2007) notes: "Accountability for the effective integration of gender perspectives into WHO programmes and operational plans will rest primarily with senior WHO staff. Successful implementation of this strategy will need leadership, particularly at senior levels, and staff with gender expertise. Implementation by staff members will be appraised with appropriate indicators through the performance management and development system."

Annexes

Annex 1
Midterm Review Framework

The following tables set out the main indicators measured and the data source and methods used.

Strategic direction No. 1:
Building WHO capacity for gender analysis and planning

MTR INDICATORS	DEFINITIONS	NOTES ON DATA SOURCES AND METHODS
Number of gender mainstreaming trainings supported by WHO per total number of selected budget centres	Training for staff and/or counterparts (e.g. government) on gender mainstreaming or equal health outcomes between men and women categorized as yes, no or don't know in response to one question on the web-based questionnaire	Web-based questionnaire applied to 200 selected budget centres. List of total number budget centres were generated by the global management system. We excluded budget centres that belong to managing officers, finance and administration, APOC, UNAIDS, Computer Centers and UNTAID
Number of people who participated in GMS trainings	Number of participants entered as numerical value in response to one question in the web-based questionnaire	
Number of Member States supported by GMS capacity building activities	The names of Member States were asked to be inserted one by one within the web-based questionnaire	

Strategic Direction No 2:
Bringing gender into the mainstream of WHO's programme management

MTR INDICATORS	DEFINITIONS	NOTES ON DATA SOURCE AND METHODS
Number of budget centre work plans including at least one product or service classified as gender responsive/total number of budget centres.	Gender responsive products consider gender norms, roles, relations and include the following to actively address them: 1. Promote use of age & sex disaggregated data and gender analysis 2. Addresses specific health needs, situation, access and control over health resources, and contribution to health of women & men	The numerator was generated by the gender classification at WHO global management system. The gender classification reads: Is this product (top task) gender responsive? (Y/N) The denominator was calculated by a list of budget centre generated by the global management system. The methodology involved taking the total number of budget centres and removing those that belong to management offices, including finance and administration, UNAIDS, Computer Centers, APOC, and UNITAID. This left 200 budget centres of which were reviewed for the Biennium 2010–2011
Number of post 2008 CCS out of those sampled that strongly integrate gender	In the content review of the CCS documents, a series of criteria are applied. For each criterion that is met, the document is given a score of 1. Scores range from 0–9. The number of CCS' that score at least 7 is totalled to arrive at this indicator value.	The same methodology as in the BA was used. A list of all CCSs completed post-2008 was provided to regional gender advisors, who were requested to identify which CCSs had been completed with GWHN support. The 10 CCSs selected for review were assessed against predefined criteria and scoring. Sample size was the same as for the Baseline, 10 CCSs and 14 workplans. There were seven questions in assessment and scoring criteria to assess whether the CCS adequately reflects the WHO Guiding Framework (2005).[a]
Percentage of all professional and administrative long-term and temporary posts by sex, and grade-level (cumulative) until 31 December 2009. Percentage of all long-term and temporary new appointments in 2009 by sex and WHO category (Professional, National Professional Officers and General Service).	"Long-term" posts or appointments refer to positions lasting longer than 12 months. "Temporary" posts or appointments refer to positions lasting 12 months or less. Grade levels are Professional (P1-P6, D1, D2, UG); National Professional Officer (A, B, C and D); and General Service (G1–G7).	For the Human Resources indicators, the Human Resources 2009 Annual Report (22 April 2010, A63/40) was used as a basis for calculations. PAHO data, which is not recorded in the Human Resources Annual Report, was added.

[a] The WHO *Guiding Framework* (2005) for CCSs emphasizes the importance of gender mainstreaming as in its introduction it states that: "The CCS … reflects and incorporates the human rights-based approach to development and the gender sensitivity adopted by the United Nations system" (p. 6). Furthermore, it states that: "Particular attention should be paid to important, cross-cutting perspectives: health and human rights, gender and ethics" (p. 12); and that information regarding human resources and gender should be included. (p. 16)

Strategic Direction No. 3:
Promoting the use of sex-disaggregated data and gender analysis

MTR INDICATOR	DEFINITIONS	NOTES ON DATA SOURCES AND METHODS
Number of new WHO publications out of those sampled that promote and/or use sex disaggregated data.	Publications that promote and/or use sex-disaggregated data are scored on the basis of a Yes or No response. If the publication scores either 1 or 2, then it is considered as promoting or using sex-disaggregated data. If it scores 0, then it does not promote or use sex-disaggregated data. The number of publications that score a 1 or 2 is totaled to arrive at this indicator value.	Twenty seven publications, four each from the six WHO regions and HQ were randomly selected from the 2009 publications list covering four categories: a) seminal institution-wide documents (e.g. World Health Report); b) policy/ governing body documents; c) evidence-type documents; and d) tools/normative guidelines. 28 publications were selected.
Number of new WHO publications out of those sampled that strongly promote and/or use gender analysis in health.	Publications that promote or use gender analysis in health are compiled from a series of criteria. The scores range from 0 to 7. Documents that score between 5 and 7 are classified as publications that strongly promote or use gender analysis. Documents that score 2–4 promote or use gender analysis somewhat, and those that score 0–1 do not promote or use gender analysis in health. The number of publications with scores of at least 5 is totaled to arrive at this indicator value.	

Strategic Direction No. 4:
Establishing accountability

INDICATOR	DEFINITIONS	DATA SOURCES AND METHODS
Number of speeches by the DG and the Regional Directors of those sampled which include at least one reference to gender.	Speeches by the Director-General and Regional Directors in which there is at least one reference to gender, using a word search for 13 words or phrases related to gender (see Annex 4) are totaled.	All (n=148) Director speeches in 2009 were listed from the relevant websites, or provided by the regional gender advisor. Speeches were randomly selected by number so that four speeches were selected from HQ and each region totaling 37.
Number of WHO resolutions that integrate/ refer to gender analysis and actions.	A draft framework to analyze the adherence of WHA and RC resolutions to the Gender Mainstreaming Strategy was developed. The five evaluative criteria were: 1. Gender Analysis: A gender analysis was conducted across the region and/or countries therein to inform the resolution 2. Language: Use of clear, inclusive and non-sexist language throughout resolution text 3. Expert and Stakeholder Participation 4. Gender relevance: Consideration of the impact of the resolution's proposed actions on gender and health equity, and 5. Monitoring and Evaluation of resolution (M&E)	Of 192 total resolutions, 110 were eligible for analysis. WHA and RC resolutions were sampled and selected for analysis in the following way. First, a comprehensive list of all resolutions passed by each Regional Committee (RC) and World Health Assembly (WHA) from 2008, 2009 and 2010 was compiled.[a] From this list, all procedural resolutions including votes of thanks or appreciation, budget reviews and staff nominations were excluded. Then, for those regions with resolutions published through 2009, two resolutions were randomly selected using the random sampling function of Microsoft Office Excel 2003.[b] For those regions with resolutions published through 2010, three resolutions were randomly selected in the same way so as to account for their relatively larger sample size. Six additional WHA resolutions and two additional resolutions per region (except for PAHO, from which three resolutions were selected to account for its larger pool of resolutions), were hand-selected for analysis.
Percentage of WHO offices with at least one accountability function in place	WHO offices with a plan for implementation of the WHO Gender Strategy or formal mechanisms for senior management reporting on gender activities categorized as yes, no or don't know in response to two questions on the web-based questionnaire	A web-based questionnaire (the same as above) with closed and open ended questions were applied to key informants interviewees selected among WHO budget centres. Criteria for selecting key informant interviewees were person with knowledge on gender mainstreaming activities in their respective department, regional or country office. 112 Gender focal points were included in the sample, one per budget centre. Where there was no gender focal point available, the Director of the department or the WHO country representative was invited to respond or to appoint an officer to respond to the questionnaire on behalf of the budget centre. Budget centres relevant to the implementation of the WHO Gender Strategy were included in the sample. A total of 200 budget centres were selected.

[a] At the time of this analysis, only EURO and the WHA had published resolutions passed in their 2010 sessions.
[b] Microsoft Support, 12 June 2010. "Help and Support: Description of the RAND function in Excel" (http://support.microsoft.com/kb/828795, accessed 23 September 2010).

Annex 2
MTR questionnaire

(Responses are yes/no unless other noted.)

Identification

1. Name of region .....
2. Name of country .....
3. Are you a gender focal point?

   ☐ Yes ☐ No
4. Are you ☐ male ☐ female
5. Please select the option that most closely describes your contractual status within the organization:

   ☐ 1. continuing appointment
   ☐ 2. fixed term appointment
   ☐ 3. other
   ☐ 4. temporary appointment.
6. What is your designated staff category? .....
7. Specify the level: .....
8. Which department or unit are you in? .....

Questionnaire

9. Has your country or regional office been involved with implementation of the UNCT Performance Indicators for Gender Equality and the Empowerment of Women (MDG3)?

   ☐ Yes ☐ No
10. Does your office have a plan for the implementation of the WHO Gender Strategy or similar?

    ☐ Yes ☐ No
11. If yes, does this include?

    ☐ 1. Time Frame
    ☐ 2. Resources required for implementation
    ☐ 3. Accountability of staff (from senior management down)
    ☐ 4. A monitoring and evaluation framework
    ☐ 5. Targets and timelines for achievements
12. Please supply a copy of the plan if any
13. Is a gender focal point in place? ☐ Yes ☐ No

14. How much of her/his time does the focal point spend on gender issues?

    ☐ 1. 0–25%
    ☐ 2. 25–50%
    ☐ 3. 50–75%
    ☐ 4. 75–100%

15. Does the gender focal point regularly attend senior management meetings?

    ☐ Yes ☐ No

16. Are senior managers (e.g. head of office and/or high level professional staff) expected to report on gender mainstreaming?

    ☐ Yes ☐ No

17. If yes, please indicate the type of reporting format (e.g. GSM, PMDS, activities reports) and the frequency of reporting?

    .....

18. Have you heard about the GSM gender classification?

    ☐ Yes ☐ No

19. Does the head of office encourage use of the GSM gender classification?

    ☐ Yes ☐ No

20. Was there any training for staff and/or counterparts (e.g. government) on gender mainstreaming or promotion of equal health outcomes between men and women undertaken in your country/office during the period of Jan 2009 and July 2010?

    ☐ Yes ☐ No

21. Name of the training .....

22. Date of Implementation .....

23. Number of participants .....

24. Target audience

    ☐ 1. Government Staff
    ☐ 2. Non Governmental Organization staff
    ☐ 3. Other
    ☐ 4. UN Organization staff, other than WHO
    ☐ 5. WHO staff

25. Names of member states supported .....

26. If trainings were offered by WHO, was there a prior assessment of the capacity of trainees?

    ☐ Yes ☐ No

27. Is there a capacity building plan on gender mainstreaming (for WHO staff/or counterparts), with measurable targets, developed by your department or country office or region?

    ☐ Yes ☐ No

28. Are there any other accountability functions (any factors that support accountability) in place?

    ☐ Yes ☐ No

29. If yes, please describe the types of accountability mechanisms and how they are used?

    .....

    .....

    .....

Annex 3

List of budget centres included in the sample

1.	EM	EM/ARD Assistant Regional Director
2.	EM	EM/CEH Centre for Environmental Health Activities, Amman
3.	EM	EM/DAF General Management
4.	EM	EM/DCD Division of Communicable Disease Control
5.	EM	EM/DHP Division of Health Protection and Promotion
6.	EM	EM/DHS Division of Health Systems & Services Development
7.	EM	EM/DRD Office of Deputy Regional Director
8.	EM	EM/POL Polio Eradication
9.	EM	EM/RDO Office of The Regional Director
10.	EM	EM_AFG WHO Representative's Office, Afghanistan
11.	EM	EM_BAA Desk Office, Bahrain
12.	EM	EM_DJI WHO Representative's Office, Djibouti
13.	EM	EM_EGY WHO Representative's Office, Egypt
14.	EM	EM_IRA WHO Representative's Office, Iran
15.	EM	EM_IRQ WHO Representative's Office, Iraq
16.	EM	EM_JOR WHO Representative's Office, Jordan
17.	EM	EM_KUW Desk Office, Kuwait
18.	EM	EM_LEB WHO Representative's Office, Lebanon
19.	EM	EM_LIY WHO Representative's Office, Libyan Arab Jamahiriya
20.	EM	EM_MOR WHO Representative's Office, Morocco
21.	EM	EM_OMA WHO Representative's Office, Oman
22.	EM	EM_PAK WHO Representative's Office, Pakistan
23.	EM	EM_PSE WHO Representative's Office, Palestine
24.	EM	EM_QAT Desk Office, Qatar
25.	EM	EM_SAA WHO Representative's Office, Saudi Arabia
26.	EM	EM_SOM WHO Representative's Office, Somalia
27.	EM	EM_SUD WHO Representative's Office, Sudan
28.	EM	EM_SYR WHO Representative's Office, Syrian Arab Republic
29.	EM	EM_TUN WHO Representative's Office, Tunisia
30.	EM	EM_UAE Desk Office, United Arab Emirates
31.	EM	EM_YEM WHO Representative's Office, Yemen
32.	EU	EU/DAF Division of Administration and Finance
33.	EU	EU/DCS Division of Country Health Systems
34.	EU	EU/DHP Division of Health Programmes
35.	EU	EU/RDO Office of Regional Director
36.	EU	EUR RO Transition Budget

37.	EU	EU_ALB WHO Country Office, Albania
38.	EU	EU_AND Desk Office, Andorra
39.	EU	EU_ARM WHO Country Office, Armenia
40.	EU	EU_AZE WHO Country Office, Azerbaijan
41.	EU	EU_BIH WHO Country Office, Bosnia & Herzegovina
42.	EU	EU_BLR WHO Country Office, Belarus
43.	EU	EU_BUL WHO Country Office, Bulgaria
44.	EU	EU_CRO WHO Country Office, Croatia
45.	EU	EU_CZH WHO Country Office, Czech Republic
46.	EU	EU_ESP Desk Office, Spain
47.	EU	EU_EST WHO Country Office, Estonia
48.	EU	EU_FIN Desk Office, Finland
49.	EU	EU_GBR Desk Office, United Kingdom of Great Britain
50.	EU	EU_GEO WHO Country Office, Georgia
51.	EU	EU_GRC Desk Office, Greece
52.	EU	EU_HUN WHO Country Office, Hungary
53.	EU	EU_ITA Desk Office, Italy
54.	EU	EU_KAZ WHO Country Office, Kazakhstan
55.	EU	EU_KGZ WHO Country Office, Kyrgyzstan
56.	EU	EU_LTU WHO Country Office, Lithuania
57.	EU	EU_LVA WHO Country Office, Latvia
58.	EU	EU_MAT Desk Office, Malta
59.	EU	EU_MDA WHO Country Office, Republic of Moldova
60.	EU	EU_MKD WHO Country Office, The former Yug Rep of Macedonia
61.	EU	EU_MNE WHO Country Office, Montenegro
62.	EU	EU_NOR Desk Office, Norway
63.	EU	EU_POL WHO Country Office, Poland
64.	EU	EU_POR Desk Office, Portugal
65.	EU	EU_ROM WHO Country Office, Romania
66.	EU	EU_RUS WHO Office for the Russian Federation
67.	EU	EU_SRB WHO Country Office, Serbia
68.	EU	EU_SVK WHO Country Office, Slovakia
69.	EU	EU_SVN WHO Country Office, Slovenia
70.	EU	EU_TJK WHO Country Office, Tajikistan
71.	EU	EU_TKM WHO Country Office, Turkmenistan
72.	EU	EU_TUR WHO Country Office, Turkey
73.	EU	EU_UKR WHO Country Office, Ukraine
74.	EU	EU_UZB WHO Country Office, Uzbekistan
75.	HQ	HQ/ALC Ageing and Life Course
76.	HQ	HQ/CAH Child and Adolescent Health and Development
77.	HQ	HQ/CCO – Country Focus
78.	HQ	HQ/CHP Chronic Diseases and Health Promotion
79.	HQ	HQ/DCO Department of Communications

80.	HQ	HQ/EHT Essential Health Technologies
81.	HQ	HQ/EMP Essential Medicines & Pharmaceutical Policies
82.	HQ	HQ/EPC Emergency Preparedness and Capacity Building
83.	HQ	HQ/ETH Ethics, Equity, Trade and Human Rights
84.	HQ	HQ/FCA FCH ADGO Office of the Assistant DG
85.	HQ	HQ/FNM Department of Finance
86.	HQ	HQ/FOS Food Safety, Zoonoses and Foodborne Diseases
87.	HQ	HQ/GAR Global Alert & Response
88.	HQ	HQ/GBS Dept for Governing Bodies and External Relations
89.	HQ	HQ/GIP – Global Influenza Programme
90.	HQ	HQ/GMA GMG ADGO Office of the Assistant DG
91.	HQ	HQ/GMP Global Malaria Programme
92.	HQ	HQ/GSC Global Service Centre
93.	HQ	HQ/GWH Gender, Women and Health
94.	HQ	HQ/HAA HAC ADGO Office of the Assistant DG
95.	HQ	HQ/HDS Health Policy, Development and Services
96.	HQ	HQ/HEA HSE ADGO Office of the Assistant DG
97.	HQ	HQ/HIV HIV/AIDS
98.	HQ	HQ/HMA HTM ADGO Office of the Assistant DG
99.	HQ	HQ/HRD Human Resources Management
100.	HQ	HQ/HRH Human Resources for Health
101.	HQ	HQ/HSA HSS ADGO Office of the Assistant DG
102.	HQ	HQ/HSF Health Systems Financing
103.	HQ	HQ/HSI Health Statistics and Informatics
104.	HQ	HQ/HSR Alliance for Health Policy and System Research
105.	HQ	HQ/HWA Global Health Workforce Alliance
106.	HQ	HQ/IEA IER ADGO Office of the Assistant DG
107.	HQ	HQ/IHR International Health Regulations Coordination
108.	HQ	HQ/IOS Office of Internal Oversight Services
109.	HQ	HQ/ITT Information Technology and Telecommunications
110.	HQ	HQ/IVB Immunization, Vaccines and Biologicals
111.	HQ	HQ/KMS Knowledge Management and Sharing
112.	HQ	HQ/LEG Office of the Legal Counsel
113.	HQ	HQ/MPS Making Pregnancy Safer
114.	HQ	HQ/MSD Mental Health and Substance Abuse
115.	HQ	HQ/NHD Nutrition for Health and Development
116.	HQ	HQ/NMA NMH ADGO Office of the Assistant DG
117.	HQ	HQ/NMC Partnership for Maternal, Newborn and Child Health
118.	HQ	HQ/NTD Control of Neglected Tropical Diseases
119.	HQ	HQ/ODG Office of the Director-General
120.	HQ	HQ/OSS Operational Support and Services
121.	HQ	HQ/PCA PCU ADGO Office of the Assistant DG
122.	HQ	HQ/PHE Protection of the Human Environment

123.	HQ	HQ/PHI Public Health, Innovation and Intellectual Property
124.	HQ	HQ/POL – Polio Eradication Initiative (HSE)
125.	HQ	HQ/PRP Planning Resource Coordination and Perf Monitoring
126.	HQ	HQ/PSP Patient Safety Programme
127.	HQ	HQ/PUN – Partnerships and UN Reform
128.	HQ	HQ/RHR Reproductive Health and Research
129.	HQ	HQ/RPC Research Policy and Cooperation
130.	HQ	HQ/RRO Emergency Response & Recovery Operations
131.	HQ	HQ/RTR Holding Workplan
132.	HQ	HQ/SPR Strategy, Policy and Resource Management
133.	HQ	HQ/STB Stop TB
134.	HQ	HQ/TBP Stop TB Partnership Secretariat
135.	HQ	HQ/TDR Spcl Prog for Research and Training in Trop Diseases
136.	HQ	HQ/TFI Tobacco Free Initiative
137.	HQ	HQ/VIP Injuries and Violence Prevention
138.	HQ	HQ/WKC WHO Centre for Health Development (Kobe, Japan)
139.	HQ	HQ/WMC WHO Mediterranean Centre for Vulnerability Reduction
140.	SE	SE/CDS Department of Communicable Diseases (CDS)
141.	SE	SE/DAF Director – Administration & Finance
142.	SE	SE/DPM Director – Programme Management
143.	SE	SE/DRD Office of Deputy Regional Director
144.	SE	SE/EHA Emergency and Humanitarian Action
145.	SE	SE/FCH Department of Family and Community Health (FCH)
146.	SE	SE/FHR Department of Family and Research
147.	SE	SE/HSD Department of Health Systems Development
148.	SE	SE/IVD Immunization and Vaccine Development
149.	SE	SE/NDS Noncomm Diseases & Social Determinants of Health
150.	SE	SE/NMH Dept of Noncommunicable Diseases & Mental Health
151.	SE	SE/RDO Regional Director's Office
152.	SE	SE/SDE Dprtmnt of Sustainable Dev and Healthy Environments
153.	SE	SE_BAN WR Office, Bangladesh
154.	SE	SE_BHU WR Office, Bhutan
155.	SE	SE_IND WR Office, India
156.	SE	SE_INO WR Office, Indonesia
157.	SE	SE_KRD WR Office, DPR Korea
158.	SE	SE_MAV WR Office, Maldives
159.	SE	SE_MMR WR Office, Myanmar
160.	SE	SE_NEP WR Office, Nepal
161.	SE	SE_SRL WR Office, Sri Lanka
162.	SE	SE_THA WR Office, Thailand
163.	SE	SE_TLS WR Office, Timor-Leste
164.	WP	WP/DAF Director, Administration and Finance
165.	WP	WP/DCC Director, Combating Communicable Diseases

166.	WP	WP/DHP Director, Building Healthy Communities & Populations
167.	WP	WP/DHS Director, Health Sector Development
168.	WP	WP/DPM Director, Programme Management
169.	WP	WP/RDO Office of the Regional Director
170.	WP	WP_ASM American Samoa
171.	WP	WP_BRN Brunei Darussalam
172.	WP	WP_CHN China
173.	WP	WP_COK Cook islands
174.	WP	WP_FJI Fiji
175.	WP	WP_FSM Federated States of Micronesia
176.	WP	WP_GUM Guam
177.	WP	WP_JPN Japan
178.	WP	WP_KHM Cambodia
179.	WP	WP_KIR Kiribati
180.	WP	WP_KOR Republic of Korea
181.	WP	WP_LAO Lao People's Democratic Republic
182.	WP	WP_MHL Marshall Islands
183.	WP	WP_MNG Mongolia
184.	WP	WP_MNP Commonwealth of the Northern Mariana Islands
185.	WP	WP_MYS Malaysia
186.	WP	WP_NIU Niue
187.	WP	WP_NRU Nauru
188.	WP	WP_PHL Philippines
189.	WP	WP_PIC Pacific Island Countries
190.	WP	WP_PLW Palau
191.	WP	WP_PNG Papua New Guinea
192.	WP	WP_PYF French Polynesia
193.	WP	WP_SGP Singapore
194.	WP	WP_SLB Solomon Islands
195.	WP	WP_TKL Tokelau
196.	WP	WP_TON Tonga
197.	WP	WP_TUV Tuvalu
198.	WP	WP_VNM Viet Nam
199.	WP	WP_VUT Vanuatu
200.	WP	WP_WSM Samoa

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