Summary Report:

What Works in Gender and Health
Setting the Agenda

Expert Consultation
29-30 April 2019, Alila Bangsar
Kuala Lumpur, Malaysia
What Works in Gender and Health
Setting the Agenda

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### Abbreviations

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<th>Description</th>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>ECOSOC</td>
<td>United Nations Economic and Social Council</td>
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<td>FENSA</td>
<td>Framework of Engagement with Non-State Actors</td>
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<td>GBV</td>
<td>Gender-based Violence</td>
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<td>GPW</td>
<td>General Programme of Work</td>
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<td>HSG</td>
<td>Health Systems Global</td>
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<td>HSS</td>
<td>Health System Strengthening</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<td>MNCAH</td>
<td>Maternal, Newborn, Child and Adolescent Health</td>
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<td>NCDs</td>
<td>Non-communicable Diseases</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations international Children’s Emergency Fund</td>
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<td>UN-SWAP</td>
<td>UN System-Wide Approach towards Gender Equality and the Empowerment of Women</td>
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<td>WGEKN</td>
<td>Women and Gender Equity Knowledge Network</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Executive Summary

There is an urgent need in global health to identify and implement evidence-based approaches that effectively transform gendered power dynamics and promote gender equality in health policies, programmes and workplaces. A meeting was co-convened by UNU-IIGH and WHO from 29-30 April 2019 to take stock, review and discuss gender mainstreaming approaches in health. This marked the beginning of a joint programme of work that will inform future interventions and initiatives with evidence on what works in gender and health.

Since the Beijing World Conference on Women twenty-five years ago, several international organisations and development agencies have adopted gender mainstreaming policies and developed monitoring tools and training programmes for staff. But progress has been slow, partly due to marginal financial and human capital investments in the gender architecture and strategic mainstreaming activities that could have catalyzed institutional change. Without investments in gender-transformative programming that re-shapes unequal gender relationships, sufficient health-specific gender expertise, and more commitment to accelerate progress from senior leaders and managers, the UN will remain off track to its commitment to promoting gender equality for health and by the health sector.

There is a need to course-correct, to measure and prioritise institutional and programmatic gender equality outcomes (not just processes), to ensure independent accountability, and to enable critical reflexivity and learning from practice. More evidence is required on what has worked in gender mainstreaming in health to ensure that the most effective and strategic approaches are prioritised and adequately resourced to meet the 2030 Agenda.

The available evidence base that supports gender mainstreaming is limited to sexual and reproductive health and rights (SRHR), maternal, newborn, child and adolescent health (MNCAH), HIV/AIDS, and gender-based violence (GBV) programming and service delivery, with major gaps in other areas such as non-communicable diseases (NCDs), technological innovations and climate change, and in other health system building blocks. However, there has also been a missed opportunity to analyse and transfer, where applicable, lessons from these area to other areas of health.

The existing evidence suggests that gender-aware programmes which take account of the differences in roles and relations between women and men have led to tangible improvements in health status, knowledge, behaviours, and healthcare utilisation. Specific gains include reduced incidence of sexually transmitted infections (STIs), HIV and intimate partner violence (IPV). Gender-transformative programmes had a broader impact, contributing to gender-equitable attitudes, promoting equitable relationships, increasing the frequency of joint decision-making by men and women, and enhancing women’s self-confidence and self-efficacy.

Drawing on evidence from research and practice, seven non-exhaustive strategies to implement gender mainstreaming are suggested in this report:

1. Developing accountability frameworks and tools for monitoring and evaluation
2. Incentivising gender mainstreaming and capacity building through innovative certification and credentialing approaches
3. Building and leveraging leadership commitment
4. Instrumentalising gender for health outcomes
5. Using strategic entry points and strategic language to communicate on gender issues
6. Multisectoral and civil society engagement
7. Foster partnerships with governments.
To move forward, the meeting proposed three main priorities for action and research:

- **Build transformative partnerships, alliances and networks** to engage new stakeholders in the co-production of an action and research agenda for gender mainstreaming;

- **Build the evidence base** by documenting and evaluating what has worked in gender and health, why, and how it can be applied to other health programmes or contexts; extend the evidence to new and emerging areas.

- **Invest** in gender expertise, data collection, impact evaluation and independent transparent accountability mechanisms.

This report speaks to diverse audiences committed to achieving gender equality and to ensuring healthy lives and well-being for all: senior leadership of UN agencies and international organisations, gender and health experts, researchers, health practitioners, donors and civil society.
Background

The 2030 Agenda for Sustainable Development recognises gender equality and women's empowerment as a standalone goal that must be achieved in its own right, as well as an accelerator that will enable and contribute to the achievement of the other Sustainable Development Goals (SDGs). The SDG 3 of ‘ensuring healthy lives and promoting well-being for all at all ages’ is inextricably linked to gender equality (SDG 5), as is any progress towards universal health coverage (UHC) and several other SDGs in the framework.

The United Nations (UN) and Member states have re-committed themselves to mainstreaming gender in all policies and programmes and the UN system has put in place several policies and processes to fulfil these commitments, such as the UN System-Wide Approach towards gender equality and the empowerment of women (UN-SWAP), and the UN Secretary-General’s Policy on Gender Parity.

Despite bold commitments, organisational processes, and a plethora of guidance documents and tools, progress has remained limited. Gender injustices persist, and the unequal distribution of power impedes our ability to affect change. Twenty-five years after the Beijing Declaration and Platform for Action as adopted by the UN, gender mainstreaming is often seen as low priority and when it is implemented, it is poorly resourced and receive inconsistent support from the top leadership of most organisations.

While there is a considerable body of evidence and lessons learned from experience in applying gender mainstreaming in certain health areas, such as SRHR, MNCAH, HIV/AIDS and GBV, there is a need to extend gender mainstreaming to other areas, such as NCDs, technological innovation, UHC, health systems strengthening (HSS) and climate change. At the institutional level, sustained efforts at organisational gender mainstreaming and better understanding of good practices and effective mechanisms are required to directly support capacity and accountability for programmatic mainstreaming.

There are several potential threats to gender mainstreaming. There is a geopolitical context that is increasingly conservative and hostile to multilateralism, civil society, human rights and gender equality. There are also significant complexities introduced by the role of industry and the private sector in health. Counterbalancing the threats, there are exciting opportunities offered through new social movements, new actors and funders, frontier technologies, and UN reform.

Business as usual is not an option; we risk losing ground and foregoing the fragile gains made to date. To accelerate change and impacts, there is an urgent need in global health to identify and implement evidence-based approaches that effectively transform gendered power dynamics and promote gender equality in health policies, programmes and workplaces, and make a real difference to women and men’s health and wellbeing.

The expert meeting

Recognising the urgent need to accelerate progress, the United Nations University International Institute for Global Health (UNU-IIGH), in collaboration with the World Health Organization (WHO) convened an expert consultation at Alila Bangsar in Kuala Lumpur, Malaysia, from 29 to 30 April 2019. It was attended by gender experts from the UN agencies responsible for global health (WHO, UNDP, UNICEF, UNFPA, UN Women), as well as a limited number of representatives from civil society and the academic community.

The purpose of the meeting was to take stock of progress in gender mainstreaming, to critically analyse contextual and other factors that contribute to successes and failures, and to set a forward-looking action and research agenda in gender and health. In particular, the objectives of expert meeting were:

1. To have an open discussion and a deep dive analysis into good practices and experiences at the country, regional and headquarter level regarding what constitutes successful gender mainstreaming. Deliberations were meant to go beyond descriptive analysis of the current status quo and recommended monitoring and evaluation or policy advice to include implementation support, and mainstreaming in non-traditional health areas;

2. To reflect on synthesised evidence and good practices in integrating gender equality programmatically, as well as in establishing effective institutional mechanisms across UN agencies and civil society organisations working on health;

3. To identify evidence, action gaps and priorities for strengthening the promotion of gender equality in different programmatic health areas, and institutional accountability mechanisms;

4. To identify next steps in implementing successful gender mainstreaming in various areas of health, including future convening, joint work priorities, and research.
As the think tank for the UN on global health, the United Nations University International Institute for Global Health (UNU-IIGH) aims to support the work of key UN health implementing agencies and programmes in this area which address the critical intersections between SDG3 and SDG5. UNU-IIGH also serves as a neutral convenor for critical intersectoral policy dialogue, evidence-based debates, and where relevant, consensus-building, as well as a South-South learning hub to support capacity building for local decision making for health systems.

Under the new strategy, one of the core functions of UNU-IIGH is the generation of policy-relevant analysis and evidence on effective approaches to reducing gender disparities in health.

In its 13th General Programme of Work (GPW 2019-2023), WHO pledges to monitor the world’s progress and its own contribution towards ‘health for all’ with three ambitious ‘triple billion’

- 1 billion more people benefitting from universal health coverage
- 1 billion more people better protected from health emergencies
- 1 billion more people enjoying better health and well-being

The GPW 13 includes gender equality and its commitment to SDG 5, as one of its cross-cutting priorities. In addition, WHO and the UN Secretary-General’s office have co-led the development of the Global Action Plan for Healthy Lives and Wellbeing for All to leverage the full potential of the multilateral system and to more effectively support countries to deliver on the health-related SDG targets.

In its action framework, gender equality has been identified as an area where a common approach and collective action will add value and increase impact. This aligns closely with the UN Secretary-General’s reform agenda. WHO already has a mandate to mainstream gender through the 2007 World Health Resolution and Strategy for integrating gender analysis and actions into WHO’s work (WHA 60.25), and a ‘Roadmap for Action (2014-2019) for Integrating Gender, Equity and Human Rights into the Work of WHO’.
The Alila consultation is the first in an engagement process to co-construct the agenda and co-produce the evidence towards strengthening gender mainstreaming. The meeting initiated a joint programme of work to review, synthesise and consolidate learning and evidence on the promotion of gender equality in health policies, programmes, practices, workplaces and people’s lives. The outcomes will inform interventions and initiatives like the Global Action Plan for Health Lives and Well-being, WHO’s 13th GPW, UN-SWAP and supplement existing frameworks for monitoring progress.

Outcomes

1. A critical scan of good practices, lessons learned and challenges in gender mainstreaming, particularly in health, across a range of contexts;

2. Evidence-informed and policy-relevant action and research agenda for the UN to continue to advance gender mainstreaming in health;

3. A joint interagency programme of work in response to pressing needs for further evidence building and policy analysis on gender mainstreaming in health.

This report presents and critically reflects on the main discussions in the expert meeting. Part 1 of the report focuses on the deliberations that directly address the title of the meeting: What works in gender mainstreaming in health; Part 2 summarises the rich context of gender mainstreaming that provides the grounding to the discussions; Part 3 outlines the priorities for research and action.
Part 1: 
What works in gender mainstreaming in health

The meeting raised several issues about the assessment of success in gender mainstreaming and health. Discussions addressed both intermediate and final outcomes, with different underlying theories of change (Payne, 2014).

1. Intermediate measures of success assess whether mainstreaming strategies had actually been implemented, i.e. whether an organisation has ‘mainstreamed’ or addressed gender, both institutionally and programmatically. Examples include the number of normative guidelines or national policy documents that integrated gender considerations (as a result of UN support).

2. The instrumental approach considers that gender mainstreaming has worked if reductions in gender inequalities in health behaviours or experiences result in improved health outcomes.

3. Regardless of demonstrable impact on health, it can be argued that health systems, policies, programmes and workplaces should promote gender equality and women’s empowerment in their own right, and be held accountable for gender equality.

1. Evidence from research

A significant body of evidence emerged towards the late 90s and early 2000s to take stock of gender mainstreaming as a new strategy. Several international organisations and development agencies conducted internal assessments, and academics took a critical look at what had happened in the decade since Beijing (Aasen, 2006; AWID, 2006; European Commission, 2005; Eyben, 2006; Hunt and Brouwers, 2003; Mehra and Gupta, 2006; Moser and Moser, 2005; Rao and Kelleher, 2005; Taukobong et al., 2016; van Reisen and Ussar, 2005). They found that most organisations had adopted gender mainstreaming policies; developed tools and guidance documents for collecting sex-disaggregated data and conducting gender analysis to inform policy and programming; and put in place gender training for staff (Moser and Moser, 2005). However, there was a major implementation gap, due to poor resourcing of internal gender machineries or strategies, and a lack of leadership and commitment to change. Where strategies or policies had been implemented, there was limited to no documentation or evaluation, which reflected a lack of adequate outcome indicators, and an internal focus on input indicators.

A seminal paper in 1997 described the evaporation of gender policies in the ‘patriarchy cooking pot’, arguing that development agencies’ gender mainstreaming attempts had been met with considerable barriers in the form of patriarchal organisational structures and culture (Longwe, 1997). Progress was also hindered by the idea that gender mainstreaming was a ‘box-ticking’ exercise that could be completed with a set of tools and activities. Additionally, gender mainstreaming was promoted as a behavioural change process, detached from political and social structures. Strategies or programmes failed to address the root causes of gender inequalities by integrating gender concerns within the status quo, and therefore the underlying gender power relations and structural reasons for gender inequalities in health were overlooked.

Evidence on gender mainstreaming in health was reviewed by the Women and Gender Equity Knowledge Network (WGEKN) in 2007, as part of the WHO Commission on Social Determinants of Health. Several other reviews were undertaken in the following decade (e.g. Sen et al., 2007; Ravindran, 2012; Payne 2015; Theobald et al., 2017), coinciding with the increased interest in evaluation from the international development field. Again, there was a disconnect between the availability of policy rhetoric vs. practice and implementation, suggesting a lack of commitment.

Other work has explored the effectiveness of gender-responsive health interventions. These are broadly categorised into gender-accommodating interventions that cater to women’s and men’s different needs without challenging unequal gender power relations; and gender-transformative interventions that acknowledge and challenge gender norms and address inequalities (Muralidharan et al., 2015). This evidence base suggests that gender-aware health interventions have led to tangible improvements in health knowledge, behaviours, healthcare utilisation and health status, for example reduced incidence of STIs, HIV and intimate partner violence. Further, transformative strategies have shaped gender-equitable attitudes, promoted equitable relationships, increased the frequency of joint decision-making by men and women, increased women’s self-confidence and self-efficacy.
Interventions that encourage some form of critical reflection among women and men on their socialisation into specific gender roles and norms are associated with the best outcomes (Muralidharan et al., 2015). These activities have been implemented alone or combined with social behaviour change communication and economic or educational empowerment activities. Most gender-aware approaches (specifically the gender-transformative ones) have often been targeted at specific age groups (e.g. adolescents) or at-risk population groups (e.g. key populations in HIV, high IPV settings) and implemented in community settings.

Although earlier reviews underscored methodological limitations, due to the small number of studies, lack of comparators, limited analysis of pathways to impact, and several self-reported indicators, more recent reviews suggest more rigorous evaluation designs, with several quasi-experimental and experimental studies (Muralidharan et al., 2015; Ravindran, 2008; Schriver et al., 2017). Nonetheless, the evidence base is skewed towards small-scale interventions, often designed and implemented by NGOs, with limited evidence of interventions being successfully scaled up or integrated into government programmes. There has not been any gender mainstreaming experimentation in health at a larger scale (e.g. nationally) that could be assessed for its impact, nor a systematic agenda to do so.

Most of the evidence is from reproductive health, maternal and child health, adolescent health, HIV/AIDS and GBV. While the field is gaining a better understanding of what works in service delivery for these health programmes, there are major gaps in other programmatic areas with large burdens of disease, including infectious diseases (like tuberculosis, malaria), NCDs, and mental health (Lo et al., 2019). There is also a paucity of evidence on effective gender-responsive approaches within the health system building blocks, besides some evidence for human resources for health, and some burgeoning work in relation to UHC (Sen et al., 2018; Witter et al., 2017; WHO, 2019).

An ongoing review of published articles on gender mainstreaming has identified 35 publications in health, and concluded that many studies are descriptive, and involve document reviews (one discourse analysis); while only a few evaluate implementation, some have no methods at all, and none assess sustainability through a longitudinal, health systems lens. Additionally, there is a concerning lack of embedded research or consistent methodologies (George, 2019).

2. Evidence from practice

There have been limited efforts to document gender mainstreaming successes within agencies, for lack of time, human and financial resources. The assessment and monitoring of gender mainstreaming within the UN has mostly focused on process-oriented outcomes, and less on the results of programmes, or measures of institutional change.

Yet, there is a wealth of experience and lessons from the past two decades, particularly among the gender specialists and gender focal points who have made up the gender architecture and have been tasked with driving the implementation of the mainstreaming agenda. Some of the strategies they have adopted to ensure that gender was being mainstreamed within their institutions and their programmes have been more successful than others, with important lessons learned. Additionally, analyses suggest that while specific activities are successfully implemented with the range of available toolkits and training programmes, these changes are not sustained beyond individual gender champions or specific programmes. Despite significant efforts by individuals, the fact that the ‘gender people’ are not resourced or given the authority to effect change, but are still held accountable for the lack thereof, has not been conducive to the progressive realisation of gender mainstreaming.

Table 1 overleaf, presents seven of these strategies that are perceived to have worked to ensure the implementation of gender mainstreaming, as mechanisms on the pathway to institutional and programmatic impact. There is no systematic evidence yet that all these strategies have led to positive outcomes for gender equality or health, but they are promising examples of how the UN agencies and the gender champions within them have addressed gender in their policies, structures, decisions and interventions.
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<th>Strategy</th>
<th>Examples of how this has been implemented with success</th>
<th>Challenges encountered</th>
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| 1. Developing accountability frameworks and tools for monitoring and evaluation (M&E) | • The UN-SWAP itself has been an important accountability tool, with unified indicators and standards, as well as visibility among the agencies’ leaders. Improvements in meeting the minimum requirements have been seen over time;  
• Standardised tools have been developed across agencies for gender-responsive data collection, gender analysis and reporting (e.g. WHO guideline development processes);  
• Integrating gender within existing tools and mechanisms (e.g. WHO guideline development processes). | • Limited capacity or availability of M&E staff to collect and analyse data;  
• Indicators are not comparable across agencies or regions;  
• Measures focus on processes and not results;  
• Reporting may not be followed by action or change. Although agencies are required to self-assess for the UN-SWAP through criteria provided by UN Women, these are not a requirement or a key performance indicator and there are no clear consequences or remedial action if progress is not being made;  
• Lack of transparency of reporting and response. |
| 2. Incentivising gender mainstreaming and capacity building through innovative certification and credentialing approaches | • Rewarding gender mainstreaming efforts, such as UNDP’s Gender Equality Seal Programme which involves a certification process for country offices that has motivated staff and promoted gender mainstreaming as something that is tangible and achievable;  
• Attracting, building and recognising gender expertise through targeted professional development programmes, such as UNICEF’s GenderPro initiative to build gender expertise and a credentialing system;  
• Institutionalisation of gender focal points and senior gender expert role in agencies’ senior management teams, such as principal gender advisors;  
• Identification of key competencies to build gender talent pool, with sector-specific expertise. | • Insufficient and dwindling number of gender experts at headquarter, regional and country levels (depending on the agency);  
• Gender experts are stretched across multiple programmes or areas of work;  
• Gender staff held accountable for gender mainstreaming, but not given the resources or authority to deliver;  
• Gender trainings are not always attended or prioritised by programme staff. |
### 3. Building and leveraging leadership commitment

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<th>Challenges encountered</th>
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<td>• Long-term investment in ongoing advocacy and engagement with organisational leaders at the agency, regional and country office level to build awareness and buy-in for gender mainstreaming, when it is lacking;</td>
<td>• Lack of, or intermittent, commitment from leaders result in back-and-forth trajectories;</td>
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<td>• When supportive and committed leaders come on board, leverage this leadership to institutionalise processes for gender mainstreaming, and engage with priority programme areas to effectively deliver results and maintain credibility;</td>
<td>• Individual efforts are not sufficient for the progressive realisation of gender mainstreaming, as they often involve fire-fighting or ‘running just to stay in place’;</td>
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<td>• Committed champions for gender equality influence other leaders to implement gender mainstreaming policies and programmes (e.g. across agencies) and pursue long-term financial engagement with donors.</td>
<td>• Resource limitations to initiate new areas of work pose severe constraints for gender strategies and programming;</td>
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### 4. Instrumentalising gender for health outcomes

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<th>Challenges encountered</th>
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<td>• Making the case to health programme managers within agencies or government counterparts that addressing gender inequality will improve health programme effectiveness and health outcomes, has been the most successful approach to getting buy-in for gender mainstreaming (building the case approach);</td>
<td>• Gender mainstreaming is sometimes too personal for gender champions and it can bring unintended consequences such as stigmatisation within teams and opposition from colleagues who were supposed to be allies.</td>
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<td>• For example, UNDP’s legal environment assessment has been used in 25 countries to demonstrate how legal barriers were operating as structural barriers to HIV programme effectiveness.</td>
<td>• There is limited data to make a strong instrumental case, especially in certain disease areas (e.g. NCDs, malaria and TB). Moreover, effectiveness data for gender-responsive interventions across health programmes is even more limited;</td>
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<td>• This strategy has been more effective for health programmes than for health system building blocks.</td>
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<td>Strategy</td>
<td>Examples of how this has been implemented with success</td>
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| 5. Using strategic entry points and strategic language to communicate on gender issues | • Framing gender mainstreaming under the umbrella of the women’s health agenda has been more politically acceptable than through SRHR strategies (despite overlap in content);  
  • Translating the lexicon of gender and women’s empowerment into pragmatic approaches and more acceptable language, such as quality of care, dignity, respectful care (depending on the context);  
  • Health policy-makers are concerned with delivering efficient, quality health services for better health outcomes, and need to know what to do practically to address gender within their daily work;  
  • Communication based on familiar language, shared understanding and concerns that builds a case for use of a gender approach;  
  • Established areas of programming, such as GBV, can serve as strong entry points for other health areas and for agency operations, such as in strategy and coordination;  
  • Using the equity and ‘Leave No One Behind’ agenda as an entry point for gender, particularly in contexts where gender work is less well received. | Areas such as SRHR or GBV are equated with women’s rights and gender equality and it may not be possible to use ‘neutral’ language to engage in some of these areas and interventions. There is also a risk of dilution and losing focus on core principles and power dynamics. |
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| 6. Multisectoral and civil society engagement (the ‘Insider- outsider’ strategy) | • Advocacy and engagement by the gender machinery within agencies can be strengthened by advocacy and lobbying from stakeholders on the outside, in particular strong civil society actors and member states;  
  
• Building relationships with these external like-minded partners and stakeholders is critical, as well as building momentum and efforts across agencies and other organisations (e.g. UNFPA, UNDP, Global Fund partnership). | Some agencies or regional offices have not been able to look beyond their programmes or countries of work to engage with other partners (in other areas or countries). |
| 7. Foster partnerships with governments                                 | • Tackling and influencing political dynamics as much as possible, including in conflict regions where humanitarian programmes are required  
  
• In some regions, high-level national leaders are political champions for gender equality and women’s rights;  
  
• Fostering links to high-level national and regional institutional mechanisms and government bodies (e.g. ASEAN). | Geopolitical context, Global North-South power dynamics, and hostile resistance in some countries towards several areas, such as family planning and SRHR, is an antagonistic force that hinders and may reverse progress. |
Key Messages

- Gender mainstreaming has been treated as ‘behaviour change’ rather than as ‘social change’, with a focus on training at the individual level.

- Gender mainstreaming has attempted to integrate gender concerns within the status quo, instead of challenging the root causes of gender inequality.

- The evidence base on effective gender-responsive approaches is primarily from SRHR, MCNAH, HIV and GBV service delivery and programming, with major gaps in other disease areas and in other health system building blocks.

- Accountability mechanisms for gender mainstreaming must be strengthened. One powerful strategy would be to hold heads of UN agencies and programmes working in health accountable for addressing gender inequality and restrictive gender norms that undermine the effectiveness of programmes.

- Key success factors include: (1) buy-in and support from senior leadership with gender champions who can broker new relationships and alliances both within and across organisations, explicitly recognising that both internal and external review and accountability are needed, (2) creatively recognise entry points, (3) mobilise resources, (4) contextualise and strategically frame gender mainstreaming to specific programmes and social contexts, without losing sight of core principles.
3. Gaps in implementation and evidence

Despite processes, mechanisms and tools that have supported gender-responsive approaches, entrenched challenges remain. The operationalisation of gender mainstreaming varies considerably across institutions and programmes, resulting in a lack of conceptual clarity and failure to articulate and track outcomes that are consistent with the underlying values of achieving gender equality. Agencies and programmes may therefore meet the threshold required for assessment, without achieving meaningful and sustainable change and impact. A different challenge is that negotiating for staff with gender expertise across programmatic areas, as well as specific technical expertise of the programmes targeted, is a constant battle. Critically, there has been only marginal investment in the gender architecture to enable mainstreaming, in terms of financial and human capital, and the power to catalyse the institutional changes required.

• **Conceptual issues:** There is a common definition of gender mainstreaming, however different agencies, CSOs and civil society interpret it differently, contributing to the lack of coherence of approaches. More clarity is needed for the definitions of gender, equity, rights, intersectionality and masculinities. For example, the gender equality definition by UN ECOSOC is not being applied across every organisation (e.g. WHO is promoting ‘gender sensitisation’). Lack of conceptual clarity is linked to ‘institutional ambivalence’ on methodologies to operationalise gender mainstreaming.

• **What has worked:** There is evidence and documentation on what was done (or not) to mainstream gender, but more evidence is needed on what has worked in gender mainstreaming in health, why and how it worked (or failed). The problems and reasons to intervene are known, but what to do and what results to expect are not clear.

• **Tools as an end:** Gender mainstreaming approaches have focussed on the development of tools and guidance documents for collecting sex-disaggregated data, conducting gender analysis to inform policy and programming, and gender training for staff. Tools facilitate programming and monitoring but they are not endpoints and do not necessarily lead to positive gender-equal outcomes.

• **Focus on process vs. outcomes:** The indicators that are regularly collected (e.g. under the UN-SWAP) assess the implementation of gender mainstreaming strategies. Indicators of progress are mostly process-related, given challenges in measuring impact on the ground. The gender and health related outcomes that these processes are designed to bring about have not been systematically documented through theories of change that should be iteratively tested.

• **Implementation challenges:** There are critical implementation gaps, partly attributed to fragile institutional mechanisms governed by tokenism with limited funding and staff resourcing and lack of leadership and commitment to change. Where the strategies or policies have been implemented, there is limited evaluation of the level of tool integration into policies, programmes, research and training. Also, there are limited external evaluators and accountability mechanisms for funding allocation.

• **Descriptive evidence:** Current evidence is descriptive rather than analytical, based on document reviews. It often fails to document the contextual factors and the specific actors and processes which led to successful mainstreaming. Gender analysis is often reduced to sex, based on comparisons between male and female, with not enough evaluation of the implementation strategies or their sustainability.

• **Holistic approaches:** Current models of impact and standardised tools for gender programming are contrary to its approach that is contextual and intersectional. The holistic nature and complexity of solutions keep gender priorities from being implemented at scale.

• **New programmatic areas:** Evidence of the extent and sources of gender differences in health outcomes is absent for programmatic areas with large burden of disease which have not traditionally had a strong gender focus, including NCDs, mental health, climate change, as well as in the context of humanitarian settings, health system strengthening and UHC.

• **Relative neglect of gender mainstreaming in health systems work:** There has been some progress towards UHC at national levels (measured through the UHC service coverage index) but there is limited evidence of gender mainstreaming applied to UHC frameworks and implementation While there is acknowledgement that gender is a critical factor, little has been done to mitigate how health systems fail to narrow and may even exacerbate gender inequalities.
• **Limited extrapolation and learning from more established areas of gender work:** SRHR and prevention and response to VAWG are areas that have received more attention. We need to consolidate what worked in these areas, and then apply to other areas to test whether and which gender mainstreaming approaches are generalisable.

• **Men and masculinities:** There is consensus that men have a crucial role in addressing gender inequality, including but not limited to GBV. Engaging men implies a deep understanding of what being a man in different cultures entails, and the masculine socialisation that dictates their roles and expectations. Mobilising men to achieve structural changes in institutions and society requires their support to contest gender-inequitable distribution of power, resources, and opportunities in workplaces, families, and communities.

• **Intersectionality:** Gender mainstreaming should consider that gendered needs will interact and vary across age, race, class and should be wary of essentialising special groups as another form of identity politics. For example, more evidence is needed for application of gender mainstreaming in programmes targeted at particular groups such as men and boys, adolescents and LGBT+ community.

### 4. Critical reflection – taking stock and moving forward

The global landscape has changed dramatically since gender mainstreaming became the primary strategy for promoting gender equality across sectors. There are serious external threats including hostility to multilateralism, social justice and equity in global policy, shrinking spaces for civil society, and a growing role of the private sector in shaping health behaviour and health systems. The backlash against women’s rights and women’s movements in particular, suggests that continuing with business as usual will mean losing ground, and forgoing fragile gains made to date. The UN, in partnership with civil society, new social movements and new actors, could potentially play a key role in reframing the discourse, and tapping new opportunities.

**Re-visit gender mainstreaming**

The UN has been trying to mainstream gender for over two decades, with limited success. This begs a number of questions:

- Is gender mainstreaming the wrong strategy?
- Is it the right strategy that has not been (well) implemented?
- Is there a need for a new approach, terminology or framing? Can we redefine the strategy based on which mechanisms and approaches have worked?

The UN-SWAP has been a useful tool to support entities to put policies and processes in place, and to guide them in what they can do (and do better) across various domains and institutional functions. It also promotes cross-agency learning for gender focal points. However, the UN-SWAP is, by its nature, a compromise between 66 UN entities on what is feasible and convenient to report, not necessarily what is most meaningful. It has a heavy focus on process indicators, and much less on results, although UN-SWAP 2.0 has a greater focus on results. It is an onerous reporting tool that appears to suffer from the “apparent tendency to ‘appear to do much’ rather than making fundamental changes” (Sen and Ostlin, 2010) and claims significant time investments from shrinking teams of gender specialists, reducing their ability to support mainstreaming efforts. The return on investment is not clear.
The apparent disconnect between UN-SWAP compliance and institutional or programmatic outcomes (like organisational culture) also suggests that it may be measuring or placing emphasis on the wrong metrics. For example, UNAIDS is a star UN-SWAP performer, but as an institution it has failed to create an inclusive gender-equitable workplace, according to a recent evaluation (UNAIDS, 2018). Others may be in the same position but have not been independently assessed.

Greater prioritisation and focus on outcomes that matter is key for accountability and progress. There has been a major shift since the MDGs towards managerialism and results-based management to guide institutional governance and performance measurement. Despite the limitations of these target-driven/checklist approaches in terms of capturing complexity and nuance, they can be used to streamline efforts towards key gender-specific and gender-transformative outcomes. Health specialists in UN agencies have responded positively to a limited set of selected gender targets, which are tangible and can be tracked.

Indeed, to move away from the box-ticking exercise that gender mainstreaming has often been reduced to, one approach has been to focus health programmes on a small set of strategic outcome measures and interventions. For example, health programmes could consider their largest investment areas, and identify one key gender-transformative target they could achieve there, rather than trying to mainstream gender in all their projects and programmatic components – some of which may not be appropriate for gender mainstreaming. Arguably, an emphasis by gender experts on complexity and holistic priorities may prevent scale up, while a more limited but streamlined approach may be more amenable to scale. Similarly, a focus on effective structural interventions that can make a big difference would be more strategic than expecting incremental/small-scale interventions to add up to large impacts. This may also be a way to reclaim and promote the two-pronged approach that was always envisaged for gender mainstreaming, with both specific programmes on gender equality and women’s empowerment, and mainstreaming efforts across other programmes and interventions.

An alternative to the ‘select and focus’ approach, would be a ‘everybody’s business minimum package’ approach, which would require identifying a minimum set of key interventions or activities that everyone would need to implement to mainstream gender across themes/sectors/interventions. Either way, there is a general lack of evidence or documentation of what these effective interventions or activities are.

In addition to investing in a better understanding of what has worked and why, this learning and evidence needs to be packaged for translation by regional and country offices, in a way that it reflects their operational realities and can support programme managers to make the right decisions and promote the right partnerships and interventions to achieve results.

**Re-politicise gender in health**

A major barrier to the implementation of gender mainstreaming has been its depoliticisation and the perception that it is a technical solution, rather than a political response. This is further reflected in the institutional ambivalence surrounding it. Fundamentally, this needs to change, and gender needs to be re-framed as one form of power with an understanding of the positive potential related to it. Reducing gender disparities in health will therefore require identifying and addressing power which includes challenging gendered power differentials, norms and relations. If this is not proactively done to promote effective gender mainstreaming, it will be (and is already being) done indirectly to disempower the process through its bureaucratisation and re-appropriation of gender jargon to weaken it.

A longstanding critique of and tension in gender mainstreaming has been the contradiction between integrating gender in the mainstream, and the fundamental need to challenge the mainstream and the status quo. By operating within patriarchal and biased structures, mainstreaming has ended up putting ‘gender’ and gender experts in a disempowered position that requires petitioning those with more power to consider changing their ways. Given the increasing attention and momentum around gender equality and women’s empowerment in certain spheres, there may be an opportunity to reclaim a position of power to effect change.

A related challenge for the gender and health field is measurement, and power in relation to data. Global data on the burden of disease, life expectancy, mortality and morbidity are central to global priority-setting and decision-making, yet the methodology for estimating these outcomes also incorporate gender biases. The way that evidence is selected and interpreted can also be biased, such as selecting one measure that shows that men are disadvantaged, while ignoring various measures that point to women’s disadvantage. Moreover, there are different standards of evidence and what measures are legitimised. Qualitative measures carry less weight in the global health space, yet power and the workings of power are difficult to quantify. More
strategic measurement of power and empowerment may be a pragmatic opportunity to ‘prove’ the value of gender mainstreaming for health outcomes. However, this constant struggle to try to fit evidence on complexity in prevailing biomedical paradigms and frameworks, which are not fit for purpose, may be doing the field a disservice.

Another juggernaut of structural power is the private sector and its commercial interests that are driving and shaping health behaviours and access to healthcare services through the exploitation of gender norms. The lack of a means of engagement with the private sector, including strong regulation and accountability mechanisms, are exacerbating the negative impact of gender power inequities on population health.

Re-claim public health paradigm

The biomedical paradigm of global health constrains the effective consideration of gender, as well as other social, political and commercial determinants of health and ill health. Improving population health will require refocusing on the public health paradigm and identifying shared determinants, risks and drivers that impact on everyone’s health, and ensuring that policies and programmes respond to the changing nature of gender norms and promote positive gender-equitable norms. However, emphasizing these social and other non-health care sector determinants of health has at times led to the abrogation of responsibility by the health sector, who view these determinants as being beyond their remit and core business. The health sector and public health field need to be held accountable to promoting gender equality through health systems and through multi-sectoral approaches and intersectoral action.

Re-mobilise, engage and partner

Although gender mainstreaming was intended to inject a concern to deal with gender inequality in all aspects of health policy and programming, it has also created a gender silo within the health field with isolated gender experts and/or focal points, rather than full integration of gender expertise and accountability across the sector. This has limited the engagement with other social justice stakeholders and new voices. One of the major achievements of Beijing was the broad mobilisation that preceded and succeeded the conference itself. This social mobilisation has weakened twenty-five years on.

Re-claiming gender as power will require re-mobilising and meaningfully engaging with new partners and actors. Strategic partnerships with civil society and women’s movements have long been recognised as central to enabling transformation, but there is also a need to learn from and effectively engage with men and young people, who bring new perspectives that embedded in the current global landscape and can effectively operate within new spaces and with new tools. There are promising examples of effective means of engagement that could be more systematically tapped and built upon (e.g. townhall mechanism).

While social mobilisation is central to the democratic process and to social justice, it can be both an enabler and a barrier to gender equality in the current climate, with waves of populism and conservative values, some of which are working against gender equality and women’s rights. Identity politics and the misuse of gender language to subvert and reverse gender equality gains, requires a bold push-back and conceptual clarity. While recognising complexity, it is critical to provide clear messages to the global health field to change the current discourse around gender, women’s health, men’s health, LGBTQ health and intersectionality.

Invest for long-term impact

The UN has been very good at having the right policies and high-level commitments in place, but there does not appear to be a real commitment to the systemic change required for gender equality. Importantly, financial commitments and investments in human resources to enable gender mainstreaming have not followed. Effective efforts to mainstream gender have required sustained engagement and advocacy by gender experts with health programmes and senior leadership. Yet, there is a systemic lack of investment in health-sector specific gender expertise, and authoritative positioning and resourcing of gender mainstreaming efforts. Gender mainstreaming is therefore more often perceived as a problem by health programmers, rather than a value or resource. The few interventions and activities that have been implemented have therefore tended to be opportunistic rather than strategic needs-based priorities.

It was noted that ‘doing gender’ cannot rely on gender experts, and requires everyone in an agency or programme to have the capacity to mainstream gender. This has led to the development of multiple basic courses and training tools that are by and large not fit-for-purpose, as they do not equip health programmers and professionals to apply a gender lens to their work. Capacity needs assessments have found that although UN staff have completed the available courses, they self-assess and indicate that they need more training. There is a need to re-focus investments in gender
expertise, rather than building skills in gender across all staff. Health-specific gender expertise is a technical area of expertise and needs to be treated as such and recognised as an area for professional development and credentialing. Targeted investments should be made in gender expertise among senior UN staff member who make programming decisions (at P4 and P5 levels).

**Tap new opportunities for gender and health**

For the first time since Beijing, there appears to be substantial interest among certain donors to invest in gender equality and women’s rights. The field needs to determine how to tap into this opportunity without compromising on principles, and through new and different alliances. Rather than compete for resources, now is the time to collaborate and come together around a shared agenda.

The SDGs and UN reform also provide avenues for multilateral interagency partnerships that can advance issues. It has and will become more difficult for UN agencies to speak separately, with inadequate resources. The purported prioritisation of equity within the SDGs and the leaving no one behind agenda also provide an entry point for the gender equality agenda. However, the underlying discourse of exclusion is politically expedient and can be misused, diverting attention from how the current political economy actively marginalises women in their integration (Beneria and Sen, 1981).
Part 2: Gender mainstreaming – the context

1. Historical perspective and evolving conceptual and evaluative frameworks on gender mainstreaming

The meeting emphasized the importance of the historical and political context of gender mainstreaming in public discourse. It was critical to acknowledge and understand that compromises and choices had been made and strategies had been developed to take advantage of contextual entry points for promoting political prioritisation of gender equality and women’s rights. Developing new approaches could therefore build on historical lessons as well as innovate, drawing on current contexts.

Gender equality and women’s rights have been on the UN’s development agenda for nearly half a century. Various initiatives on gender equality have benefited from global political processes, ranging from economic development and demographic debates to human rights considerations. Crucial landmarks are ‘The UN Decade for Women’ from 1975 to 1985, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979, the International Conference of Population and Development in Cairo in 1994 and the World Conference on Women in Beijing in 1995.

Other initiatives in global health like the Commission on Social Determinants of Health, have made some contributions to the understanding of gender dynamics and their impact on health. But despite raising the profile of gender in the development agenda, most of these concrete efforts and investments to promote gender equality have been isolated and uncoordinated. Improved knowledge and awareness have not necessarily resulted in a significant reduction in gender inequalities in health, or across other development sectors.

This year marks the 25th year of the International Conference on Population and Development (ICPD) that advanced the idea that gender and women’s rights are fundamental to sexual and reproductive health (SRH) and not solely instrumental for population control. Next year, 2020, marks the 25th year after the Beijing Conference on Women, where gender mainstreaming was put on the global agenda. These are critical milestones to assess the accountability of the UN and its member states to pledges made to achieving gender equality.

The UN Decade for Women

The awareness of the gendered impact of programmes and policies was initially raised during the ‘UN Decade for Women’. In the period spanning from 1975 to 1985, three international conferences in Mexico City, Copenhagen and Nairobi and several regional meetings involving UN agencies and NGOs were held. The main outcome of the first international conference in Mexico City (1975) was the ‘Declaration of Mexico on the Equality of Women and Their Contribution to Development and Peace’ which was endorsed by the UN General Assembly and later integrated in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979.

During the ‘UN Decade for Women’, the United Nations Voluntary Fund for the Decade on Women (UNIFEM) was established to provide financial and technical assistance to strategies and programmes that promoted women’s human rights, political participation and economic security. The first reference to gender mainstreaming in the work of the UN was in the ‘Forward-Looking Strategies for the Advancement of Women’ adopted at the Third World Conference on Women that took place in Nairobi in 1985. The strategies called for ‘effective participation of women in development [to] be integrated in the formulation and implementation of mainstream programs and projects’.

The Beijing Declaration

Following the ‘UN Decade for Women’, the ‘Fourth World Conference on Women: Action for Equality, Development and Peace’ held in Beijing in 1995, popularised the term ‘gender mainstreaming’. Despite all the work that women’s organisations, feminist theorists, feminist advocates and civil society had been doing, gender and gender mainstreaming had not been visible before the Beijing Conference. The major contribution of the conference was to strengthen the distinction between gender and biological sex, and to explain gender differences by the socialisation of power relations.
The commitment to gender mainstreaming was formalised through the Beijing Declaration and Platform for Action (Beijing Declaration) as a strategy to redress women’s unequal position in twelve critical areas of concern, including education, health, gender-based violence, armed conflict, the economy, decision-making and human rights.

**Gender mainstreaming in health**

Gender mainstreaming in health seeks a transformation of the public health agenda that includes the participation of women (and other marginalised groups) in defining and implementing public health priorities and activities. Started as a feminist project, its objective is to ensure that organisational procedures and mechanisms do not reinforce gender inequalities, but ideally are transformative to redress them. Gender inequality should be dealt with in every aspect of organisational structure, culture and programming, rather than as a separate, add-on activity that does not challenge the patriarchal status-quo. Therefore, gender equality considerations should be integrated in global health strategic agendas, policy statements and the monitoring and evaluation of organisational performance.

Gender mainstreaming in health has been conflated with women’s health programming since the early 2000s. While important in their own right, women’s health and men’s health programmes are based on physiological sex-based differences. By contrast, while much of the health field has focused on the role of biology in underpinning sex differences, the commercial sector has been exploiting social differences and gender ideologies in their advertising (tobacco, alcohol) for advancing their profit margins.

Early gender work was informed by concerns with SRHR. To that end, there has been a focus on women, used interchangeably with ‘gender’. With maturity in the scholarship and understanding of the role of power, there is a growing body of evidence on masculinity and its role in gender power dynamics as well as the role of masculinity in shaping health risk, health-seeking behaviour and health outcomes. These evolving frameworks can lead to conceptual blurring and often give rise to tensions of competing vulnerabilities.

**The intersectionality approach**

More recent conceptual developments have introduced intersectionality to examine the complex and dynamic relationship and interaction between factors such as gender, age, race, class, disability, to determine how health is shaped across multiple segments of society and geographical contexts (Kapilashrami and Hankivsky, 2018). Intersectionality can advance the ‘Leave No One Behind’ agenda by attending to multiple disadvantages and advantages that underpin exclusion of certain population groups. The analysis that an intersectional approach entails enhances understanding of not only who is left behind but why and how.

The intersectionality approach achieves two crucial aims. First, it brings attention to important differences within population groups that are often portrayed as relatively homogenous such as women, men, migrants, Indigenous peoples, and visible minorities. Second, it sheds light on the fact that individual and group inequities are shaped by multiple institutions with varying levels of power, such as families, governments, laws and policies. These institutions have embedded structures of discrimination such as sexism, ableism, and racism that are resultant from historical, economic and societal processes linked to globalisation and neoliberalism (Kapilashrami and Hankivsky, 2018).

Debates continue about the place of men and boys in gender mainstreaming approaches. There has also been a conflation between gender, gender identities and sexual orientation that constitute overlapping but distinct forms of marginalization. A relational approach has been highlighted as important, which considers women in relationship with partners, fathers, friends, employers, leaders and the state.

**WHO Gender, Equity and Rights framework**

The institutionalisation of gender and gender mainstreaming in WHO has had a chequered history, reflecting similar political commitment issues that have plagued other institutions (see Table 1 for the evolution of the WHO gender and health initiatives). In 2012, WHO adopted an integrated gender, equity and human rights (GER) framework that considers social determinants of health rather than exclusively biomedical factors. The GER approach was motivated by pressure from member
states with the aim of bringing gender, equity and rights together as one unit with the mandate to mainstream gender in a coherent approach.

Regardless of the broader institutional strategy to mainstream gender, various departments led important initiatives that have strengthened the field. Within WHO’s Department for Reproductive Health Research and HRP (the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction).

Beyond the dialogues as a one-off initiative, individuals both within HRP and the women’s health movements had a long-term vision. The governing body of HRP created the Gender Advisory Panel (later called Gender and Rights Advisory Panel), which is a formal expert advisory body that guides HRP’s research and normative work to integrate a gender equality and human rights perspective. GAP includes representation of community voices working on SRH, including women’s health advocates as well as experts on gender equality and human rights. Similar initiatives have been adopted by other departments including TDR, the polio eradication program and the STOP TB initiative.

Figure 1: Chronology of institutional and programmatic gender approaches at WHO:
Key Messages

• Critical reflection of gender and health should be based on documentation of the history of political prioritisation, role of social movements, evolution of conceptual frameworks and analysis of gender. This political and historical context of gender is important to understand, as we analyse contemporary generational, contextual and technological realities.

• Policy development and implementation reflects negotiated coalition building in diverse and dynamic contexts.

• Women’s health movements have changed laws, policies and socio-cultural norms but they always faced backlash, resistance and tokenism (e.g. programmes not adequately resourced).

• It is important to be strategic to prioritise what will move the gender mainstreaming agenda in agencies and countries. Issues that have a momentum of evidence, political will, tools, constituency can be used as the entry point for moving other items in the agenda forward.

• Tools have been essential to provide framing and guidance for programming, but they need to be coupled with political will and commitment to build sustainability. Reducing gender mainstreaming to a set of tools and activities depoliticises gender, shifting the focus away from unequal power and gender equality.
2. Gender mainstreaming across the UN

Two years after the Beijing Declaration and Platform for Action, the UN Commission on the Status of Women, the UN Secretary General, and the UN Economic and Social Council (ECOSOC) organised a high-level panel discussion on gender mainstreaming. ECOSOC urged the UN to ‘promote an active and visible policy of mainstreaming a gender perspective’. It also encouraged the General Assembly to direct all of its committees and bodies ‘to the need to mainstream a gender perspective systematically into all areas of their work, in particular in macroeconomic questions, operational activities for development, poverty eradication, human rights, humanitarian assistance, budgeting, disarmament, peace and security, and legal and political matters.’ The ECOSOC framework of gender mainstreaming put forward in 1997 was reviewed and endorsed by the UN Secretary-General in 2004, despite the recognition of a gap between policy and practice.

More recently, four of the UN agencies with health-related mandates (UN Women, UNFPA, UNICEF and UNDP) adopted a common chapter in their strategies, which includes six areas of collaborative advantage, including improving adolescent and maternal health and achieving gender equality and the empowerment of women and girls. The four agencies seek to coordinate efforts and to adopt a strategic division of labour around shared SDG indicators and targets. Joint efforts are facilitated by joint programmes, such as the Inter-Agency Network on Women and Gender Equality and the UN Joint Programme on Essential Services for Victims and Survivors of Violence. From an organisational perspective, the UN-SWAP, led by UN Women, aims to jointly establish processes and implement effective approaches to address gender inequality. UN SWAP and its updated version UN SWAP 2.0 highlight the importance of gender parity, particularly in senior leadership roles across UN agencies, while tracks budget allocated to gender mainstreaming activities (not successfully implemented by many organisations and UN agencies).

The four UN agencies had a dedicated gender unit at headquarters, staffed with gender specialists. However, their position within the organigram, their size and capacity differed considerably. UNICEF has a gender and development team; UNDP and UNFPA have dedicated gender teams; UNAIDS has gender experts and a Gender Action Plan Challenge Group; WHO has a Gender, Equity and Rights (GER) unit, which was until recently under the Family, Women’s and Children’s health cluster, but now reports to the Executive Office. While UNICEF, UNDP, and UNFPA have dedicated gender specialists at the regional level, most agencies appoint non-specialist gender focal points at the country level. WHO’s regional experts have a broader mandate that covers gender, equity and rights. UNDP is moving away from a focal point system to a team-based system, where teams assign specific gender focal points’ functions (gender balance, human resources, programming, etc.) to different staff members, with the teams reporting to a senior manager.

In July 2010, the UN General Assembly created UN Women, the United Nations Entity for Gender Equality and the Empowerment of Women, to address challenges related to challenges in its efforts to promote gender equality globally, including inadequate funding and no single recognised driver to direct UN activities on gender equality issues.
Key Messages

- Gender mainstreaming was envisaged as an extension of women-focused strategies – twin track approach – but that approach has not been fully realised.

- Although the main strategies and outcomes of the agencies vary by the nature of their mandates, they share several commonalities, with women’s health and empowerment as a top priority, together with a focus on better collection of gender-disaggregated data.

- Having non-specialist gender focal points at the country office level (normally with several roles and time constraints) should not preclude the appointment of gender specialists at a senior level to support the gender focal points.

- There have been promising initiatives from the UN, including gender mainstreaming tool kits, manuals, handbooks, and checklists which have attempted to operationalise the complexity of gender power relations into measurable programmatic interventions. Some of initiatives have ambitiously tried to move from addressing gender to including composite issues of equity and human rights frameworks.
Part 3: Priorities for action and research

Priority 1: Establish transformative partnerships, alliances and networks to engage new stakeholders in the co-production of an action and research agenda for gender mainstreaming

Achieving the fundamental changes needed within and beyond the UN system requires the creation of new alliances with new actors, in civil society and academia, to create powerful social and political momentum for gender equality while changing the discourse around gender and health (e.g. through joint programmes, regular meetings, conferences and fora for engagement and learning).

Suggested next steps:

**An interagency platform for knowledge exchange and learning on gender and health**

Establish an interagency and multi-stakeholder knowledge generation and learning platform on gender and health, with clearly defined roles and responsibilities based on institutional commitment, capacity and mandates. This platform could be convened by UNU-IIGH with the purpose of: (a) identifying evidence gaps, challenges, opportunities and next steps; and (b) jointly mobilising resources for programme implementation. This platform could be aligned to the Global Action Plan for Healthy Lives and Well-being for All’s social determinants of health accelerator discussion frame.

Engage proactively with new stakeholders and movements for gender equality to co-design and co-produce the research agenda and knowledge products

- Map key organisations and stakeholders (including sectors beyond health), and identify their institutional strengths, barriers and champions. Conducting a systematic review to understand the landscape of gender mainstreaming across sectors, starting with the UN system and expanding to external stakeholder analysis.

- Engage with different groups and populations, including grassroots voices reflecting the perspectives of women, men/boys, young and older adults, indigenous communities, rural population and the LGBT+ community.

Communicate and change the discourse

- Build conceptual clarity in gender and health that promotes a coherent discourse and consistent approaches, through examples (e.g. how newer areas align with broad feminist agenda).
- Identify specific strategies to deal with power and resistance within a political economy framework, recognising how power imbalances are manifested.
- Identify political win-wins by capitalising on the current commitment for gender equality in the SDGs to build leadership across organisations.
- Reframe gender norms, attitudes and behaviours within health systems, and setting standards in data, laws and policies to move to more inclusive gender systems in health.
- Develop new communication and advocacy tools and promote more effective engagement formats with policy-makers and programme managers (e.g. through virtual platforms).
Priority 2: Build the evidence base by documenting and evaluating what works in gender and health, why, and how it can be applied to other areas or contexts

The field should move towards a realist assessment of what works, where and why, building on existing evidence and how it can be applied in other health areas and programmes. A conscious effort is needed to generate new rigorous evidence and systematically document and consolidate the evidence of ‘what works’ across particular areas (e.g. GBV, SRHR, MNCAH, HIV and Leave no one behind/Equality, Gender and Rights) and review whether this can be generalised to new areas such as NCDs and climate change.

Given that most of the existing evidence is descriptive and based on an impact model of ‘one size fits all’, priority should be placed on the development of stronger and well-articulated theories of change ensuring the ‘Leaving no one behind principle’. There is also a need for better understanding of a range of health and gender equality outcomes, their desirability to various stakeholders, pathways of effect, contextual enablers and barriers, costs and return on investment.

Suggested steps in building evidence:

• Review existing evidence of the impact of gender mainstreaming on health outcomes, particularly on what works in specific health areas (namely MNCAH, SRHR, HIV, GBV) to inform approaches in other programmatic areas and health system building blocks.

• Identify lessons with scope for cross-fertilisation between programmatic and institutional mainstreaming.

• Conduct impact assessments with robust designs for evaluating long-term impact and unintended consequences of gender mainstreaming programmes.

• Document lessons from successful gender markers to track expenditures on gender equality and women’s empowerment.

• Translate academic research into practical and relevant recommendations for programmes to maximise the impact of collective work, supporting embedded research informed by grounded realities.

• Build partnerships and capacity in both academia and implementing agencies at country level to support ongoing learning agenda and embedded research as alternative to universal designs and studies led by the global north.
Priority 3: Generate new evidence in emerging areas

The field needs more evidence on ‘how’ to mainstream gender in emerging areas with large burdens of disease but where there has not traditionally been a strong gender focus, namely NCDs, mental health, digital health, climate change, as well as in the context of humanitarian settings, health system strengthening and universal health coverage.

Recommended areas of investigation:

Service delivery and health programmes

- Review evidence on how gender inequality impacts on NCDs and NCD responses.
- Analyse the impact of industry on gender inequality in health, and particularly on the intersection between gender and the commercial determinants of health.
- Review proof of concepts happening on the ground in topics relevant for civil society (e.g. financial risk protection) and whether they have been informing academic research.
- Identify gender-transformative and scalable interventions that act on the structural determinants of gender inequalities in health.
- Conduct a gender mainstreaming drivers and barriers analysis focusing on gender including all demand and supply side barriers for all programs.
- There is a need to engage better with big data and digital technologies as ways to understand and intervene on gender-related areas of work.
- For GBV, identify the wide spectrum of violence and coercion, how it is measured, who measures it and who makes the decisions on what is measured, and develop principles for addressing violence based on evidence of good and bad practices (e.g. through decision trees).

Universal Health Coverage (UHC) and health systems

- Conduct country case studies with a comprehensive health systems’ review across all diseases, including effective coverage and building blocks, to be embedded in country-level political and economic analyses. This should include an assessment of what has been done and available materials and mechanisms to better inform the specific gaps in programming.
- Using the UHC service coverage index as an opportunity to explore how poverty is intertwined with gender, for example in female-headed households.
- Identify how quality and safety of care looks like from a gender lens and mapping strategic spaces where gender analysis can be effective, with a specific focus on the structural determinants of health.
Priority 4: Invest in gender expertise, data and independent transparent accountability mechanisms

There is a price tag to advancing gender equality in health, and investments will have to be made if commitments are to be fulfilled. Greater focus on priority outcomes that matter, strong data and gender expertise is key for accountability and progress. This should be coupled with greater transparency, external scrutiny and independent evaluation. These are currently lacking across the board.

Suggested priorities for action:

• Use evidence to support the prioritisation of a range of output and outcome indicators and targets to monitor progress (to be led by WHO), consulting existing gender experts and focal points in developing accountability mechanisms.

• Add a range of new indicators with a number of new measures to the voluntary progress reporting of the SDGs at the national and regional levels (e.g. evidence of new forms of institutional advocacy, documenting what can be adapted for laws and policies).

• Draw on the experience of the Independent Accountability Panel for the UN Secretary General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, to inform a potential accountability mechanism, once clear results have been set.

• Support structures and initiatives to collect gender-disaggregated data related to health to inform policy and health programmes design.

• Identify key competences and build a talent pool by: (a) providing training and mentoring; and (b) integrating gender mainstreaming within existing tools and mechanisms to address the limited expertise available.

• Integrate gender training into the in-service curriculum of health workers to build future cohorts of health workers that are equipped to promote gender equality through the health system, and deliver gender-responsive quality and safety of care.

• Develop accountability measures for engagement with industry, building on the Framework of Engagement with Non-State Actors (FENSA), the UN Global Compact and the system-wide engagement framework.
Conclusion

The expert meeting ‘What works in Gender and Health: Setting the Agenda’ was the first step of an engagement process to co-construct the agenda and co-produce the evidence towards strengthening gender mainstreaming. The meeting initiated a joint programme of work to review, synthesise and consolidate learning and evidence on the promotion of gender equality in health policies, programmes, practices, workplaces and people’s lives.

Gender mainstreaming initiatives within UN agencies have not been systematically implemented and successes not adequately documented partially due to limited financial and human resources. A major barrier to the implementation of gender mainstreaming has been its depoliticisation and the perception that it is a technical solution, rather than a political response which aims to address the root causes of gender inequality. There has also been an over-emphasis on processes compared to result-oriented outcomes and on behavioural change rather than social change, revealing an attempt to integrate gender concerns within the status quo.

A range of available policies, toolkits and training programmes have tried to operationalise the complexity of gender power relations into measurable programmatic interventions, but positive change has not been sustained beyond individual gender champions or specific programmes. Promising strategies to implementing gender mainstreaming are buy-in and support from senior leadership with gender champions who can broker new relationships and alliances, creatively recognise entry points, mobilise resources, contextualise and strategically frame gender mainstreaming to specific programmes and social contexts, without losing sight of core principles.

It is important to address gaps in research and implementation that are hindering progress. More evidence for what works in gender mainstreaming in health is required in new programmatic areas such as NCDs and climate change, many approaches are still siloed and not tested across different programmes, and conceptual issues contribute to lack of coherence of approaches. Priorities for action and research are to engage new stakeholders in the co-production of an action and research agenda; to build the evidence base of what works, why, how and in which contexts, particularly in emerging health areas; and invest in gender expertise, data and independent transparent accountability mechanisms.

Business as usual is not an option; we risk losing ground and foregoing the fragile gains made to date. To accelerate change and impacts, there is an urgent need in global health to identify and implement evidence-based approaches that effectively transform gendered power dynamics and promote gender equality in health policies, programmes and workplaces, and make a real difference to women and men’s health and wellbeing.
References


Annex 1

1. Definitions

**Gender** refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and learned through socialisation processes, are context/time-specific and changeable (OSAGI, 2001).

**Gender-accommodating** solutions not only show awareness of gender differences but also commit to adjust and adapt to those differences. However, they do not address the inequalities generated by unequal norms, roles and relations (i.e., no remedial or transformative action is developed) (UNICEF 2018).

**Gender-sensitive** solutions see gender as a means to reach set development goals. They address gender norms, roles and access to resources in so far as needed to reach project goals (UN Women, 2017).

**Gender-transformative** solutions see gender as central to promoting gender equality and achieving positive development outcomes. They aim at transforming unequal gender relations to promote shared power, control of resources, decision-making, and support for women’s empowerment (UN Women, 2017).

**Gender analysis** identifies, assesses and informs actions to address inequality that come from: (1) different gender norms, roles and relations; (2) unequal power relations between and among groups of men and women; and (3) the interaction of contextual factors with gender such as sexual orientation, ethnicity, education or employment status. Gender analysis in health examines whether sex and gender-based differences impact on health and assesses the extent to which policies, programmes, and interventions address these differences (WHO, 2011).

**Gender-aware** solutions take account of the differences in roles and relations between women and men. It recognises that the life experiences, expectations, and needs of women and men are different.

**Gender-based differences** in access to and control over resources refer to the near-universal pattern of women and girls having access to fewer resources including tangible resources such as education and income as well as intangible resources such as self-esteem and confidence, autonomy, and power (WHO, 2002). The two concepts are interlinked: access is having a resource at hand, while control is the ability to define and make binding decisions about the use of a resource.

**Gender equality** is the absence of discrimination on the basis of a person’s sex in opportunities, in the allocation of resources and benefits or in access to services (WHO, 2002).

**Gender mainstreaming** is the process of assessing the implications for women and man of any planned action, including legislation, policies and programmes, in any area and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between men and women is not perpetuated. The ultimate goal is to achieve gender equality (ECOSOC, 1997).

**Gender norms** relate to expectations imposed by society based on beliefs about the relative value of women and men, boys and girls that are passed through the process of socialisation, that differ over time and across cultures and populations. Gender norms lead to inequality if they reinforce: a) mistreatment of one group or sex over the other; b) differences in power and opportunities.
Gender roles refer to the entrenched division of labour and tasks between women/girls and men/boys in most societies. Gender roles and norms often influence women’s and men’s access to and control over resources which can affect the implementation and outcomes of an intervention (WHO, 2011).

Empowerment of women concerns their gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality (UN Women, 2017).

Feminism is the belief in social, economic and political equality of the sexes.

Institutional Mainstreaming involves addressing the internal dynamics of formal (and informal) institutions, such as their goals, agenda setting, governance structures, and procedures related to day-to-day functioning, so that these supports and promote gender equality (Ravindran and Kelkar-Khambete, 2008).

Masculinities conveys that there are many socially constructed definitions for being a man and that these can change over time and from place to place. The term relates to perceived notions and ideals about how men should or are expected to behave in a given setting (Connell et al., 1999).

Programmatic (or operational) mainstreaming refers to the integration of equality concerns into the content of policies, programmes, and projects to ensure that these have a positive impact on women and reduce gender inequalities (Ravindran and Kelkar-Khambete, 2008).
## 2. Agenda

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<td>Michelle Remme</td>
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<tr>
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## Annex 3

### 2. List of Participants

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<thead>
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<th>Name</th>
<th>Organization</th>
<th>Role</th>
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<tbody>
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