A COMPENDIUM OF

THE HISTORY OF GENDER MAINSTREAMING

IN FIVE UNITED NATIONS AGENCIES

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**Gender &
Health Hub**

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United Nations University International Institute for Global Health (UNU-IIGH), Kuala Lumpur, Malaysia, is the designated UN think tank on global health. It builds global health knowledge and decision-making capacity and advances evidence-based policy on key health issues of sustainable development, peace, and global security.

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LIST OF ABBREVIATIONS

AoR	Area of Responsibility
CCO	Committee of Cosponsoring Organizations
CCS	Country Cooperation Strategies
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
ECOSOC	Economic and Social Council
EDGE	Economic Dividends for Gender Equality
FGM	Female Genital Mutilation
GAP	Gender Action Plan
GAT	Gender Assessment Tool
GBV	Gender-based Violence
GBViE	Gender-based Violence in Emergencies
GCWA	Global Coalition on Women and AIDS
GEN	Code/Indicator for a Gender Marker
GER	Gender, Equity, and Rights
GES	Gender Equality Strategy
GEWE	Gender Equality and Women's Empowerment
GFT	Gender Focal Team
GFP	Gender Focal Point
GIDP	Gender in Development Programme
GMI	Gender Mainstreaming Initiative
GPECM	Global Programme to Accelerate Action to End Child Marriage
GPW13	13th General Programme of Work
GSIC	Gender Steering and Implementation Committee
GWH	Gender, Women, and Health
HRP	Special Programme of Research, Development and Research Training in Human Reproduction
HPV	Human Papillomavirus
IASC	Inter-Agency Steering Committee
ICPD PoA	International Conference on Population and Development Programme of Action
IEP	Independent Expert Panel
LEA	Legal Environment Assessment
MAP	UNAIDS Management Action Plan
MCH	Maternal and Child Health Care
MHH	Menstrual Health and Hygiene
NGO	Non-governmental Organisations
PAHO	Regional Office for the Americas of the World Health Organization
PCB	Programme Coordinating Board
PLHIV	People Living with HIV
RHR	Reproductive Health and Research
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-based Violence

SRH	Department of Sexual and Reproductive Health and Research
SRHR	Sexual and Reproductive Health and Rights
SRHRiE	Sexual and Reproductive Health and Rights in Emergencies
TDR	The Special Programme on Research and Training in Tropical Diseases
TOC	Theory of Change
UBRAF	Unified Budget, Results and Accountability Framework
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGA	UN General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN-SWAP	UN System-Wide Action Plan
UNU-IIGH	United Nations University International Institute for Global Health
US	United States
WASH	Water, Sanitation, and Hygiene
WHA	World Health Assembly
WID	Women in Development
WLHIV	Women Living with HIV
WHO	World Health Organization
WHO/EURO	WHO Regional Office for Europe
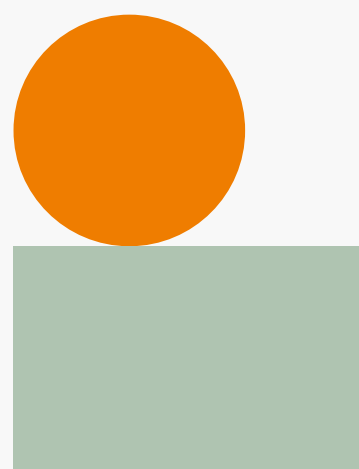
1. INTRODUCTION

The COVID pandemic has set back the modest progress made towards gender equality over the past few decades by a generation [1]. The present crisis overlays existing challenges, such as rampant social and economic inequalities, the climate emergency, conflict, and the alarming rise of movements against multilateralism, human rights, gender equality, and civil society. One redeeming factor has been the role played by the United Nations (UN) and its agencies in keeping women at the centre of COVID responses and not allowing gender equality to be a mere afterthought. Nonetheless, much needs to be done to regain lost ground.

Given its global reach and broad mandate for setting norms and standards, the UN and its agencies are uniquely positioned to take a leadership role in gender equality. The organisation has amassed an extensive body of knowledge and experience on gender and health. Part of that role has involved learning from past experiences and building on outcomes where gender has been successfully integrated into the UN's core business.

Towards such efforts, the United Nations University International Institute for Global Health (UNU-IIGH) led and co-produced with partners the report What Works in Gender and Health in the United Nations: Lessons Learned from Cases of Successful Gender Mainstreaming across Five UN Agencies [2].[1]

Through an analysis of successful cases of programmatic and institutional gender mainstreaming in global health, the report:

- documented the types of outcomes that UN agencies have achieved through successful programmatic and institutional gender mainstreaming in health

- identified the contextual factors and mechanisms that led to the successful outcomes across cases of programmatic and institutional gender mainstreaming in health

- distilled commonalities and lessons learned across successful cases to constructively inform future work on gender mainstreaming within the UN system and other bilateral and multilateral organisations working in health.

This compendium complements the report, making public much of the background research on the history of efforts to integrate gender equality considerations institutionally and within health programmes implemented in the five UN agencies with a health mandate.[1] Evaluations of gender mainstreaming in UN agencies have noted the near absence of knowledge management strategies on gender mainstreaming, thus hampering institutional memory and making learning from past experiences more difficult [3–5]. The compendium aims to address this lacuna. It serves as a public resource documenting, in a single place, the history of gender mainstreaming efforts within each agency. It is not an analysis of this history.

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1   Agencies included the United Nations Joint Programme on HIV/AIDS (UNAIDS) Secretariat, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), and the World Health Organization (WHO).

1.1 METHODOLOGY AND PROCESS

The compendium was developed mainly from desk reviews undertaken as part of the abovementioned study [2]. Between March 2020 and June 2020, a review of both publicly available and internal documents from 2012[2] onwards was undertaken for each agency. The reviewed documents included agency-specific gender policies, strategic plans, evaluation reports, annual reports, reports to the executive or governing bodies, knowledge products, tools, and guidance related to gender and health. Detailed web searches were also conducted, including combing through news stories and project-specific descriptions to obtain insights into the nature of gender mainstreamed programmes. The desk review of publicly available information formed the basis for a preliminary background report for each agency. The process provided insights into the broader policy, organisational, and operational contexts within which institutions delivered on the promise of gender equality and women's empowerment (GEWE). A large proportion of the data compiled in this compendium was gathered as part of the background report in preparation for the larger study. In 2022, the material was updated following a web search for the latest gender policies and strategies, and the most recent information available on institutional and programmatic gender mainstreaming was included.

1.2 OVERVIEW OF COMPENDIUM

Each section presents a history of each of the five agency's efforts in gender mainstreaming. For each agency the organisational context is briefly described, followed by a historical account of the agency's gender strategies and policies. An overview of advances made in institutional gender mainstreaming is then presented, providing an overview of each agency's current status regarding gender parity in staffing, gender architecture, resource allocation and accountability mechanisms. Finally, examples of agency efforts in integrating gender equality considerations are summarised.

It is important to note that this compendium is not intended to be a comprehensive account of the history of gender mainstreaming in the agencies, nor is it meant to provide a comparative picture of the five agencies. Instead, the information dispersed in the public domain has been collated to create a snapshot of the history of institutional gender mainstreaming and programmatic gender mainstreaming in health in the selected agencies. It is intended as a resource for others to use for further analysis and learning, supporting managers, staff, implementing partners, researchers, and decision-makers to understand the historical and contextual factors that affect and shape gender mainstreaming in organisational settings.

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2   In some cases, gender strategies and documents predating 2001 relating to specific gender and health programmes were also reviewed.

2. UNAIDS

2.1 THE ORGANISATIONAL CONTEXT

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is leading the UN effort to end HIV/AIDS by 2030. As an entity, the Secretariat coordinates the only cosponsored joint programme in the UN system (see Figure 1) with 11 UN organisations – the UNAIDS cosponsors [6, 7]. The joint programme is guided by its multi-stakeholder Programme Coordinating Board (PCB), a small governance structure that reviews and decides on the planning and execution of HIV programming [8]. The PCB comprises 22 governments from priority countries, UNAIDS cosponsors, and five non-governmental organisations (NGOs), including associations of those living with or affected by HIV. In addition, three of the NGOs represent developing countries, while two are from developed countries or countries with economies in transition. While these NGOs participate in the PCB meetings, they do not participate in the formal decision-making process and have no right to vote [9, 10]. Nonetheless, it is the only United Nations entity with civil society representation on its governing body [11].

The joint programme also has a Committee of Cosponsoring Organisations (CCO), including the Secretariat and representatives from the cosponsors [9]. The CCO serves as a forum where the executive directors of the cosponsoring agencies meet twice yearly to assess the policies, strategies and operations of UNAIDS [9]. The CCO also ensures that the cosponsors' boards discuss PCB decisions and incorporate the UNAIDS global-level results framework into their respective results frameworks, with the aim of improving HIV coordination across the UN landscape.

Overall, the Secretariat and cosponsors divide up tasks and draw on expertise to provide specialised technical support to countries, avoid duplication, and deliver an integrated response from global and country levels [9, 12]. The Secretariat's responsibility is to ensure a strategic focus and accountability for an effective global AIDS response by:

- mobilising leadership and advocacy for effective action on the epidemic

- providing strategic information and policies to guide efforts in the AIDS response worldwide

- tracking, monitoring and evaluation of the epidemic as the world's leading resource for AIDS-related epidemiological data and analysis

- engaging civil society and developing partnerships

- mobilising financial, human and technical resources to support an effective response [12].

The Secretariat is headquartered in Geneva, Switzerland. It is led by an executive director, appointed by the UN Secretary-General based on recommendations and a consensus from the cosponsors [9, 10].

UNAIDS has six regional offices, three liaison offices, and over 78 country offices worldwide [10, 14], with 70% of its staff based in the field [11]. The coordination of all UNAIDS field-level activities to support national action on HIV/AIDS is done by the UN Theme Group on HIV/AIDS[3] via the UN Resident Coordinator system. However, national governments are ultimately responsible

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3 The UN Theme Group on HIV/AIDS was established by the UN Resident Coordinator and comprises all heads of UNAIDS cosponsors, including representatives of national governments if they choose to be included.

FIGURE 1. UNAIDS JOINT PROGRAMME STRUCTURE

Source: UNAIDS, 2020 [6].

for all national HIV/AIDS issues. Secretariat staff may be assigned to support the theme group's chairperson [9, 10].

The Secretariat works closely with cosponsors to strengthen partnerships and mobilise financial resources from governments, corporations, and foundations to support its global, regional, and country-level HIV activities. Despite a global commitment to scale up resources to at least US$26 billion by 2020, donor reinvestment has been progressively slow [13]. Since 2012, expected core revenue has not matched the approved budgetary target, with the funding gap widening between 2015 and 2019 (Figure 2). For example, in 2015, the gap was a little over $41.5 million, compared to over $58.2 million in 2019 [13]. In 2016, funding gaps resulted in a reduction of in-country and regional-level expertise for several cosponsors and, in some countries, the cancellation or postponement of programmes [13]. By 2020, the gap had closed slightly to a shortfall of $48.3 million [13]. The funding shortfall negatively affects the Secretariat's

ability to meet its strategic monitoring and accountability function within the joint programme and threatens to stall ongoing efforts to accelerate the prevention, treatment, and care services to end AIDS by 2030.

2.2 GENDER MAINSTREAMING EFFORTS WITHIN UNAIDS SECRETARIAT

2.2.1 Institutional gender mainstreaming

Policies and strategies

Women's vulnerability to HIV has been recognised within the UN since the early days of the epidemic. However, the increasingly visible feminisation of the epidemic in the early 2000s created pressure for UNAIDS to incorporate gender deliberately into its overall strategy and functioning. In 2001, the UN General Assembly (UNGA) held a Special Session on HIV/AIDS, resulting in the Declaration of Commitment on HIV/AIDS. The Declaration demonstrated the political commitment from the UN and

FIGURE 2. FUNDING (USD), UNAIDS 2012–2020 (APPROVED BUDGET, REVENUE AND FINANCING GAP)
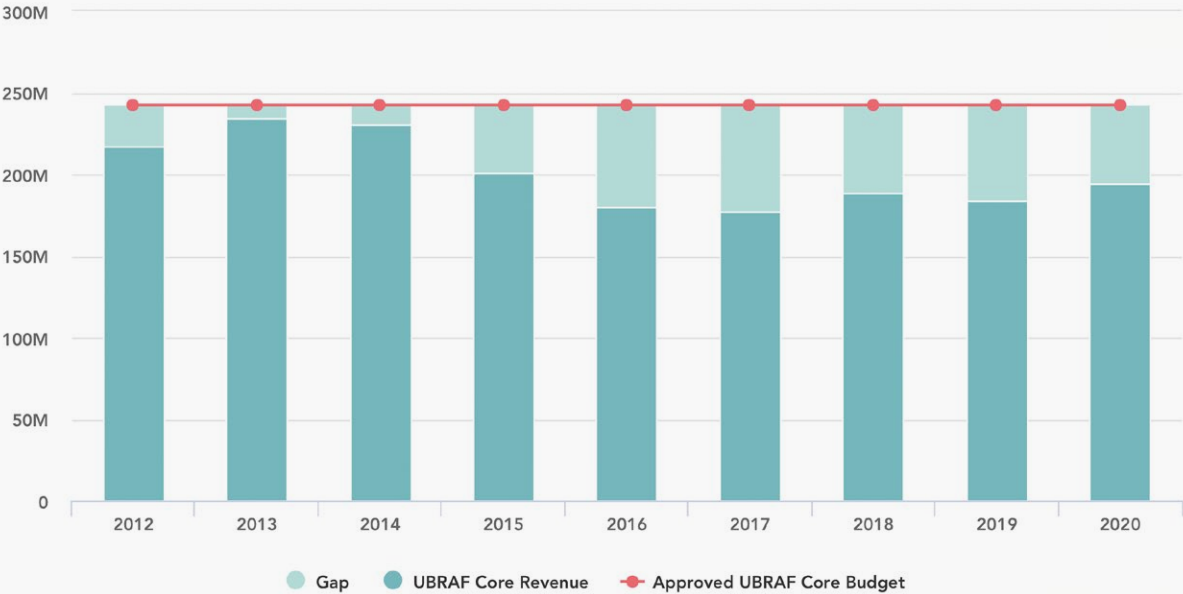
governments to address the HIV/AIDS epidemic. It stressed that GEWE is central to the HIV/AIDS response [16]. However, the Declaration missed opportunities to recognise other critical issues equally crucial to gender equality – equal access to care and support after infection and acknowledging how differences between women and men facilitate discrimination and increased vulnerability [17].

In 2003, a UN Southern Africa mission report[4] reiterated the lack of progress to "reduce women's risks, to protect (sic) them from sexual aggression and violence, to ease their burden or to support their coping and caring efforts" in the context of the epidemic [18]. To ensure that women's issues were not sidelined or ignored as part of the HIV/AIDS response, the United Nations Secretary-General convened the

Task Force on Women and Girls and HIV/AIDS in Southern Africa. The task force identified concrete recommendations that focused on:

- preventing HIV in girls and young women

- ensuring girls' enrolment and retention in schools

- protecting women and girls from violence

- ensuring women and girls have property rights

- improving community-based care

- ensuring access to care and treatment and protection from stigma and discrimination [18].

The task force's work subsequently led to the launch of the Global Coalition on Women and

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4 A joint mission in Lesotho, Malawi, Zambia and Zimbabwe led by James T. Morris, former Executive Director of the World Food Programme (WFP) and Special Envoy of the Secretary-General for Humanitarian Needs in Southern Africa and Stephen Lewis, Special Envoy of the Secretary-General for HIV/AIDS in Africa.

BOX 1. EXAMPLES OF PRIORITY ACTIONS FOR GEWE IN THE GLOBAL AIDS STRATEGY 2021–26

- promote the use of disaggregated data by sex and age and related analyses in HIV responses

- strengthen gender equality expertise among country stakeholders to develop, implement, fund and monitor gender-transformative HIV responses

- create and sustain platforms for the meaningful engagement of women and girls living with HIV in all aspects of HIV responses at regional, national, subnational and community levels

- advocate for increased financing and support for networks, other organisations and mobilisation mechanisms for women and girls, including those living with or affected by HIV

- promote the implementation and scale-up of community-led interventions that work

with men and boys, and women and girls, in all their diversity, to transform unequal gender norms, attitudes and behaviours, reduce gender-based and sexual violence, and prevent HIV infection or help mitigate its impact

- support partners in identifying and addressing specific barriers that face women and girls, and men and boys, in all their diversity, in accessing HIV prevention, treatment and care services

- promote the economic empowerment of women, especially those living with and affected by HIV

- build partnerships and collaborations to catalyse actions across sectors to address the gender dimensions of the AIDS epidemic.

Source: UNAIDS, 2021 [23].

AIDS (GCWA) in 2004,[5] hosted by the UNAIDS Secretariat [19]. The areas of action by the GCWA, including women's sexual and reproductive health and rights (SRHR) and shifting international aid architecture, are closely aligned with the task force's recommendations [19].

Despite the high levels of internal advocacy and awareness, much of UNAIDS' gender programming work appears to have been limited. In 2009, the UNAIDS Board, through the executive director, asked to set up a task force to develop a gender plan for girls and women. The gender plan resulted in the 2009 Action

Framework[6] and an accompanying 2010 Country-Level Action Plan[7] to guide the implementation of gender work on the ground. Together, these strategic documents enabled a shift from gender advocacy to gender programming in HIV, more focused programming on gender-based violence (GBV) and a strengthened gender architecture at headquarters, regional and country office levels. This was followed by the development of a critical, innovative Gender Assessment Tool (GAT) to guide UNAIDS technical support to countries in order to understand the gendered dimensions of the HIV epidemic at the country level.

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5 The GCWA is an alliance of civil society organisations (CSOs) comprising networks of WLHV, women's rights organisations, AIDS service delivery institutions, faith-based organisations, the private sector and UN system agencies.
6 UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV, 2009.
7 Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV: Operational plan for UNAIDS Action Framework – Addressing Women, Girls, Gender Equality and HIV, 2010–2014.

A watershed moment occurred in 2011, when a UNGA High-Level Meeting adopted the Political Declaration on HIV and AIDS [20]. This Declaration strongly focused on women and girls and acknowledged the interconnectedness of HIV with gender inequality and GBV.

In the UNAIDS 2011–2015 strategy, gender equality and zero tolerance for GBV were considered critical strategic priorities [21]. They included specific targets for Member States on gender mainstreaming to achieve gender equality by 2015. The 2016–2021 strategy took the agenda forward on gender-equality programming through interventions to improve access to and uptake of sexual and reproductive health (SRH) services, community mobilisation to promote egalitarian gender norms and ending GBV, and empowering women and girls [22].

The current UNAIDS 2021–2026 strategy (*End Inequalities. End AIDS*.) has accorded a central role for gender equality and human rights. Its ambitious targets and commitments include that, by 2025, less than 10% of people living with HIV (PLHIV) will experience stigma and discrimination, and less than 10% of women and girls and other key populations will experience gender-based inequalities and GBV. Another target is that, by 2025, at least 95% of women will have access to SRH services [23].

The strategy identifies priority actions across 10 result areas and five crosscutting issues towards realising the vision of zero new infections, zero discrimination and zero AIDS-related deaths. Result area 6 is focused on gender equality:

Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality and work together to end GBV and to mitigate the risk and impact of HIV [23].

Several priority actions to reduce gender-based inequalities have been outlined under result area 6 (see Box 1). Moreover, actions to address the specific needs of women and girls and mitigate the effects of gender-based inequalities are found under all other result areas [23].

The Secretariat has also produced two successive dedicated gender action plans (GAP 2018–2023 and GAP 2013–2018), in which the overarching objective is to achieve a gender-equal workplace [24, 25]. In addition to GAP 2018–2023, several other complementary action documents and frameworks include the UNAIDS Management Action Plan (MAP), the Independent Expert Panel (IEP) Report and the UN System-Wide Action Plan (UN-SWAP) Report. Collectively, these documents and frameworks guide the Secretariat's institutional gender mainstreaming efforts [26, 27] and are expected to enable the Secretariat to build an inclusive, respectful, and safe workplace by removing harmful behaviours and ensuring greater accountability and transparency.

Gender parity in staffing

Since 2008, the Secretariat has made significant progress towards gender parity. Sustained gains have been driven, in part, by senior leadership's commitment to implementing GAP 2013–2018 [24, 28]. Female representation in management positions has increased substantially from the 2013 baseline. In 2019 at the country director level, women held 46% of positions compared to 27% in 2013. Similarly, for P5 positions, women held 46% of these in 2019 compared to 36% in 2013. At the P4 level, the proportion of women increased to 62% in 2019 from 44% in 2013 [24].

GAP 2018–2023 reiterates a commitment to gender parity at all staff levels and outlines specific actions to accelerate progress towards parity, including addressing bias in job design, developing inclusive recruitment policies, and mitigating discrimination and inequality across the career pathway [24]. In particular, the Secretariat has expressed a commitment in GAP 2018–2023 to boost women's leadership and enable effective gender mainstreaming practices.

For example, Target 3 of the GAP aspires to ensure that all UNAIDS female staff are eligible to participate in the UNAIDS Women's Leadership Programme and Mentoring Programme [24]. In 2014, the Secretariat launched its leadership programme for women. Five cohorts of female staff – 124 women at senior management levels – trained under this initiative prior to 2019 [28]. The UNAIDS Mentoring Programme for Women, also initiated in 2014, aimed to increase job satisfaction and facilitate professional development across all staffing levels [28]. It has been expanded to include all staff and is managed through a portal to match mentors and mentees. By 2019, these two programmes had together benefitted more than half of the female staff working in UNAIDS [28].[8]

Gender architecture

Currently, the executive director of UNAIDS is a woman as are the five regional directors[9]. Towards the end of 2020, a director of gender equality, human rights and community engagement was appointed, serving as the gender lead within UNAIDS. Prior to this position, the director of community support, social justice and inclusion, with support from technical staff across the headquarters, regional offices and country offices, oversaw the technical support to countries to ensure that HIV responses were rights-based and gender-transformative, and worked to support communities and engage different stakeholders to advance gender equality and apply human rights standards in the UN, regional and national HIV-related policies.

The Gender Action Plan Challenge Group guides implementation of the GAP [24]. Led by the UNAIDS deputy executive director, management and governance, the Challenge Group is composed of 11 elected staff members representing the diversity of the UNAIDS workforce. The Challenge Group convenes monthly and is responsible for monitoring progress towards the full achievement of GAP targets and related action areas, and for raising critical voices and challenges to senior management [24].

In 2017, the UNAIDS PCB called for equal representation of women and men in all its delegations, thus contributing to gender equality in governance [24].

Financial resources and allocations

GAP 2018–2023 declares a financial benchmark, with a target of 15% of expenditure by the Secretariat to support actions that address GEWE as a principal objective [24]. However, despite this commitment, the kinds of financial reports available (e.g. the Unified Budget, Results and Accountability Framework – UBRAF) lacks sufficient detail to track such allocations or expenses concerning either mainstreaming gender in the Secretariat's activities or allocations made where gender equality was a principal goal [29, 30]. Similarly, for cosponsors' strategic result areas, a lack of disaggregation of the total budget and expenses for gender mainstreaming activities and investment makes it difficult to identify the extent of GEWE investments. In addition, gender-related initiatives and activities that span multiple result areas may further compound the problem of lack of disaggregation.

Based on the limited data available, we observe that over the period 2016–2021, the total budget allocation, both core and non-core for strategic result area 5 (gender inequality and GBV), has actually declined. For example, core allocations for cosponsors have declined by 57%, from a high of $18.21 million in 2016–2017 to $7.80 million in 2020–2021. Similarly, non-core allocations have fallen from $70.03 million in 2016–2017 to $45.91 million in 2020–2021 [29].

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8 The mentoring programme is now open to male mentees as well.
9 UNAIDS Leadership. https://www.unaids.org/en/aboutunaids/unaidsleadership.

FIGURE 3. ACCOUNTABILITY FOR IMPLEMENTATION OF UNAIDS GAP 2018–2023

EXECUTIVE DIRECTOR AND CABINET

The Executive Director sponsors the Gender Action Plan through leadership, external advocacy and the Geneva chapter of the International Gender Champions.

The Cabinet ensures that the executive leadership of UNAIDS is fully engaged in the Gender Action Plan including ongoing monitoring of results and high-level support to its activities.

EVERY STAFF MEMBER

Every UNAIDS staff member includes gender considerations in their work and learning objectives as part of the performance management process. Staff are expected to actively contribute to the Action Areas, such as the Panel Parity Pledge and taking action against harassment.

SENIOR MANAGEMENT TEAM (SMT)

The SMT ensures that the Gender Action Plan is implemented across all levels of UNAIDS. Progress is reviewed as part of regular staffing updates, and its included on the agenda of SMT meetings and retreats.

DEPARTMENT OF HUMAN RESOURCES MANAGEMENTS (HRM)

HRM coordinates the implementation of the Gender Action Plan, including monitoring and reporting.

MANAGERS

Heads of Country Offices and HQ Divisions identify concrete ways for the Action Plan to be implemented in their offices, taking into count the specific context of their teams.

GENDER ACTION PLAN CHALLENGE GROUP

The Challenge Group will guide implementation of the Gender Action Plan, and include up to 10 staff members representing the diversity of the UNAIDS workforce.

Source: UNAIDS, 2018 [24].

Accountability mechanisms

Accountability mechanisms refer to internal structures and persons answerable for ensuring that gender mainstreaming is effectively implemented within the organisational structure and in all its policies, programmes, and interventions, and the processes that have been put in place to enable this.

Multiple actors are responsible for ensuring accountability to goals and objectives outlined in the strategy and the GAP at the secretariat level [23, 24]. Figure 3 summarises the accountability mechanisms.

Other important accountability indicators for tracking gender-related commitments include the following:

- A gender equality marker application, which enables the joint programme and the Secretariat to monitor investments against work plans and priorities within the UN-SWAP framework.

- UBRAF indicators on:

  — country-level HIV strategies or policies promoting gender equality

  — country-level interventions aimed at preventing GBV

  — the proportion of women and men at each staffing level

  — the percentage of staff setting personal gender-sensitive work and learning objectives

  — progress on senior leadership actions on MAP is a standing agenda item on the senior management team and regional management team meetings

— progress update on policy development related to HIV through Global AIDS Monitoring and the associated Global AIDS Report.

2.2.2 Programmatic gender mainstreaming in health

Programmatic gender mainstreaming is concerned with developing programmes and interventions that contribute to gender equality. It is important to reiterate that the Secretariat does not function as a primary programme implementer, but works with cosponsors to provide strategic direction, advocacy, and technical assistance for a better-coordinated and coherent UN system response to HIV/AIDS.

Some examples of country-level initiatives aimed at addressing gender issues include policy advocacy to influence national legislation and programmes, enabling networks of PLHIV/AIDS and women's organisations and other civil society organisations (CSOs) to provide support services, as well as facilitating gender-sensitisation and training in SRHR for healthcare providers, government officials and decision-makers, and CSOs (Table 1).

The UNAIDS global initiatives for gender equality can be described, essentially, as collaborative coalitions, partnerships, or platforms. Examples of building alliances around programmatic mainstreaming efforts include:

- **GCWA.** This worldwide alliance is hosted by the UNAIDS Secretariat, and strives to contribute to the strategic positioning of women and girls as integral to the HIV response. It is composed of civil society groups (including networks of women living with HIV (WLHIV), AIDS service organisations, faith-based organisations, men's and boys' organisations working explicitly for gender equality), the private sector, and the United Nations system [19].

- **The Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination.** It comprises UNDP, UN Women, the Global Network of PLHIV, the PCB NGO Delegation, the Global Fund to Fight HIV, TB and Malaria, and the UNAIDS Secretariat. The Global Partnership collaborates with governments and key stakeholders to assess the situation of stigma and discrimination in countries by offering evidence-based interventions to address gender-based discrimination in the context of HIV [29, 31]. The priority areas are healthcare, education, workplace, legal and justice, family and community, and emergency and humanitarian settings. Each of the 19 Member States works on HIV-related stigma and discrimination in three of the six priorities in the first year, with the commitment to cover all settings over 5 years through measurable programmes that can be brought to scale [32].

- **The Joint UN Regional Programme on SRHR/HIV and Sexual and Gender-Based Violence (SGBV) Integration in Eastern and Southern Africa.** The joint UN regional programme supports Lesotho, Malawi, Zambia, and Zimbabwe governments to reduce unintentional pregnancies, sexually transmitted infections, new HIV infections, maternal mortality, and SGBV [33]. The government of Sweden provided funds of $45 million to the 4-year programme, which is implemented by the regional offices of UNAIDS, UNFPA, UNICEF and WHO. The programme will work to achieve its goals by addressing the policy and legal barriers that prevent people from exercising their SRHR, scaling up delivery of integrated HIV/SRHR and GBV services, working with communities, and strengthening data collection, quality, and analysis [34].

TABLE 1. UNAIDS GENDER-EQUALITY INITIATIVES BY REGION AND COUNTRY

Region	Country	Initiatives and activities
East Asia and the Pacific	China	A national dialogue on the elimination of GBV was held in January 2018. Co-organised by UNDP, UNESCO, and UN Women The dialogue resulted in the submission of three legislative bills to the annual National People's Congress and the Chinese People's Political Consultative Conference. The bills proposed changing gender markers on education certificates and implementing inclusive domestic violence legislation.
	Indonesia	A joint programme supported establishing the Network of Indonesian Women Who Use Drugs in 12 cities. The United Nations Office on Drugs and Crime (UNODC) produced a global training manual, *Gender-Responsive HIV Services for Women Who Inject Drugs*, which was adapted to the local context, and a workshop was conducted to pilot this manual.
	Papua New Guinea	The 2018 media awards for excellence in journalism on HIV and GBV was sponsored by the UNAIDS Secretariat and cosponsored by UN Women.
Eastern Europe and Central Asia	Tajikistan	With support from UNFPA, eight victim support rooms were established within health facilities. Training was conducted with 40 service providers in reproductive health centres, designed to increase their knowledge of rights-based, gender-sensitive SRH services to victims of GBV.
	Ukraine	Gender mainstreaming of HIV services for women who use drugs.
Eastern and Southern Africa	Botswana	The joint programme and the Botswana National Assembly led a parliament advocacy meeting on GBV and HIV prevention among adolescent girls and young women to discuss legislation on the sociocultural drivers of HIV and GBV and potential solutions.
	Eritrea	With significant help from the joint programme, the National Union of Eritrean Women conducted sensitisation training at the local level on GBV and women's reproductive health.
	Ethiopia	The joint team advocated for safe workplaces free from harassment and supported the Orange Day international campaign to prevent and end violence against women and girls, which increased awareness of the link between GBV and HIV.
	Malawi	A perception study on gender norms and HIV explored how particular norms in each district influence the status of HIV and violence against women and girls. Results are expected to inform programming.
	Mozambique	The Rapariga Biz project, led by UNFPA, UNESCO, UNICEF, and UN Women empowered 442,468 girls and young women aged 10–24 years with knowledge on their SRHR in safe spaces. Some 57,731 girls and young women visited youth-friendly health services, and 30,963 were tested for HIV. A total of 2,532 adolescent girls aged 10–19 were reintegrated into school.
	Zimbabwe	The joint team supported an HIV and law symposium with key recommendations calling for the repeal of Section 79 (1) of the Criminal Law Act on the deliberate transmission of HIV.

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Region	Country	Initiatives and activities
West and Central Africa	Cape Verde	UNAIDS Secretariat and cosponsors supported the government and partners to develop the HIV/AIDS National Strategic Plan 2017–2020, which includes operational roadmaps related to ensuring gender equality, preventing GBV, and addressing human rights violations.
	Democratic Republic of Congo	The joint team supported the country to monitor the equity of women, and train municipal and district officials, departmental councils and management, village and neighbourhood leaders, religious leaders, physicians, school district managers, etc.
	Gabon	Joint support from the UNAIDS Secretariat and UNFPA catalysed the partnership between the National Network for the Promotion of Sexual and Reproductive Health among Adolescents and Young People and the High Council of Islamic Affairs of Gabon to promote SRH of adolescents within the Muslim community, including an awareness campaign to prevent GBV, HIV, and early pregnancy that reached 53 Muslim religious leaders, 22 men, 47 young girls, and 98 women.
	Gambia	Through financial and technical support of the UNAIDS Secretariat and UNDP, the joint team facilitated the first gender assessment of the national HIV/AIDS and TB responses, which analysed the gender dimensions of the epidemics and assessed the availability of gender-disaggregated data.
Latin America and the Caribbean	Colombia	The joint programme implemented a sensitisation campaign towards the general population on the issue of GBV.
	Costa Rica	With the support of the joint programme, the National Programme developed a protocol for the integrated care and treatment of victims of sexual violence, including post-exposure prophylaxis (PrEP) within the first 72 hours of incidence. Services are available in four of 10 areas with the highest levels of sexual violence recorded.
	Guatemala	Under the leadership of UN Women, the joint team established an alliance with the Office of the Human Rights Ombudsman to assess comprehensive care for women in prisons to help strengthen the capacity of the penitentiary system to address GBV and HIV among women in prison.
	Guyana	The joint programme provided technical and financial support for a roundtable discussion on GBV and HIV, targeting women, girls and transgender people, and supported a nationwide sensitisation campaign on GBV, including towards men.
	Mexico	Since 2009, UNAIDS has been part of the working group of women and HIV, and has developed a political agenda to guide national public policies on HIV/AIDS and women until 2018.

Source: Compiled by the authors based on information in the UNAIDS transparency portal (https://open.unaids.org/countries#).

3. UNDP

3.1 THE ORGANISATIONAL CONTEXT

UNDP is the specialised UN agency on development. It has an overall mandate of supporting Member States to address critical issues at the intersection of the SDGs and poverty reduction, including reducing inequalities and exclusion [35]. The agency's 2022-2025 Strategic Plan emphasises three broad directions of change:

- leaving no-one behind to ensure inclusion, empowerment and equity

- accelerating structural transformations for sustainable development

- building resilience to crises and shocks in countries [36].

To address these complex and interconnected challenges, UNDP has prioritised and implemented six crosscutting approaches known as "signature solutions". Strengthening gender equality and the empowerment of women and girls is one of these signature solutions.

In addition to UNDP's programmatic work towards meeting the SDGs, the organisation also coordinates the UN system's developmental response through the UN Sustainable Development Group. This platform is the UN system's internal coordination mechanism at the global level, enabling policy actions on the ground [37]. UNDP provides policy and technical support, including guidance to facilitate UN country teams' work to assist governments.

In the context of its global health response, UNDP is a crucial UNAIDS cosponsor. Additionally, it has international health partnerships, including with the Global Fund to Fight AIDS, TB and Malaria, and the Global

Action Plan for Healthy Lives and Well-Being for All. UNDP has a strong track record of convening across its priority programmes, and fostering and supporting global, regional, and national strategic partnerships, including facilitating knowledge and sharing best practices to advance the Sustainable Development Goals (SDGs).

UNDP headquarters are in New York, managed by a senior leadership team, and led by an administrator, with support from an associate administrator and four bureau directors (also designated as UN assistant secretaries-general). Each bureau director is responsible for strategic guidance in their respective areas of expertise, including external relations and advocacy, management services, policy and programmes, and crisis management [35]. The responsibility of leading UNDP at headquarters and connecting local results for global change lies with the associate administrator and assistant secretaries-general [35].

There are five regional bureau directors at UNDP headquarters – Africa, Asia and the Pacific, Latin America and the Caribbean, Europe and Central Asia, and the Arab States. These directors are responsible for providing oversight, managing, and guiding UNDP regional and country office programmes. Within the regions, there are also five corresponding service centres or hubs. The centres or hubs were established to implement regional programmes and provide advisory and technical support to the country offices to address poverty and reduce inequalities and exclusion [38].

UNDP receives funding from a diverse range of partners, including non-earmarked regular or core resources and other resources earmarked for programmes. Over the last decade, annual contributions to UNDP have fluctuated. Core

FIGURE 4. TRENDS IN REGULAR AND OTHER RESOURCES IN UNDP, 2015-2020
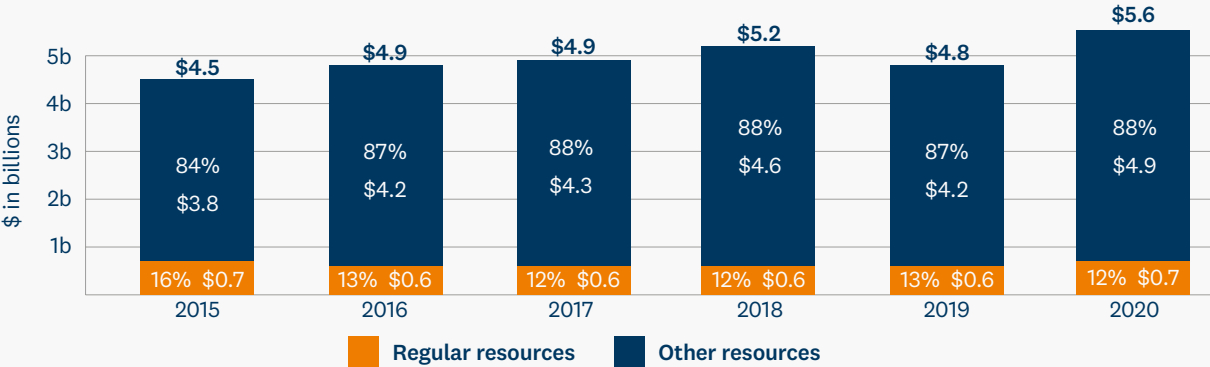
* Includes a $12 million contribution to regular resources for 2019 which was received in 2020.   Source: UNDP, 2020 [39].

funding increased from $612 million in 2017 to $696 million in 2020, but the proportion of core resources compared to non-core resources fell to 12% from 16% in 2015 (Figure 4). As core resources are crucial for UNDP's support to developing countries, the fall in the proportion of core non-earmarked resources may undermine the organisation's ability to make sustained investments to achieve its mandate [39, 40].

The decline in the proportion of core un-earmarked funding has been attributed to the steady growth in earmarked other resources [39]. Earmarked funding can be restrictive as donors direct it towards specific programmes (for example, HIV, health systems, gender) or activities or even in particular countries. From Figure 4, we see that total other resources have increased from $3.8 billion in 2015 to $4.9 billion in 2020, with the most contributions from donor country governments (39%) and multilateral organisations (39%) [39].

Overall, UNDP is well placed to contribute to the GEWE agenda within the UN system and at country level. For example, the mandate on HIV, health and development, governance, capacity strengthening, and geographic presence are critical strengths that could be leveraged to strengthen national and regional policy, programmes, and advocacy for better health and gender-related outcomes in the health

portfolio. Also, its inter-agency partnerships and networks and convening power could be a critical entry point for providing technical assistance for gender-responsive institutional and programmatic reforms, policy design and implementation.

3.2 GENDER MAINSTREAMING EFFORTS WITHIN UNDP

3.2.1 Institutional gender mainstreaming

Policies and strategies

Over the last 25 years, UNDP has issued several strategic corporate gender documents (Figure 5) and normative guidance on programmatic and institutional gender-related work. These corporate strategic plans have consistently affirmed a commitment to GEWE. For example, the 2008–2011 Strategic Plan committed to "integrate a gender perspective" into its four focus areas: (1) poverty eradication and achieving the Millennium Development Goals; (2) democratic governance; (3) environment and sustainable development; and (4) crisis prevention and recovery [42]. Similarly, the 2014–2017 Strategic Plan noted that "sustainable human development will not be fully achieved unless women and girls can contribute on an equal basis with men and boys to their societies" [43]. In the most recent Strategic Plans 2018-2021

FIGURE 5. A SNAPSHOT OF UNDP CORPORATE GENDER POLICIES AND STRATEGIES

1995 Gender Balance in Management Policy
2009 Gender Action Plan
2018-2021 Gender Equality Strategy
2018-2021 Gender Parity Strategy
1996 Direct budget Line 11 intitiated by administrator
2008-2011 Gender Equality Strategy
2014-2017 Gender Parity Strategy
2014-2017 Gender Equality Strategy
2022-2025 Gender Equality Strategy
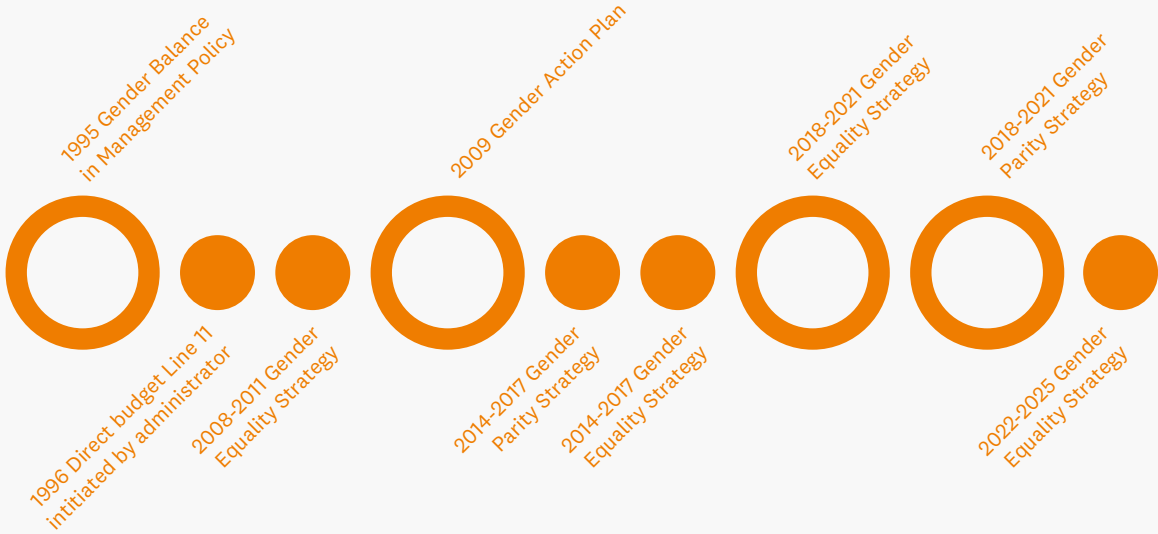
and 2022-2025, GEWE was elevated as one of the six crucial signature solutions to respond to poverty eradication, structural transformations for sustainable development, and building resilience to shocks and crises [36].

UNDP's HIV and health portfolio includes a stand-alone HIV and Health Strategy 2022-2025. The strategy has three interconnected pillars, focusing on inequalities that drive poor health, effective and inclusive governance for health, and building resilient and sustainable systems for health [44]. The pillar on reducing inequalities focuses significantly on intersectional gender issues. One of the notable positives of this strategy is that gender has been explicitly mainstreamed into the HIV and health portfolio strategy.

UNDP's gender equality strategies (GESs) outline critical programmatic and institutional priorities, outcomes, and implementation mechanisms to advance GEWE within UNDP. Figure 5 provides a snapshot of UNDP's gender strategies and policies. For GEWE programmes, both the 2008–2011 and 2014–2017 GES identify at least one specific outcome for GEWE and opportunities for integrating gender issues within the agency's broad thematic areas of work [42, 45, 46]. The

subsequent GES 2018-2021 and 2022-2025 are different, given their emphasis on deep-rooted structural barriers to gender equality, as well as the specific programme priorities and entry points it aims to address within the strategic period [48]. In addition to the corporate GES, 69% of country offices have developed their own GES and action plans to address the contextual GEWE challenges and ensure that investments align with country needs [41, 47].

UNDP's GESs both identify the following priority institutional areas that are critical to operationalising the strategy: investment in gender architecture; gender parity in staffing; financing for GEWE; building capacities, systems and tools for gender mainstreaming; and accountability mechanisms for GEWE [45, 46, 48]. In addition, central to the 2022-2025 GES is that leadership, both in terms of vision, passion and commitment, is an essential element towards achieving institutional GEWE goals [48].

Gender architecture

UNDP's gender architecture dates back to 1975 with its first Women in Development (WID) Unit, accompanied by the establishment of a focal point for Women and WID focal points in its

TABLE 2. GENDER CAPACITIES AT UNDP GLOBAL AND REGIONAL LEVELS, 2014–2020

Location	Number of staff[a]					
	2014	2015	2016	2018	2019	2020
Headquarters (New York)	8	8	8	5	8	9
Addis Ababa	5	5	5	3	3	3
Bangkok	1	1	1	1	1	1
Cairo[b]	2	-	-	-	-	-
Amman	-	2	2	1	2	2
Istanbul	2	2	2	2	2	2
Panama	4	3	3	2	3	4
Total	**22**	**21**	**21**	**14**	**19**	**21**

Notes:
[a] Between 2014 and 2016, each gender team in the regional hubs was complemented by additional gender staffing from other professional domains. These are not included in the table.
[b] Regional Hub relocated to Amman.

Sources: UNDP, 2015 (See United Nations Development Programme Annual report of the Administrator on the implementation of the gender equality strategy in 2014. https://undocs.org/DP/2015/12), 2016 (See United Nations Development Programme Annual report of the Administrator on the implementation of the UNDP gender equality strategy in 2015. https://undocs.org/DP/2016/11), 2019, 2020 [47, 49, 50].

regional bureaux. A decade later, this unit was converted into a Gender in Development Division, with focal points established throughout the organisation. In 1992, a Gender in Development Programme (GIDP) commenced and ran until 2008, when a gender team was created and housed within the UNDP's Bureau for Policy and Programme Support [3].

UNDP has a dedicated gender team strategically located within the Global Policy Network. The gender team is considered the backbone of the agency's gender architecture and comprises a three-tier structure: headquarters, regional bureaux and country offices [41, 47]. The GES 2014–2017 committed to having not less than 15 gender policy advisers posted at the headquarters, global policy centres and regional centres [45, 49]. The GES 2022-2025 does not make such an explicit commitment but prioritises

strengthening the current gender architecture and capacities in line with UN system policies [48].[10] The number of gender experts at the headquarters and regional level has fluctuated over the years and stood at 21 in 2020 (Table 2). In 2020, 81 country offices (63%) reported having a total of 141 gender advisers or gender specialists, indicating that several offices have more than one gender specialist [41].

The headquarters gender team plays a critical role in providing policy advice internally and serving as the Gender Steering and Implementation Committee (GSIC) Secretariat. It also plays a crucial role, leading UNDP's annual progress reporting on GEWE, submitted to the Executive Board. Gender teams at the regional hubs are responsible for advising and providing guidance and organising training, information sharing, and producing knowledge products –

10 General Assembly resolution 71/243 of 21 December 2016 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system and UN-SWAP for Gender Equality and the Empowerment of Women.

manuals and handbooks – on gender-related issues at the country level [3, 49].

At the level of country offices, UNDP has promoted multidisciplinary gender focal teams (GFTs) rather than individual gender focal points (GFPs). The idea is to build robust and consistent gender architecture. The GFT is spearheaded by the deputy representative or country director [3, 47, 49, 50] to advance co-ownership of the gender equality agenda. Experience suggests that the GFT has:

> prove[n] to be an effective mechanism to promote integration, improve vertical and horizontal coordination, and connect internal organisational structures to UNDP programmes/impact and results on the ground [50].

In the GES 2022-2025, UNDP commits to further enhance the gender architecture at country offices by measures such as a new network of gender specialists supporting country offices, new gender teams in each regional hub, hiring of gender specialists at country office level and integrating them into management mechanisms and in crisis countries it will be mandatory to recruit at least one full-time gender specialist [48].

Gender parity and inclusion

UNDP has long demonstrated a commitment to achieving gender parity within the organisation. The current GES 2022-2025 reiterates the commitment to achieve gender parity across the organisation, with a special focus on conflict and post-conflict contexts [48].

Overall, women consistently make up a little over 50% of all staff entry-level (international professionals at P1–3 level), general services and national officers' positions [47, 50, 51]. As of December 2020, 50% of all UNDP staff were women. Despite meeting the target of gender parity among senior management ahead of the UN required timeline, there are persistent gaps at some senior (D1 and D2) and middle management (P4 and P5) levels [47, 50]. For example, in 2019, women's leadership at the D2 level was 42%, D1 43%, P5 41% and P4 42% [47].

UNDP's *People for 2030 Strategy* commits to maintaining full gender parity among all staff at every level by 2026 and all senior management roles by 2021[11]. The strategy extends beyond numbers, to transforming the internal culture and capacity to enable staff to deliver on the organisational gender strategy.

Enabling organisational culture for inclusion

The GES (2022-2025) commits to transforming the work environment to facilitate equal opportunities for all staff members to progress in their careers. This is to be achieved in an atmosphere of respect, care, and flexibility of work-life balance, free from any bias, discrimination, or harassment [48].

Commitments to an inclusive and transformed working environment are also reflected in UNDP corporate policy on zero tolerance to harassment, abuse of authority, sexual exploitation, and sexual abuse. In 2018, a senior-level task force was established on preventing sexual harassment, leading to a policy revision and the introduction of several initiatives to help prevent and address sexual harassment [47]. These actions included:

- setting up an independent, accessible, and externally managed 24–hour helpline in more than 250 languages for reporting sexual harassment

- providing counselling services to personnel experiencing sexual harassment through an independent team of counsellors

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11 See United Nations Development Programme Report titled People for 2030 United Nations Development Programme People Strategy (2019-2021). https://www.undp.org/sites/g/files/zskgke326/files/undp/library/corporate/jobs/Peoplefor-2030.pdf

- removing time limits for reporting sexual harassment

- increasing capacity to investigate cases and legal action within 6 months – a female investigator specialising in sexual harassment and two additional lawyers recruited

- ensuring more comprehensive socialisation of the policy for all UNDP personnel.

Building staff capacity and tools for gender mainstreaming

Several strategic documents, including the People Strategy 2030, highlight the importance of transforming institutional culture and capacity to deliver better results. While recognising the importance of gender capacities, the GES 2022-2025 does not provide detailed content of the potential training requirements for gender equality work or how such training would be funded [48]. The previous GES 2014–2017 recommended that at least 10% of learning budgets, from headquarters to country offices, should be earmarked for gender-related learning needs [45]. It also stressed the need for a basic familiarity and adequate technical capacity in gender mainstreaming. All staff are required to take the Gender Journey Course: Thinking Outside the Box as part of staff capacity-building for gender mainstreaming [45]. The course is currently being re-vamped to enhance staff capacity to deliver on GEWE goals.

Several gender mainstreaming learning resources have been undertaken to further enhance staff development. These include, for example:

- online courses (e.g. ethics, harassment, discrimination and abuse of authority in the workplace)

- face-to-face workshops (such as on manuals, tools, and checklists)

- tailored gender analysis and training segments in substantive areas (e.g. gender and climate change and mainstreaming gender into national HIV strategies and plans).

Data suggest that, by 2015, a total of 3,807 staff members had completed the gender journey course, and another 2,680 had completed the sexual harassment course [49]. However, there has been no systematic assessment to document how this training has helped influence staff members' ability to accomplish gender-related tasks [49].

Beyond training resources, the GES 2014–2017 also recommended including technical and functional gender competencies in recruiting new staff and consultants. It was expected that all new personnel and consultants would have a basic understanding and demonstrate a commitment to work in a gender-sensitive manner [45].

Financial commitments

Following the UN-SWAP requirements, the UNDP's UNDP's GES 2022-2025 continues commitments of a 15% financial benchmark allocation of all country programmes and project budgets to promote GEWE [48]. Available data[12] from the transparency portal show that, between 2018 and 2020, total expenditures on projects to strengthen gender equality and women and girls across UNDP's three development priority areas has been declining. In 2018, a total of $43.17 million was spent, falling to $35.95 million in 2019 and $29.85 million in 2020 [51]. These expenditure data only represent funding from donor resources. The share of core resources compared to non-core resources spent on commitments on GEWE is unclear.

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12 Expenditure data for the years 2018, 2019 and 2020 were compiled by the UNU-IIGH research team from the UNDP transparency portal.

TABLE 3. UNDP TOTAL EXPENDITURE (USD) BY PROPORTION ALLOCATED FOR GEWE, 2014–2020

Category	2013	2014	2015	2016	2017	2018	2019	2020
GEN0: Noticeable contribution to gender equality	17%	16%	13%	18%	8%	5%	4%	3%
GEN1: Some contributions to gender equality	53%	50%	52%	45%	45%	39%	38%	33%
GEN2: Significant contributions to gender equality	26%	29%	31%	33%	44%	49%	50%	56%
GEN3: Gender equality is a principal objective	4%	5%	4%	4%	4%	7%	9%	7%
Budget allocations for GMIs		2.3m	1.6m	1.6m		1.05m	1.67m	1.93m

Sources: UNDP, 2015 (See United Nations Development Programme Annual report of the Administrator on the implementation of the gender equality strategy in 2014. https://undocs.org/DP/2015/12) , 2016 (See United Nations Development Programme Annual report of the Administrator on the implementation of the UNDP gender equality strategy in 2015. https://undocs.org/DP/2016/11), 2019, 2020 [47, 49, 50].

UNDP also has a dedicated fund for gender mainstreaming initiatives (GMIs), covering various programming and institutional activities (Table 3). Data show that the GMI budget allocations, including UN-SWAP commitments, the Gender Equality Seal Certification Programme for Public and Private Enterprises, and engagement in inter-agency initiatives have been stable, increasing steadily between 2018 and 2020, from $1.05 million to $1.93 million, respectively.

UNDP has a gender marker, which tracks budget allocations and investments towards GEWE. Data from the gender marker[13] show a noticeable increase in expenditure for initiatives making a significant (GEN2)[14] or principal contribution (GEN3) to GEWE. UNDP continues to leverage the gender marker as a key criterion to assess funding allocations from multi-partner trust funds to guide gender-equality programming.

Accountability mechanisms

The GES 2022-2025 places the highest level of accountability for delivery on GEWE results with the administrator, bureau directors, and country resident representatives [48].

Within the organisation, the GES GSIC is responsible for oversight of implementation, and:

- monitors implementation of the strategy and provides policy guidance

- acts as a peer review group for ensuring the integration of gender equality at each domain of work

13 Figures for the gender marker were compiled from the annual reports of the administrator on the implementation of the UNDP GES for the years 2015, 2016, 2019, and 2020.
14 GEN is the code/indicator of the gender marker that describes the extent to which an activity is contributing or expected to contribute to GEWE.

- reviews gender marker findings and documents progress on gender parity

- makes binding recommendations for delivering on gender equality outcomes [49].

Second, the UNDP is held accountable to its executive board through the administrator's annual reports and GSIC gender progress reports. Experience shows that where the Executive Board did not mandate or endorse a policy (for example, the first GES) or set priorities, implementation and reporting were considered voluntary, especially in the context of multiple competing priorities [49]. In addition, to increase transparency, the GES 2022-2025, states that UNDP will create a mechanism comprising civil society and external experts to guide and track implementation of the strategy [48].

Unlike the current GES, the 2018-2021 GES emphasised, at senior management level, the need to include results related to GEWE in their unit's performance plans and assessment (Box 2). Since 2019, all heads of offices, including deputy directors, have a mandatory performance evaluation goal to ensure that the GES 2018–2021 and the Gender Parity Strategy 2018–2021 are implemented effectively. Other accompanying oversight mechanisms mentioned in the GES 2018-2021 are highlighted in Box 2.

The UNDP gender marker also acts as an accountability mechanism for the agency to monitor investments towards GEWE objectives. The gender marker is a mandatory process, especially at the early stages of budget submission. This has heightened awareness of the need to consider gender, women, and girls' issues in project and programme budgetary allocation [49].

Another layer of accountability that provides an incentive for UNDP country offices and units to deliver transformational gender equality results is the Gender Equality Seal, introduced in 2011. The Gender Equality Seal is a corporate certification initiative that recognises the good performance of country offices meeting gender

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BOX 2. COMPONENTS OF ACCOUNTABILITY MECHANISMS FOR GENDER EQUALITY WITHIN UNDP

Gender-responsive staff performance management

UNDP will ensure that implementing the GES and gender parity action plans are recognised as a criterion of good performance in all senior and middle managers' performance assessment. Senior managers will be expected to identify those elements of the GES relevant to their unit/offices' work and agree with their staff on which outputs can be achieved, and track compliance with this agreement through various performance plans and assessments.

The UNDP corporate monitoring system (results-based management) and tools mainstream GEWE to enable the organisation to assess progress toward the three development outcomes established in the strategic plan.

Auditing and evaluation

All UNDP evaluations will be designed and implemented per the norms and standards for assessment in the United Nations system, including the gender-related norms and standards. Implementation of the UNDP GES will be evaluated at least once. Gender will be included in risk-based audits undertaken by the organisation annually.

Source: UNDP, https://www.undp.org/publications/undp-gender-equality-strategy-2018-2021

FIGURE 6. STRATEGIC ACTION AREAS AND KEY PRIORITIES, UNDP 2022-2025

ACTION AREA 1

Reducing inequalities and exclusion that affect health and drive epidemics

Key priorities

1.1 Promoting gender equality and empowering women and girls.

1.2 Ensuring inclusion of key populations at risk of HIV and other excluded groups.

1.3 Strengthening inclusive social protection.

ACTION AREA 2

Promoting effective and inclusive governance for health

Key priorities

2.1 Enabling legal, policy and regulatory environments for HIV and health.

2.2 Strengthening governance, including to address NCDs, mental health and accelerate tobacco control.

2.3 Enhancing sustainable financing for HIV and health.

ACTION AREA 3

Building resilient and sustainable systems for health

Key priorities

3.1 Implementation support and capacity development for large-scale health programmes.

3.2 Planetary health, including climate, energy and health.

3.3 Pandemic preparedness.

Source: UNDP, 2022 [44].

equality standards, enables country offices to establish baselines and address gaps and challenges to catalyse both organisational transformation and development results. The Gender Equality Seal tracks actions for gender mainstreaming and their impacts at three levels:

- the organisation – policies, procedures, culture, and people

- the development of interventions supported by the organisation

- the larger national context, including the socioeconomic, cultural and political environment, the policies and programmes of development partners, and the perspectives and strategies of women's movements and other civil society actors.

3.2.2 Programmatic gender mainstreaming in health

In this section, we explore examples of health programmes or programmes that address underlying the determinants of health and wellbeing, which integrate GEWE goals.

Since the 1995 Beijing Conference, UNDP has also been instrumental in thought leadership and evidence generation on GEWE in development programming. Indeed, gender and development were the central focus of its 1995 *Human Development Report*, which articulated that "human development concepts – productivity, equity and sustainability and empowerment – demand that gender issues be addressed as development issues and as human rights concerns" [56].

The current UNDP Health Strategy (2022-2025) outlines the organisation's global health response. Three main health policy and programming priorities, also called action areas (Figure 6) have been identified for investment [44, 52, 53]. UNDP works across these three interrelated areas to:

- address the underlying inequalities that produce and drive HIV and poor health

- ensure that institutions have the capacity and robust governance structures to plan and deliver on health and its associated services

- support the building of resilient health systems to respond to shocks during human-made and environmental emergencies.

Gender equality and empowering women and girls is a stand-alone priority in action area 1 and mainstreamed in action areas 2 and 3.

In the context of UNAIDS' division of labour, UNDP convenes the work of the joint programme on human rights, stigma and discrimination, HIV prevention among key populations (together with UNFPA), and ensuring investments and efficiencies in financing the HIV response (together with the World Bank). Until 2018, the UNDP co-convened the joint programme's efforts to prioritise gender equality in global actions on HIV with UN Women and UNFPA (now convened by UN Women). These partnerships collectively aim to ensure an integrated joint response and collaboration to accelerate progress towards achieving SDG 3 and other health-related goals within the SDGs.

Examples of health programming, gender equality, and women empowerment

UNDP works closely with national and local governments, multilateral, CSOs, academia, and the private sector to deliver and build technical capacity at the intersection of its health-related priority areas and GEWE. UNDP's work in programmatic gender mainstreaming in health can be categorised under three broad areas:

1. developing tools and guidelines

2. technical and policy support to Member States in priority areas

3. strengthening the evidence base on gender and health.

Each of these three broad areas is discussed in more detail below.

TABLE 4. EXAMPLES OF MAINSTREAMING TOOLS FOR GENDER, HUMAN RIGHTS, AND HIV BY YEAR

Making the Law Work for Women and Girls in the Context of HIV	2020
Gender and Recovery Toolkit: Advancing Gender Equality and Women's Empowerment in Crisis and Recovery Settings	2019
Legal Environment Assessment for Tuberculosis: An Operational Guide	2017
How to Conduct a Gender Analysis	2016
Checklist for Integrating Gender into the New Funding Model of the Global Fund to Fight AIDS, TB, and Malaria	2014
Legal Environment Assessment for HIV: An Operational Guide to Conducting National Legal, Regulatory and Policy Assessment for HIV	2014
Gender Mainstreaming Made Easy: Handbook for Programme Staff	2013
Making Joint Gender Programmes Work	2013
A User's Guide for Measuring Gender-Sensitive Basic Service Delivery	2009
Programming for Justice: Access for All. A Practitioner's Guide to a Human Rights-Based Access to Justice	2003
Learning and Information Pack: Gender Analysis	2001

Developing tools and guidelines

UNDP has, sometimes with partners, produced several critical knowledge management tools and documents on health, gender and human rights, and guidelines for designing, implementing, and monitoring programmes. These have included, for example, a series of tools for gender analysis, a checklist for integrating gender into the new funding model of the Global Fund to Fight AIDS, TB and Malaria, tools for assessing laws and policies on HIV and TB, a guide for assessing the gender-sensitivity of health services, and a 2020 guide on making the law work for women and girls in the context of HIV (Table 4).

Technical and policy support to Member States in priority areas

Reducing inequality, discrimination and exclusion, which may harm people's health and impede their development, especially for the disadvantaged, lies at the heart of UNDP's activities on global health [53]. Programming in this area targets women and girls, LGBTQ+ people, ethnic minorities, and other disadvantaged groups, helping them gain access to prevention and treatment services.

In the context of advancing inclusion and promoting access to HIV and health services for key populations, UNDP works with and has supported national governments, civil society, and other development partners to improve health outcomes through strengthening good governance and enhancing legal and policy environments. This helps them respond appropriately to HIV, health, and other related development challenges [54]. The agency also works to increase the capacities of key populations, women, and girls to realise their health and human rights, thereby mitigating their risks of contracting HIV.

Examples of UNDP initiatives in this area include the following:

- **Social protection for key populations.** UNDP supported 38 countries in HIV-sensitive social protection programmes. In Cambodia, transgender people, people who use drugs, entertainment workers and PLHIV were included in Poor ID, a national initiative to identify poor households and determine their eligibility for various social protection programmes [53].

- **Leveraging laws to empower vulnerable groups.** UNDP has provided support to over 30 countries to undertake a legal environment assessment (LEA) to understand how national laws and policies either facilitate or act as a barrier to government responses to HIV or other health issues [53]. The assessments also generate valuable insights for countries to align and ensure that national laws are consistent with international agreements and frameworks. Through this support, several countries are taking (or have taken) steps to facilitate an enabling environment for better health outcomes. In Gabon, findings from the LEA have informed the development of a new policy on gender [54]. In Mozambique and Seychelles, there has been a repeal of laws criminalising the unintentional transmission of HIV and consensual same-sex conduct, respectively [8].

Strengthening the evidence base on gender, human rights, and health

The global HIV and health team within UNDP has led, supported or partnered with UN entities and other critical stakeholders to produce a series of useful knowledge products. These include a series of significant flagship reports, research pieces, indicators, and assessments on issues at the intersection of gender, inequities, and human rights in programmes and policies around HIV/AIDS, GBV, livelihoods, and law reforms, such as the following:

- UNDP convened The Global Commission on HIV and the Law in 2010 with a mandate to develop evidence-informed recommendations to promote effective HIV responses to the HIV epidemic. The Global Commission's 2012 flagship report and 2018 supplement highlighted the links between enabling legal and policy environments and HIV vulnerability[15]. It also highlighted the legal and structural barriers to women's and girls' access to HIV and SRH services [52]. The Global Commission also noted that inadequate legal frameworks perpetuate discrimination and GBV. The recommendations from the report and the supplementary report have informed the work of UNDP and UNAIDS on enabling legal and regulatory environments as a pathway to effective HIV prevention, treatment and care for women and key populations.

- As part of a research consortium,[16] UNDP supported research to generate evidence to understand what works to tackle the structural drivers of HIV and health, emphasising harmful practices – alcohol use, intimate partner violence, stigma, and sex work. UNDP is committed to working with partners to enable UN Member States to translate the research into programmes and policies [54].

- The UNDP LGBTQ+ Inclusion Index, which consists of 51 indicators, assesses LGBTQ+ people's experiences related to political participation, access to health, education, and safety. The index has being piloted in selected countries, and the resulting data aim to improve the agency's understanding of the needs of LGBTQ+ people and address gaps in service provision [54, 55].

Advocacy on HIV for key populations

UNDP is also a convenor of several stakeholder engagements globally, with national governments, civil societies, and networks of PLHIV, including key populations. UNDP's convening power provides an opportunity to mobilise global and national solidarity for concrete, country-level action to end stigma and discrimination, including women and girls and key populations. For example, in 2019, UNDP convened stakeholders from sub-Saharan Africa to develop a vision and strategic framework to advance LGBTQ+ rights and inclusion. The resultant framework identified six mutually supportive ways towards reaching this goal by 2030. The domains included social norms, laws, public-sector services, inclusive governance, social movements, and knowledge. UNDP and other stakeholders have already employed this framework in their programming and activities to advance LGBTQ+ rights within the region [53].

In 2015, UNDP also strengthened governance institutions for HIV and TB. The Africa Regional Judges Forum brings together a group of senior judges who discuss the pressing issues related to LGBTQ+ people, key populations, young women and girls, and human rights in the context of HIV and TB. This forum enables change in the legal training curriculum and develops regional resources on human rights and HIV and TB. The Judges Forum has had a ripple effect, resulting in similar platforms in several regions being established: the Caribbean Judges Forum on HIV, Human Rights and the Law, and the Eastern Europe and Central Asia Regional Judges Forum on HIV, Tuberculosis, Human Rights and the Law [52, 54, 55].

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4. UNFPA

4.1 THE ORGANISATIONAL CONTEXT

UNFPA occupies a central place within the UN system in terms of gender mainstreaming. GEWE is an essential part of UNFPA's mandate in its role as the UN agency steering the implementation of the Programme of Action of the International Conference on Population and Development, Cairo, 1994 (ICPD PoA). For UNFPA, GEWE is itself a goal and key to achieving UNFPA's mandate to promote SRH. Principle 4 of the ICPD PoA states:

> Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. [56]

Since 2015, the era of sustainable development has positioned UNFPA as one of the key players in achieving some key SDG goals. All areas of UNFPA's work feature among the SDGs. Goal 3 on health includes SRH. SDG 5 (gender equality) references reproductive rights. Other central elements of SRH, including maternal and newborn mortality and HIV, are addressed under targets for SDG 3 and GBV, and harmful practices under SDG 5 [57]. UNFPA is part of a common chapter for promoting SDG goals alongside UNDP, UNICEF, and UN Women. The four organisations are committed to implementing interventions designed to advance the agreed set of SDG indicators [58].

UNFPA is mainly a field-based organisation with most of its staff stationed in six regional and two sub-regional offices and 136 country offices [59]. The mandate of regional and country offices is mainly programme implementation [58]. UNFPA

is also the lead for the GBV area of responsibility (AoR) in (non-refugee) humanitarian settings. Consequently, when gender equality goals are a part of the strategic plan outcomes, there is a high probability of making a change on the ground in addressing gender-based inequalities.

UNFPA has a track record of working with a broad range of CSOs at the country level, including those promoting human rights and women's rights, youth organisations and faith-based organisations [60]. The collaborative approach further enhances the agency's capability for advancing GEWE through the programmes it supports.

A 36-member executive board, elected by the UN Economic and Social Council (ECOSOC), usually for 3-year terms, is responsible for UNFPA's governance. The board establishes policies, approves programmes, and decides on administrative and financial plans and budgets [61]. The executive director, and regional and country directors have significant control over decisions. Consequently, leaders who champion gender mainstreaming can help move the gender agenda forward within the organisation and its programmes with a supportive executive board.

However, UNFPA, as an organisation, faces some significant challenges. Issues on the SRHR agenda include access to modern contraception methods, comprehensive sexuality education, access to safe abortion and sexual rights, and non-discrimination against sexual minorities. But such issues have been contested since 1994. Even as late as 2014, regional reviews leading up to ICPD+20 were mired in controversy [62].

UNFPA depends entirely on voluntary funding by Member States, private donors, and other sources. During the period 2014–2017, a third ($1,126.2m) of the agency's funds were core

FIGURE 7. UNFPA'S GENDER POLICIES AND STRATEGIES

2008-11	2011-13	2018-21
Strategic Framework on Gender Mainstreaming and Women's Empowerment (2008-11)	Strategic Framework on Gender Mainstreaming and Women's Empowerment (2011-13)	Gender Equality Policy (2018-21)

Sources: UNFPA 2007, 2011, 2017 [66, 67, 69].

resources (contributions without restrictions), and two thirds ($2,009.0m) were non-core resources (contributions towards specific activities) [59]. The proportion of core funds declined to 27% in 2019 and further to 23% in 2020 [59, 63]. The funding ratio limits the possibility of core funding for gender work and places UNFPA in competition with other UN agencies and international organisations for funding from donors who support gender work.

Another funding challenge that UNFPA has faced for many decades is the volatility in funding by the United States government. For example, in 2015 and 2016, the US was UNFPA's third-largest bilateral donor, contributing $75m and $69m respectively to its operations. When President Trump took office in January 2017, he indicated his administration's intention to cut funding for UNFPA, which became effective from 3 April 2017 [64]. There was no funding from the US for the subsequent 4 years. The Biden administration made available US$32.5 million in 2021 and in 2022, a much lower level of funding compared with 2016 [65]. The budgetary cuts necessary under such circumstances have dampened new investments in strengthening gender architecture and initiating additional interventions.

4.2 GENDER MAINSTREAMING EFFORTS WITHIN UNFPA

4.2.1 Institutional gender mainstreaming

Policies and strategies

Given the intimate linkages between population growth and women's fertility behaviour, since its very inception UNFPA has engaged with issues related to women's status and its impact on their fertility and acceptance of family planning. However, it was not until the ICPD in 1994 and the Fourth World Conference on Women in 1995 that GEWE became a core area of UNFPA's focus.

Following the 1997 UN ECOSOC Resolution on gender mainstreaming, UNFPA issued a circular (29 November 1997) calling for all staff to mainstream gender across all sectors [66]. In 1998, UNFPA developed a specific policy and programmatic guideline to mainstream gender into its operations. GEWE was one of three goals of the multi-year financing framework for 2000–2003, while gender concerns were mainstreamed into the other two goals [67]. In 2010, UNFPA began to focus on mainstreaming gender into its work on SRHR following UN Women's formal establishment. UNFPA's specific gender-related goal of preventing GBV and harmful practices against girls and women, including in humanitarian settings, was implemented in collaboration with other UN agencies working on these issues, such as UNICEF and UN Women [68].

The UNFPA issued three GES documents spanning from 2007 to 2018, covering the same periods as the programme strategies (Figure 7).

The first GES was issued in 2007 and covered the period 2008–2011 [67]; the second, published in 2011, covered 2011–2013 [66]. No GES was issued alongside the organisation's 2014–2017 strategic plan. However, the strategic plan outlined the nature of gender-related priorities. It promoted gender equality as one of the enabling factors

for universal access to SRH, realise reproductive rights, and reduce maternal mortality to accelerate progress towards the ICPD agenda [68]. The third GES was issued in 2018, covering 2018–2021 [69].

All three GESs adopt an integrated human rights and gender equality perspective in their approach to programmes. Likewise, they adopt a twin-track strategy, which recognises the need for gender mainstreaming across all UNFPA programmes while also developing programmes with a specific focus on women and girls.

The first track integrates gender concerns in SRH programmes, mainly through engendered service delivery models in interventions for maternal mortality and morbidity reduction, family planning, and HIV/AIDS programmes [66, 67, 69].

The second track has an exclusive focus on women and girls and consists of programmes addressing GBV, including in humanitarian settings and harmful traditional practices such as early, forced and child marriage and female genital mutilation (FGM). UNFPA's GESs have also prioritised working with men and boys to bring about changes in social norms and practices that sustain gender inequalities.

Institutional gender mainstreaming components such as strengthening accountability, committing adequate human and financial resources and building in-house gender capacity also find a place in the GES [66, 67, 69]. The broad priorities have remained consistent across the three strategies. However, the latest strategy links the priority objective and the modalities through which it is achieved explicitly – for example, working with civil society and communities to change social norms and increasing multi-sectoral capacity to prevent and address GBV in humanitarian development settings.

UNFPA's strategic plan (2018–21) includes GEWE as Outcome 3: "Gender equality, the

empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings" [60].

UNFPA's Results Framework focuses on outputs corresponding to Outcome 3 from UNFPA's strategic plan. The four outputs of Outcome 3 in the strategic plan include the following:

1. Output 9 – strengthened legal, policy and accountability frameworks to advance gender equality and empower women and girls to exercise their reproductive rights and to be protected from GBV and harmful practices

2. Output 10 – strengthened civil society and community mobilisation to eliminate discriminatory gender and sociocultural norms affecting women and girls

3. Output 11 – increased multi-sectoral capacity to prevent and address GBV using a continuum approach in all contexts, with a focus on advocacy, data, health and health systems, psychosocial support and coordination

4. Output 12 – strengthened response to eliminate harmful practices, including child, early and forced marriage, FGM, and preferences for male children [69].

Many of the activities corresponding to the outputs of Outcomes 1 and 2 also emphasise attention to several gender concerns. These two outcomes are about ensuring access to SRH services for women, adolescents and youth and enabling them to exercise their reproductive rights, in all contexts, free from coercion, discrimination and violence [60]. Some examples of gender mainstreaming Outcomes 1 and 2 include addressing gender-based barriers to service access, engaging men and boys to mitigate gendered barriers, and specific attention to the most marginalised groups of women, adolescents and youth, and those identifying as LGBTQ+.

Gender architecture

Soon after the first gender mainstreaming guidelines were issued in 1998, a gender branch was created in UNFPA's Technical Support Division and is now the Gender and Human Rights Branch. Gender advisers were appointed to country support teams, and GFPs were nominated in all organisational units [62].

UNFPA's hub of gender expertise consists of the organisation's extensive network of gender and GBV staff in its headquarters and many of its 150 country and regional offices. At the headquarters' level, the Gender and Human Rights Branch is in the Technical Division. The chief of the branch is supported by senior technical experts in gender and GBV. The gender-based violence in emergencies (GBViE) team, located in the Humanitarian and Fragile Contexts Branch of the Programme Division, also consists of a team of senior gender experts.

All regional offices have a gender adviser at the P5 level and in most instances, at least one more gender specialist at the P4 level. There are also coordinators for GBV and harmful practices who have gender expertise. Programming at the country level is undertaken either by gender specialists or by GFPs for whom this is not usually a full-time responsibility [69].

Gender parity in staffing

The UN Secretary-General's System-Wide Strategy for Gender Parity in 2017 calls for achieving gender parity at senior leadership levels by 2021 and ultimately in 2028 across the board. The 2021 report on gender parity in the United Nations shows that in UNFPA, 50.5% of all professional staff (P1–P5) and senior managers (D1, D2, and UG) were women. There was a slightly higher proportion of women working in headquarters (52.5%) compared with other locations (49.8%). Figure 8 presents the proportion of women at each professional level [70]. There was a much higher proportion of women in levels P1–P3 compared with P4 and P5, and a low representation at the D2 level. The patterns are broadly similar at HQ and non-HQ locations.

FIGURE 8. PROPORTION OF WOMEN AMONG PROFESSIONAL STAFF, UNFPA DECEMBER 2019
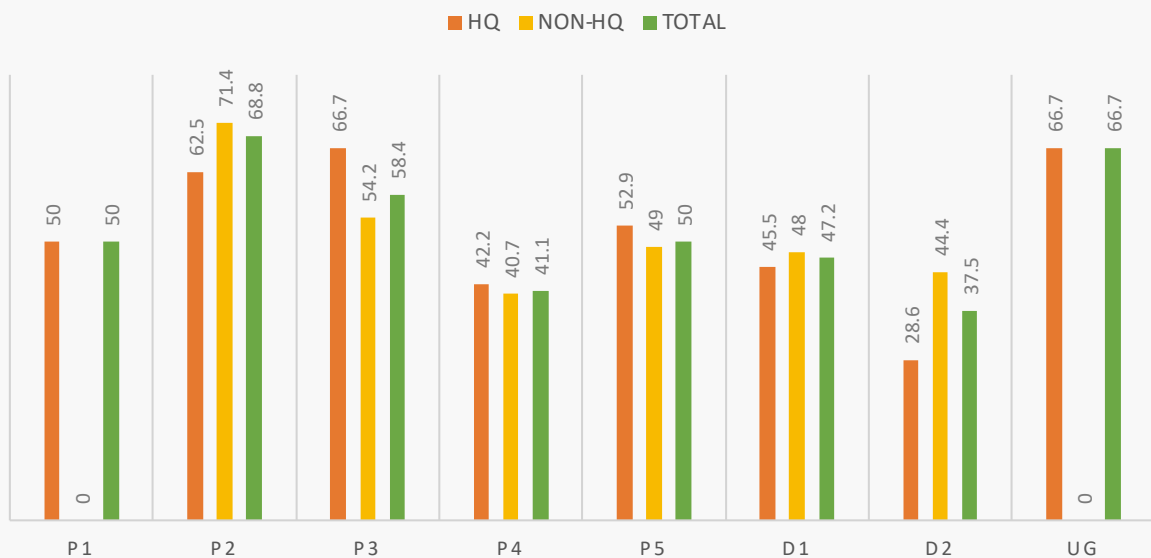
Source: Computed from Annex 1 UN Women, 2021 [70].

UNFPA's zero-tolerance policy for sexual exploitation and abuse may be seen as a step towards creating an enabling environment for a gender-equal workplace. There is a coordinator responsible for protection from sexual exploitation and abuse at the P5 level that sits in headquarters, responsible for ensuring that any cases of harassment, whether at headquarters or the country level, are dealt with in the right way.

Building staff capacity for gender mainstreaming

Various GES documents make commitments to building staff capacity for gender mainstreaming. According to the GES for 2018–21, all UNFPA staff members go through the *I Know Gender* mandatory training on gender equality for UN Staff. Staff training also included an e-orientation entitled *One Voice* on the importance of gender analysis in all programming as essential to the UNFPA mandate. The strategy also commits to identifying opportunities for enhancing staff capacity on gender programming [69].

While we are aware that many training initiatives are undertaken, specific information on these is not available. For example, we could not find information on the actual number of training workshops or courses in a reporting year, or the number of staff members at various levels who have completed in-house and external training, disaggregated by the training topics. Also, the gender capacity assessment of staff was based on self-reporting via a survey questionnaire, not on objective criteria of the ability of staff to carry out gender-related tasks effectively.

Besides the training workshops, staff receive guidance on using gender analysis for programme development, monitoring, implementation, and evaluation of programmes. UNFPA's Programme Review Committee supports country offices for gender mainstreaming country programmes [69].

Financial resources

UNFPA uses the gender marker to track the organisation's investment in gender mainstreaming and women's empowerment. The marker, which was instituted in 2014, tracks allocation of programme funds based on the extent to which GEWE is considered and addressed throughout the design, implementation, and monitoring and evaluation process. The gender marker is now a mandatory component of UNFPA's work plans and has been instituted across all levels of the UNFPA, from headquarters down to the country offices [69].

All activities are classified into four categories:

1. activities with GEWE as their primary objective

2. activities that contribute substantially to GEWE

3. activities that make some contribution to GEWE

4. activities that do not contribute GEWE.

The classification is based on guidelines from the UN system's finance and budget [71]. The annual reports for 2016 and 2017 show that 15.5% and 16.3% respectively of the total programme budget was allocated for activities whose primary objectives are promoting GEWE [59, 72]. Comparable data for recent years were not available in the public domain.

Accountability mechanisms

Several mechanisms are in place to ensure accountability for gender mainstreaming in UNFPA, beginning with a strong strategic plan that prioritises gender and holds senior management at all levels of the organisation accountable to the Executive Board and donors. Having gender as one of four outcomes in the organisation-wide strategic plan was seen as

protecting the organisation from the shocks of new leadership that may not be as committed to gender equality. There are two indicators related to gender equality in the latest strategic plan and one each related to GBV and human rights, and all offices are expected to deliver on that [69]. The gender marker is another accountability mechanism.

UNFPA incentivises good performance for gender mainstreaming, adopting a "recognition toolkit" in 2016, which included a provision for recognition of excellent work promoting GEWE [69]. Templates for annual reporting include sections for reporting on gender outcomes and outputs in the strategic plan, further encouraging staff to work on gender equality issues.

Since 2012, UNFPA reports on its progress in gender mainstreaming as part of the UN-SWAP for gender mainstreaming. Currently, the organisation reports on 17 indicators, most of which are concerned with assessing progress in institutional gender mainstreaming. It is important to note that UN-SWAP indicators have been integrated into UNFPA's strategic plan (2018–21) [60]. Therefore, the organisation has dual accountability to the UN-SWAP indicators – reporting to UN Women and the Executive Board.

4.2.2 Programmatic gender mainstreaming in health

Our focus in this section is on UNFPA's health and health-related programmes. In the following pages, we present some examples of GEWE programming in health programmes or programmes that address important determinants of SRH. Many of UNFPA's GEWE programmes are planned and implemented jointly with other UN agencies, such as programmes addressing harmful practices

against girls and women and GBV in development and humanitarian settings.

UNFPA–UNICEF Joint Programme on the Abandonment of FGM: Accelerating change

This programme was initiated in 2008, funded by multiple donors and coordinated and administered by UNFPA. The programme is now in its third phase (2018–23) and being implemented in 16 countries.[17] This programme is well documented, and detailed evaluation reports are available [73].

Activities of the joint programme are implemented at three levels: global, regional, and national. At the global level, work is focused on advocacy to raise awareness and garner political and financial support. The global headquarters of both agencies also provide technical assistance to country offices to support the efforts of their respective regional offices. At the regional level, activities include engaging with regional institutions such as the African Union, supporting regional CSOs working on FGM, and providing technical assistance to country offices. At the country level, activities include advocacy for policies and laws to eliminate FGM, strengthening the country's capacity for health service delivery while opposing the medicalisation of FGM, and strategic community-level interventions to change social norms that support FGM [73].

Phase 3 of the joint programme prioritises transforming unequal power relations, structures and norms that sustain gender inequality and harmful practices. Informed by the SDG call to "leave no one behind", the focus is on intersectional vulnerabilities, and girls further disadvantaged by ethnicity, socioeconomic position, disability, sexual orientation, conflict situations, and so on [73].

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17 Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Mali, Mauritania, Nigeria, Senegal, Somalia, Sudan, and Uganda.

UNFPA–UNICEF Global Programme to Accelerate Action to End Child Marriage (GPECM)

This global programme was launched in 2016 jointly by UNFPA and UNICEF, with UNICEF as the convener and administrator. It is to be implemented in three phases over 15 years, acknowledging the long-term engagement needed to alter deeply entrenched social norms that support child marriage. GPECM was designed to contribute to the achievement of Target 5.3 of the SDGs [74].

The theory of change (TOC) identifies gender discrimination and inequalities as one of the key drivers of child marriage, and its strategies seek to address these drivers at multiple levels, from the adolescent girls and communities concerned to economic factors and legal and policy frameworks [74].

According to an evaluation report of the first phase (2016–19), this global programme far exceeded its goal of reaching 2.5 million girls with targeted programmes (life skills education, health information, economic empowerment or social protection) by the end of 2019 and had already benefitted 5.5 million girls by mid-2018 [74].

UN Women/UNFPA/UNDP/WHO/UNODC Joint Global Programme on Essential Services for Women and Girls Subject to Violence

The United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence was launched by UNFPA and UN Women in December 2013. Five UN agencies participate in this joint programme: UNFPA, UN WOMEN, WHO, UNDP, and UNODC [75].

The first phase of the project was conducted between 2013 and 2016. A salient contribution of the joint programme in 2015 was the Essential Services Package for Women and Girls Subject to Violence. The package identified the most critical services to be provided by the health, social services, police, and justice sectors. The package was complemented by an online course of five modules, intended to provide basic knowledge and skills for implementing the essential service package [75].

In the second phase (2016–18), the standards and guidelines were tested in 10 countries to ensure that each country has a plan in place to achieve the standards as well as monitoring and accountability mechanisms. Lessons following the testing are being used for further refinement of the package. During the current phase of the programme, the essential services package is being rolled out in countries across different regions [75].

The Joint EU-UN Spotlight Initiative to eliminate all forms of violence against women and girls

UNFPA is a part of the Spotlight Initiative to eliminate all forms of violence against women and girls. The initiative was jointly launched by the European Union and the United Nations in September 2017. Implementation is to be carried out by UNDP, UNFPA and UN Women, and overseen by the Executive Office of the UN Secretary-General [76].

The Spotlight Initiative has been rolled out in all the regions, with different priorities in each (European Union, 2019). The health sector's explicit involvement is in the services pillar of the implementation strategy. Health services to be made available to survivors of violence are those spelt out in the health module of "Essential Services for Women and Girls Subject to Violence". The indicator of interest is the proportion of women, including those facing multiple intersecting forms of discrimination, who report experiencing physical or sexual violence, by sector. At the end of 1 year of implementation, the initiative reported a 15% increase in the use of support services.

Disaggregated data for health services were not reported [77].

UNFPA's gender and health programmes in humanitarian settings

UNFPA works in non-refugee humanitarian settings across the globe and is responsible for implementing programmes on GBViE and Sexual and Reproductive Health and Rights in Emergencies (SRHRiE).

UNFPA has played a salient role in humanitarian settings in many countries, responding to GBV against women and girls through the provision of health and psychosocial counselling services and setting up shelters for GBV survivors. UNFPA also plays a coordinating role for GBV under the Inter-Agency Steering Committee (IASC) architecture. Since 2016, UNFPA has been the leader of the GBV AoR within the Global Protection Cluster led by UNHCR. The GBV AoR provides support to countries in addressing GBV in emergencies through supporting field operations, capacity-building, setting norms and standards, and advocating for increased action, research and accountability [78].

UNFPA is responsible for supplying life-saving reproductive health resources for numerous partners across different humanitarian contexts and assists countries to achieve reproductive health resource security in countries, including those facing humanitarian crises [78].

An evaluation report of UNFPA's programmes in humanitarian settings observes that these programmes have done more to ensure service coverage, rather than change social norms underlying GBV and eradicate barriers to SRH service access [78].

Other gender and health programmes implemented by UNFPA

In addition to UNFPA's large number of country-level initiatives that are a part of inter-agency programmes or in humanitarian settings, there are also programmes on specific gender and health areas. Some are at the regional or multi-regional level, while others are country-specific initiatives.

Gender-biased sex selection

For more than two decades UNFPA has drawn attention to the practice of gender-biased sex selection in some regions of the world. It has contributed to evidence-building and policy action in countries such as India, Vietnam, Albania, Armenia and Azerbaijan. In 2017, UNFPA launched the Global Programme to Prevent Son Preference and Gender-Biased Sex Selection. This programme works with governments and local partners to gather data about unequal sex ratios at birth in Asia and the Caucasus, and aims to help design human rights-based and gender-equality focused interventions [79].

Comprehensive sexuality education (CSE) interventions

UNFPA advocates for policies and investments to support CSE in countries that are grounded in principles of human rights and gender equality. The agency also works with governments and partners to implement school-based and out-of-school CSE programmes in many countries. The Y-PEER programme, a youth network that uses experiential learning methods, social media and edutainment, is an example of an out-of-school CSE programme supported by UNFPA. Another example is the Safeguard Young People programme in eight countries of Eastern and Southern Africa, providing CSE and youth-friendly health services in school and community settings [75].

Examples of tailoring programmes to country contexts

In many instances, UNFPA supports country-level interventions on SRHR and GBV that are locally

conceived and implemented. The examples of country-level initiatives listed in Table 5 are gleaned from news on "gender-snapshots" from UNFPA's website [80]. They are not exhaustive and are intended only to acquaint the reader with the nature of UNFPA's country-level programming for GEWE in programmes related to health.

TABLE 5. EXAMPLES OF UNFPA'S SUPPORT TO COUNTRY-LEVEL INITIATIVES ON GENDER AND HEALTH

Focus area	Countries and initiatives
Humanitarian settings and fragile states	**Iraq:** Women's centres in displacement camps to raise awareness on gender equality. **Yemen:** UNFPA holds sessions to raise awareness about GBV and availability of services for survivors of GBV in displacements camps. Its partners run a nationwide toll-free hotline providing support services, centres for mental health and legal support.
SRHR	**Honduras:** Television drama series *Es Cosa D-2* on teen pregnancies aimed at changing gender norms related to sexuality and reproduction. **Sierra Leone:** The Girls' Access to Education and Services Programme is putting Guidance Counsellors in nearly 200 junior secondary schools to teach life skills and provide information on SRH. **Jordan:** Study on the impact of COVID-19 on GBV and SRHR of adolescent girls (aged 10–17 years) and young women (18–24 years).
GBV	**Malawi:** Girls' education and action to end GBV. **Ukraine:** Mobile psychosocial assistance teams. **Afghanistan:** Training for police, judicial professionals, and healthcare providers to better respond to GBV survivors. **Bangladesh, Cambodia, China, Indonesia, Papua New Guinea, and Vietnam:** Family support groups to prevent domestic violence. **Cambodia:** Group sessions for adolescents and their caregivers on positive relationships for the prevention of GBV. **Cambodia:** The Good Men campaign to encourage men to stop violence against women. Uses social mobilisation, radio dramas, TV panels and mobile phones, among other media.

Source: UNFPA, 2021 [80].

5. UNICEF

5.1 THE ORGANISATIONAL CONTEXT

Constituted in 1946 as an emergency fund to provide relief in countries severely affected by the second world war, UNICEF is now the global leader for protecting children's rights. While children remain the agency's key focus, the agency's work encompasses women and girls. UNICEF's work covers a wide range of sectors in development and humanitarian settings on issues such as health, nutrition, water, sanitation, and hygiene (WASH), child protection, social protection, and education [81].

The agency is well-known for its significant contributions in the health sector. From the 1950s to the 1960s, the agency undertook several interventions and mass campaigns to prevent diseases such as TB, yaws, trachoma, leprosy, and malaria. As many developing countries gained independence, UNICEF played a significant role in developing a primary health care approach in 1978. Subsequently, the agency established the Universal Immunisation Programme to address infant and child mortality from vaccine-preventable diseases and played a critical role in strengthening maternal and child healthcare (MCH) in low and low-middle income countries. Its work in the health sector also includes some areas of adolescent health [81].

UNICEF has a vast network of offices across the globe to implement its programmes, while the agency's headquarters are in New York. There are seven regional offices: the Middle East and North Africa, Eastern and Southern Africa, West and Central Africa, South Asia, East Asia and the Pacific, Latin America and the Caribbean, and Europe and Central Asia. A regional director heads each regional office. UNICEF has a presence in over 190 countries and territories with an estimated staff size of over 14,000. UNICEF's headquarters helps to coordinate and provide technical guidance to the initiatives of country offices. A 36-member executive board elected by UN ECOSOC, usually for three-year terms, is responsible for UNICEF's governance [82, 83].

UNICEF is a relatively well-funded agency. Total receipts amounted to $7.2 billion in 2020, increasing by 13% from $6.4 billion in 2019. Some 76% of the funds ($5.45 billion) are from government partners, including the European Commission. The private sector accounted for 22% of the total income ($1.6 billion) in 2020. Other sources, including income from interest and procurement services, accounted for 2% of the total income of UNICEF in 2020 [84].

As a UN fund, UNICEF has a wide latitude to receive voluntary contributions from any source. These funds can be spent on virtually any supplies, technical assistance, or services in line with its financial accountability mechanisms.

Many organisational features of UNICEF appear to be enablers for gender mainstreaming. First, as the global champion for children's rights, its mandate for children's rights, safety, and wellbeing enjoys widespread support. This support facilitates UNICEF's work in mainstreaming gender concerns in its programmes for children and adolescents. Secondly, the executive director and regional and country directors have significant control over decisions. Consequently, leaders who champion gender mainstreaming are likely to be able to move the agenda significantly forward. Thirdly, its funding situation allows for sustained core funding, given the political will. Finally, UNICEF is involved in programme implementation in partnership with governments and non-

FIGURE 9. UNICEF'S GENDER POLICIES AND STRATEGIES

Gender equality and women's empowerment policy in pogramming

Strategic Priority Action Plan for Gender Equality

Gender Action Plan (GAP)-2

| 1985 | 1994 | 2010 | 2010-12 | 2014-17 | 2018-21 | 2022-25 |

Policy for advancing the rights of women and girls

Policy on Gender equality and Empowerment of Women and Girls

Gender Action Plan (GAP)-1

Gender Action Plan (GAP)-3

governmental entities. This collaboration allows for a cohesive and well-conceived roadmap for programmatic gender mainstreaming to impact on people's lived experiences.

5.2 GENDER MAINSTREAMING EFFORTS WITHIN UNICEF

5.2.1 Institutional gender mainstreaming

Policies and strategies

UNICEF recognises that "gender-responsive institutional strategies and systems are critical for achieving programmatic results and necessary […] to meet its organisational commitments to gender equality" [85]. UNICEF's executive board approved its first policy for advancing the rights of women and girls in 1985. There have been a series of GEWE policies since then (Figure 9). The three GAPs issued in 2014, 2018 and 2022 have all been qualitatively different from one another and achieved major

strides in gender mainstreaming within UNICEF, both institutionally and programmatically [86, 87. 88].

The 2014–2017 GAP (GAP-1) sought to create an internal environment that would enable programmatic gender mainstreaming and systematically integrate a gender perspective in all its work. For programmatic gender mainstreaming, the GAP adopted a twin-track approach. The first was to mainstream gender across all seven programme outcomes outlined in the agency-wide strategic plan for 2014–2017. For example, gender-equality indicators were included wherever appropriate across all sectors: health, HIV/AIDS, WASH, nutrition, education, child protection and social inclusion. The second track focused on targeted priorities for empowering adolescent girls: gender-responsive adolescent health programmes, promoting girls' secondary education, ending child marriage, and preventing violence against women and girls in emergencies [86].

FIGURE 10. THEORY OF CHANGE UNDERLYING THE UNICEF GENDER ACTION PLAN 2022–2025
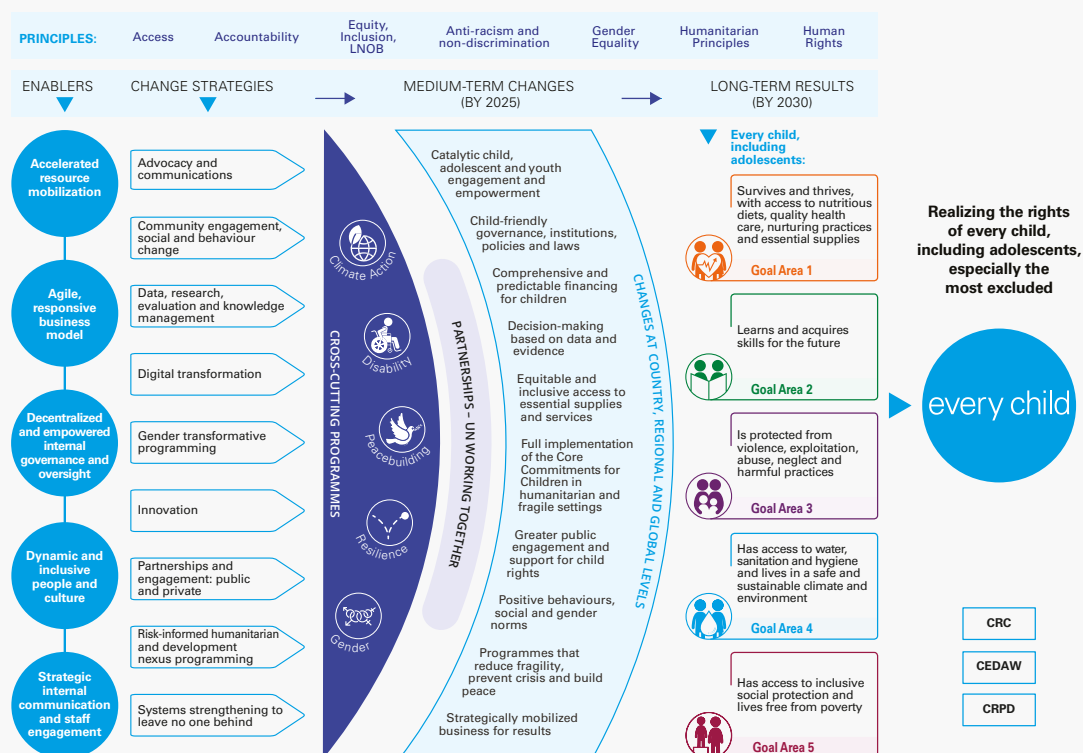
Source: UNICEF, 2021 [91].

GAP-1 also included a roadmap for institutional gender mainstreaming, including strengthening the gender architecture, gender capacity-building, improving gender parity in staffing, and creating an enabling work environment. In alignment with the UN-SWAP framework, gender parity targets were set at the P5 level, a dedicated gender result was included in the strategic plan, and a benchmark of 15% was set for financial allocation to gender in the mainstreamed programmes. Substantial allocations were also made in the targeted priority programmes. Systems for reporting on progress on GAP-1, including follow-up progress, were established [86].

The 2018–2021 GAP (GAP-2) continued the work under GAP-1, with some adjustments, including strengthening both institutional and programmatic gender mainstreaming, integrating gender across all programme goals and having targeted priority programmes for adolescent girls. GAP-2 promised to sustain the gains recorded in integrating gender-equality concerns within UNICEF by strengthening gender analysis, gender data and tools, documenting and sharing best practices, as well as improving resources for gender mainstreaming [87]. Furthermore, GAP-2 added a fifth targeted priority – menstrual hygiene management – to the four targeted priorities for adolescent girls in GAP-1 [87].

The recently launched GAP-3 integrates gender-equality priorities in all the five strategic goals areas of the organisation. It continues with the twin-track approach and seeks to both advance gender-equality priorities throughout the life course and promote targeted action for advancing the leadership and wellbeing of adolescent girls [88]. GAP-3 (2022–25) commits to an organisational change strategy to facilitate gender-transformative programming. Its specific

commitments include strong and accountable leadership at all levels, dedicated gender expertise in sectors, a well-resourced gender architecture, and gender parity at all levels [88].

All three GAPs are aligned to the cycle, content, and indicators of the agency-wide strategic plans for 2014–2017, 2018–2021 and 2022–2025 [89–91]. Thus, rather than a stand-alone document on gender, the GAPs are documents that elaborate on how to achieve the results outlined in the agency's strategic plans. This alignment was a major switch signalling the high priority accorded to gender equality at the highest levels of the agency.

Like the second GAP, GAP-3 has articulated a TOC for achieving the desired impact. That is, girls and women live safe, healthy, empowered lives and engage equally in leading change [91]. This TOC (see Figure 10) builds and significantly expands on the TOC outlined in GAP-2, in which the main outcome is stated in terms of gender mainstreaming within UNICEF's programmes and institutional structures. The programmatic results and institutional strengthening results have also been spelt out in greater detail [91].

Gender architecture

Major changes in the organisation's approach to gender began around 2011. Some $12 million was committed for UNICEF to put in place and strengthen the core of its gender architecture [85, 87, 92]. In addition to three senior P5 gender positions at headquarters, seven new P5 senior regional advisers were created in each the seven regional offices. Country offices with budgets of more than $20 million were encouraged to have at least one dedicated gender specialist at P3 and P4 levels [85]. Country offices below this budgetary threshold were encouraged to have a GFP with at least 20% dedicated time. As of 2020, 33 country offices had a dedicated gender specialist, and there were 17 sectoral gender specialists, up from only 3 in 2019 [93].

The gender advisers are located strategically within the organisational hierarchy so that they can leverage power and resources. The principal adviser regarding gender and development at HQ is in the Programme Division and reports to the director of programmes. Gender advisers in regional offices report to the deputy regional director (in one regional office they report to the regional director) and in some country offices the gender specialist (where they exist) reports to the deputy country representative.
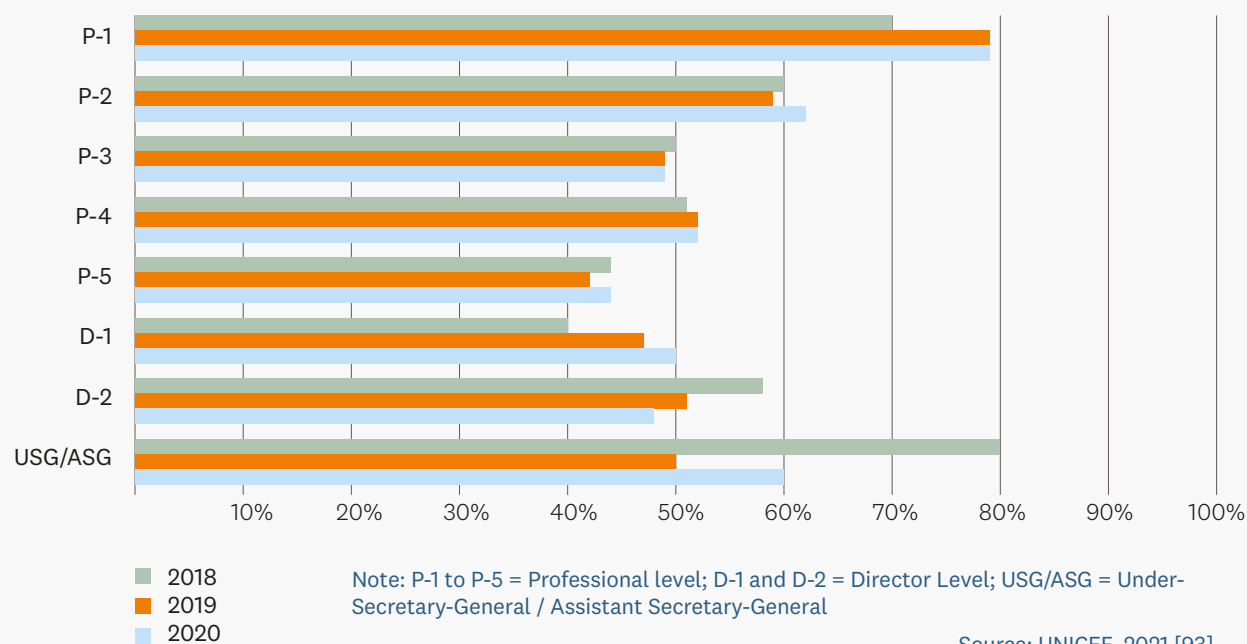
Gender parity in staffing

Across the GAPs, achieving gender parity and ensuring a more gender-responsive and inclusive workplace is a key priority. UNICEF falls just short of achieving gender parity among professional staff at 48% women among those at P1–P5 levels and above (Figure 11). Progress has been made towards gender parity in some staffing levels, and in some instances, even exceeding expectations (e.g. P1, P2, P4, and USG/ASG). Still, there is a need to strengthen efforts to recruit more women, especially at senior-level posts (e.g. D1 and P5) where parity gaps remain persistent [93].

Several steps are being taken to address these gaps, including, but not limited to:

- the introduction of flexible working arrangements [87]

- prioritising parity in senior staff rotations [85, 93]

- recruiting offices and division impact assessments of how selected candidate(s) affect the gender balance within their teams [94]

- ensuring gender balance in selection panels [92]

- ensuring that shortlisted candidates include women [92]

Note: P-1 to P-5 = Professional level; D-1 and D-2 = Director Level; USG/ASG = Under-Secretary-General / Assistant Secretary-General

Source: UNICEF, 2021 [93].

Legend: 2018, 2019, 2020

- building a pool of qualified candidates by nurturing female staff from the middle level [92]

- introducing initiatives for gender equality in the workplace at regional offices (e.g. Eastern and Southern Africa Female Talent initiative, Western and Central Africa Transforming Our Workplace Initiative) [85].

Other initiatives have been undertaken to help create an enabling environment for gender equality. For example, in June 2018, UNICEF was the first UN agency to earn the Economic Dividends for Gender Equality (EDGE) certification. EDGE is a global assessment of standards, based on an agency-wide survey of staff members' experience and perceptions of gender equality in the workplace. In 2018, UNICEF was at the top 11% of all EDGE certified organisations that year.

An important step by the (present) executive director was the appointment of an independent task force on workplace gender discrimination, sexual harassment, harassment, and abuse of authority. The recommendations of this task force led to organisation-wide discussions and action to change the work culture. A principal adviser of organisational culture was appointed, and a high-level group was appointed to implement the recommendations, many of which related to a more gender-equal organisational culture. The executive director and deputy executive directors have been engaging with an informal gender push group consisting of like-minded individuals across UNICEF. The group has been advocating for policies that would nurture a gender-equal, family-friendly work culture within UNICEF [95]. These measures appear to be making a difference.

Staff capacity for gender mainstreaming

UNICEF recognises the need for gender expertise in each of the sectors of its work, across all levels of the organisation. The 2014–2017 and 2018–2021 GAPs made a commitment to develop and

strengthen staff members' capacities to execute gender equality goals [86, 87].

UNICEF has institutionalised capacity-building for gender through its GenderPro course (funded by the Bill and Melinda Gates Foundation). The course aims to:

• support more robust capacity around gender analysis, data, measurement and applied programming among GFPs and all staff

• build a cadre of high-quality gender specialists, especially across sectors with knowledge of applied programming and measurement in gender in key sectors [87].

GenderPro has several features which incentivise UNICEF staff to attend the course. First, it is a university-based (George Washington University) and globally accredited course. Second, it is tailor-made for specific sectors (e.g. education, WASH, health). The course is practical, and trainees learn through projects and assignments within their sector of work. Third, it is a hybrid course combining online and in-person training, making it convenient for participants to enrol in and complete successfully.

In 2019, 258 UNICEF education-sector staff members and 48 external partners completed training on gender integration in education systems through GenderPro. By the end of 2020, staff in 75% of UNICEF country offices had completed the GenderPro programme or credentialing examination [93].

A new Organisation Learning Plan on Gender Equality (2021–25) intends to build gender competencies for all programme staff such as sector specialists and GFPs. Most importantly, there will be initiatives to strengthen gender learning for senior leadership to create a broader enabling environment for advancing GEWE [96].

Financial resources

Some US$19 million of core funding was made available to implement the 2014-2017 GAP, compared to the 2018–2021 GAP, which has seen a decline in core financial commitments to US$4.4 million [85]. In addition to core funds, thematic funds are also an important source for UNICEF, which allows agency partners to contribute to a funding pool for specific outcome areas at all levels – global, regional and national. The decrease in core funding for the 2018–2021 GAP has been offset, to some extent, by thematic funds and private funds, bringing the total funding for GAP 2 to roughly US$13 million, compared with nearly US$20 million for the previous GAP [85].

FIGURE 12. PROGRAMME EXPENDITURE ON GENDER TRANSFORMATION, UNICEF 2013–2020
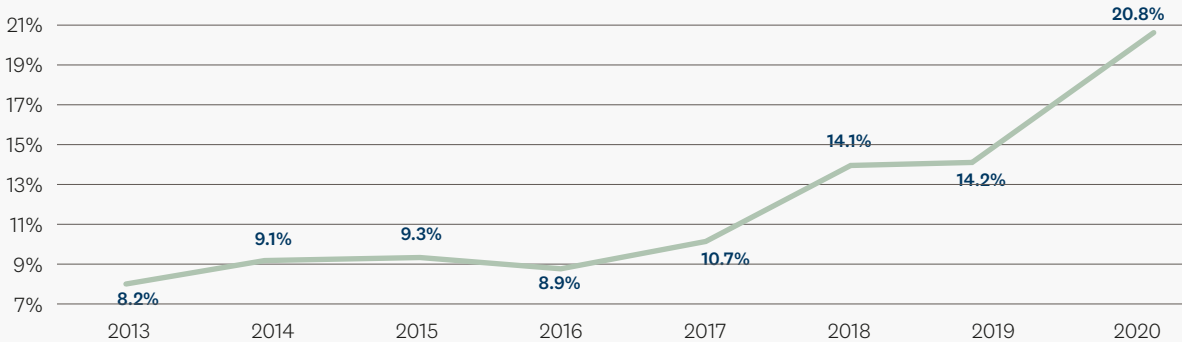
Source: UNICEF, 2021 [93].

TABLE 6. THE GAP INSTITUTIONAL STANDARD, UNICEF

Key areas of the institutional standard	gender programmatic review	
	gender integration into programme documents	
	identification of gender results in country programme document results framework in	*integrated results*
		adolescent girls' priorities
	gender-tagged standard indicators	
	accountability structure for implementing gender priorities	
	definition of responsibility for gender results	
	gender expenditure	
	gender staffing	

Source: UNICEF, 2019 [85].

Expenditure on gender equality within programmes or projects at the country level is tracked through UNICEF's Gender Equality Marker. The Gender Equality Marker codes[18] indicate whether activities have gender equality as a principal (code 3), significant (code 2), marginal (code 1), or no gender objective (code 0), based on the proportion of expenditure linked to gender [85]. In 2020, an estimated 20.8% of the total expenditure was spent on programmes contributing to gender mainstreaming [93] (Figure 12).

Accountability mechanisms

Several mechanisms are in place to ensure accountability for gender mainstreaming. One of these is an internal steering committee chaired by the deputy executive director of programmes. The committee includes three of the seven regional directors, the deputy executive director, and the deputy executive of director partnerships. The steering committee meets twice a year.

A second mechanism involves an annual report to the Executive Board on progress on the GAP. Gender is the only area besides humanitarian and emergencies work required to report annually. This means that progress against monitoring indicators is documented at least once a year, for presentation to the Executive Board.

The gender assessment of country programmes is a third accountability mechanism related to the GAP. Regional offices must report on the number of country gender assessments they have carried out, and any actions taken.[19]

End-of-term evaluation is another accountability mechanism in place. There was a detailed evaluation of performance at the end of the term of the first GAP. The evaluation identified areas that needed further strengthening and the subsequent GAP incorporated the recommendations of the evaluation[20].

In 2019, the UNICEF launched a composite GAP institutional standard (Table 6). This is to be applied to monitor the extent to which

18 A tagging system (yes/no) for all activity-level specific intervention codes (SICs) has also been introduced, describing output indicators and activities as either gender-responsive or gender-transformative/gender-targeted.
19 Based on various country-specific gender assessment reports found on UNICEF's website.
20 Based on UNICEF gender evaluation reports retrieved from web searches.

country offices meet institutional standards for gender mainstreaming. These ranged from having a gender programmatic review carried out, and progress towards gender outputs in integrated and priority programmes, to gender architecture, gender parity in staffing and expenditure on programmes with a gender focus. Regional offices review the standing of their country offices on this standard annually in their regional management meetings. In 2019, 65% of the country offices had met the institutional standard for gender mainstreaming [97].

5.2.2 Programmatic gender mainstreaming in health

The previous section describes the strong institutional base that UNICEF has built for facilitating programmatic gender mainstreaming in health. UNICEF has done well to build on this enabling environment to ensure that gender-equality goals are a part of the agency's core business and addressed across the board in all its programmes.

FIGURE 13. UNICEF GENDER ACTION PLAN 2022–2025: RESULTS FRAMEWORK

	Goal Area 1	Goal Area 2	Goal Area 3	Goal Area 4	Goal Area 5
Cross-cutting organizational priorities	Address gender-based violence				
	Gender equality programming for transformative results, including to address discriminatory gender norms				
	Gender-responsive workplaces and institutional accountability				
Gender priorities across the life course	Quality maternal health care and nutition, and HIV testing, counselling and care	Gender-responsive education systems and equitable access to education for all	Addressing violence against women and children, including gender-based violence and harmful practices	Equitable water sanitation and hygiene	Gender-responsive social protection systems and care work
Adolescent girls' leadership and well-being	Promote adolescent girls' nutrition and pregnancy care, and the prevention of HIV/AIDS and human papillomavirus	Advance girls' education, learning and skills, including science, technology, engineering, mathematics and digital skills	Eliminate child marriage and early unions	Promote accessible and dignified menstrual melth and hygiene services, including tackling taboos about menstruation	

Source: UNICEF, 2021 [88].

As previously highlighted, UNICEF adopts a twin-track approach with gender priorities across all major goal areas, as well as targeted programmes for girls and women. This has been reflected in the 2014–17, 2018–21, and 2022–2025 GAPs [86-88]. Figure 13 shows that GAP-3 has three crosscutting organisational priorities: (1) addressing GBV; (2) gender-equality programming; and (3) gender-responsive workplaces and institutional accountability [88]. Gender priorities have been integrated across the life course, and there are specific outcomes related to advancing the leadership and wellbeing of adolescent girls.

The results framework informs programming. Table 7 presents examples listed in a report of targeted health programmes under the GAP 2018–21, illustrating how the results framework translates into concrete action on the ground.

UNICEF also implements a number of joint programmes with other UN agencies focused on advancing GEWE. These include the UNFPA–UNICEF Global Programme to End Child Marriage and the UNFPA–UNICEF Joint Programme on the Elimination of FGM. UNICEF is also a lead organisation working on GBV in humanitarian settings under the IASC architecture. UNICEF is a part of the GBV AoR within the Global Protection Cluster led by the UNHCR. The GBV AoR provides support to countries in addressing GBV in emergencies through supporting field operations, capacity-building, setting norms and standards, and advocating for increased action, research, and accountability.

TABLE 7. GENDER-INTEGRATED AND TARGETED GENDER-PRIORITISED HEALTH PROGRAMMES IN UNICEF

Gender-equality results (health-related)	Examples of programmes
Result 1. Equal health care and nutrition for girls and boys	**Equal access to SRH information and services** In Madagascar, UNICEF supported increased access to and quality of community health services for adolescent girls and boys, reaching them with SRHR-related information. The Let Youth Lead initiative in Lesotho led to an improvement in adolescents' knowledge about sexual and reproductive health (from a level of 30% to 72%).
Result 2. Quality dignified maternal care	**Attention to respectful maternal care** In Bangladesh, Ghana, Kenya, Malawi and the United Republic of Tanzania, mechanisms to improve rights-based care in health facilities included processes to report abuse, leading to a reduction of all forms of abuse.
Result 3. Gender equality in health systems and the health workforce	**The professionalisation of community health workers** (the majority of whom are women) In Somalia and Yemen, UNICEF built the capacity of more than 1,500 workers (approximately 75% women) to provide local communities with critical health information and nutrition services and to make timely referrals for malaria, TB, HIV, and GBV counselling services. UNICEF is developing tools to help countries to identify the gender-related barriers to women being engaged as community health workers.

Table continues on next page

Gender-equality results (health-related)	Examples of programmes
Result 6. Addressing GBV against girls, boys and women	**The Safe to Learn Initiative** Targets violence in schools, with a focus on gender. As part of the Spotlight Initiative, which is making targeted, large-scale investments to respond to and prevent gender-based violence, in Uganda, at least 15,000 parents and caregivers were reached with community engagement to prevent sexual and GBV, and violence against children through promoting non-violent parenting practices and challenging harmful gender norms. With its partners, UNICEF contributed to strengthened national legal frameworks, enhanced coordination among child protection actors, and improved awareness about FGM-related health risks, and generated changes in discourse related to FGM in the 21 countries with FGM programmes.
Result 7. Gender-responsive water, sanitation and hygiene systems	UNICEF promotes the meaningful participation of women and girls in community water-management committees, especially in leadership positions, including in Eritrea, Myanmar, Somalia and South Sudan. Between 2017 and 2019, UNICEF supported improved sex-segregated WASH facilities and programmes in 63 countries. This typically consisted of age-appropriate, inclusive, accessible and sex-segregated WASH facilities, including incinerators for sanitary waste.
Result 9. Girls' nutrition, pregnancy care and HIV and HPV prevention	Gender programming has broadened in relation to teen pregnancy prevention and care, HPV vaccination, and gender-responsive adolescent health, including SRHR. Nutrition outcomes remained largely focused on anaemia prevention, with some emerging work around dietary diversity and body confidence.
Result 11. GBViE	UNICEF continues to strengthen its partnerships, and its high-impact contributions to the humanitarian community of practice, while scaling up support to countries to institutionalise GBV responses, prevention and risk mitigation. On prevention, UNICEF supported a range of awareness-raising, information dissemination, life skills and risk-mitigation activities, such as cross-sectoral participatory safety audits.
Result 13. Dignified menstrual health and hygiene (MHH)	In 2019, UNICEF provided MHH-related services – distribution of dignity kits, provision of private washing and disposal facilities, and MHH information – to 1 million women and girls from 39 emergency countries. UNICEF continued to support national partners to institutionalise MHH into national education and health systems. UNICEF also supported schools with MHH services. This included the construction of private and secure sanitation and washing facilities, menstrual pad disposal facilities, and MHH/hygiene education.

6. WHO

6.1 THE ORGANISATIONAL CONTEXT

WHO is a specialised agency of the United Nations, with the objective of "the attainment by all peoples of the highest possible level of health" [98]. Being an inter-governmental body impacts WHO's decisions related to work on and resource allocation for gender. The World Health Assembly (WHA) is the WHO's decision-making body and comprises representatives from WHO's 194 Member States, and convenes annually. It is through WHA Resolutions that crucial decisions related to changes in WHO strategies and policies come into force [99, 100]. While this means that most governments support WHO's policies, it also makes the decision to prioritise gender more complex.

There are considerable regional variations in WHO's gender work, owing to its organisational structure. WHO has its headquarters in Geneva and six regional offices are located across the globe. The six regional offices are semi-autonomous, governed by their respective regional committees made up of representatives of Member States from each region. The regional committees make policy decisions for the region and appoint the regional directors. Resources for regional offices come partially from the headquarters and partially from the constituent Member States. Therefore, support for gender work within any region depends on the positions taken by the regional committees and senior management. In addition, the regional committees must endorse any gender policy or strategy adopted by the WHA to become operational within the regions [98].

Of the six regional offices, the regional office for the Americas, better known as the Pan American Health Organization (PAHO) has consistently invested more into the issue of gender, largely because of its different governance and financing structure and ways of functioning. PAHO existed before the formation of WHO and continues to wear two hats: (1) as the regional office of WHO for the Americas; and (2) the specialised health entity of the Organization of American States [101].

WHO's budget is considered to be incommensurate with its mandate. The scope of its work has been increasing, and repeated pandemics and emergencies make considerable demands on its limited resources. WHO's chronic financial crisis and the demands on resources may constrain funding to promote gender equality. During the decade 2007–17, WHO was often unable to fund its programme budget fully [102]. WHO's budget of $4.421 billion for the biennium 2018–19 was a fraction spent on global health overall[21]. WHO's budget for 2020–21 was much higher, at $7.6 billion. However, most of the funding continues to be from earmarked private sources. During 2020–21, only about 13% of WHO's funding came from Member States' assessed contributions. About 77% of funding was from specified voluntary contributions that were earmarked for specific activities, about 7% of the funding was thematic funding from voluntary sources, which is partially flexible, and 3% was flexible funding from voluntary sources [103].

WHO's altered stature in the evolving institutional landscape of global health and its struggle to retain leadership in global health may contribute to the limited attention paid to prioritising gender equality as a crosscutting

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21 See World Health Organization Financing of the Programme budget 2018–2019. https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_30-en.pdf.

organisational priority. Since the 1980s, and especially in the late 1990s and later, many new global health initiatives and institutions have come into existence, challenging WHO's leadership role in directing and coordinating global health action. Many of these entities are well-resourced public-private partnerships, with WHO as a partner [102, 104].

6.2 GENDER MAINSTREAMING EFFORTS WITHIN WHO
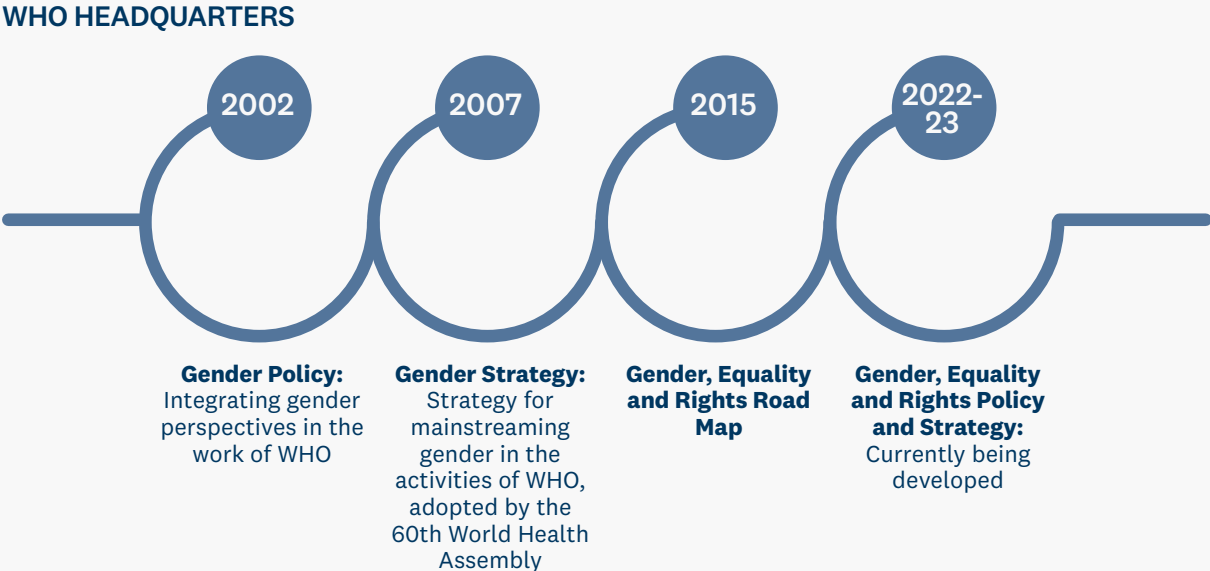
6.2.1 Institutional gender mainstreaming

Gender policies and strategies in WHO

Three key policy and strategy documents spell out WHO's commitment to advancing gender equality in health, in addition to strategy documents adopted by some of its regional offices (Figure 14).

Following the call of the Beijing Conference for gender mainstreaming in health, the Women's Health Unit formed a taskforce on gender and health in 1996. However, it was not until 2002 that WHO had an official gender policy. The goal of the 2002 gender policy was to "contribute to better health for both women and men through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between women and men" [105]. Thus, the policy addresses women and men, with gender equity and equality framed as a means to the end of better health for women and men.

A comprehensive gender mainstreaming strategy was adopted in 2007 by the 60th WHA (Resolution WHA60.25). This strategy provided a clear blueprint for programmatic gender mainstreaming and supportive institutional

FIGURE 14. GENDER POLICIES IN WHO HEADQUARTERS AND REGIONAL OFFICES

WHO HEADQUARTERS

2002	**2007**	**2015**	**2022-23**
Gender Policy: Integrating gender perspectives in the work of WHO	**Gender Strategy:** Strategy for mainstreaming gender in the activities of WHO, adopted by the 60th World Health Assembly	**Gender, Equality and Rights Road Map**	**Gender, Equality and Rights Policy and Strategy:** Currently being developed

REGIONAL OFFICES

2003	AFRO adopts the Regional Strategy for Women's Health
2005	PAHO adopts the Gender Equality Policy, followed by an implementation plan for 2009-14. Two further implementation plans developed for 2015-19 and 2020-24, with additional priorities
2016	EURO adopts a Women's Health and Wellbeing Strategy
2018	EURO adopts a Men's Health and Wellbeing Strategy

structures and indicators for monitoring and evaluation [106]. Over the next few years, following the formation of the gender, equity and rights (GER) unit in 2011, the document *Integrating Equity, Gender, Human Rights, and Social Determinants into the Work of WHO: Roadmap for Action, 2014–2019* [107] was released. The roadmap contained a set of targets and indicators for integrating gender, equity, human rights, and social determinants as crosscutting themes across all of WHO's work [107]. In addition, WHO 13th General Programme of Work (GPW13) introduced an integrated strategic focus on GER mainstreaming for the entire work of the organisation.

Following an evaluation in 2021 of the work of the GER unit, a decision has been taken to formulate a GER policy for WHO, accompanied by a strategy for its implementation [108]. Work on developing the GER policy and strategy is currently underway.

Regional offices

In addition to the policies and strategies adopted by WHO's headquarters, some of the WHO regional offices have their specific policies and strategies. For example, in 2003, the Regional Office for Africa [109] adopted a regional strategy for women's health [109].

In 2005, the Directing Council of PAHO adopted a gender-equality policy [110]. PAHO's strategic priorities were different from those identified by WHO's 2007 gender mainstreaming strategy in one key area – civil society participation. Also, PAHO followed up its strategy with a clear implementation plan for 2009–14 [111]. Two further implementation plans were developed

(2015–2019 and 2020–2024), with additional areas and themes identified as priorities. For example, the 2015–2019 strategy aimed to "expand conceptual framework and modalities to promote and address gender identities, including LGBT and masculinities (among others), and their linkages with ethnicity and other social determinants of health" [112].

In 2016 and 2018, respectively, WHO's Regional Office for Europe (WHO/EURO) issued the strategy on women's health and wellbeing in the WHO European region and the strategy on men's health and wellbeing in the WHO European region. Two separate and complementary strategies address the health of women and girls and men and boys. Both strategies take an integrated gender, equity, and human rights approach. The women's and girls' strategy adopts a human rights-based approach centred on women's rights and the right to health. In addition, the strategies are equity-driven and consider the intersection of gender with other social inequalities, such as race, economic class, migration status, and age. Hence, the strategies recognise and address inequities in health among women and men by race, ethnicity, economic status, and so on, and transform the gender norms that impact the health of women and men [113, 114].

Gender parity in staffing

Gender parity in staffing has been on WHO's agenda for almost four decades. As early as in 1981, the WHA called upon the director-general to appoint more women at senior levels. Since then, there have been a series of WHA Resolutions through the 1980s and to the present day.[22]

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22 By resolution WHA36.19 (1983), the Health Assembly set a target of 20% of all professional and higher-graded posts to be occupied by women. The target was subsequently raised to 30% by resolution WHA38.12 (1985), and a time-limit of September 1995 for reaching it was introduced by resolution WHA46.24 (1993). The target was reiterated in resolution WHA49.9 (1996). At that point, the proportion of women on staff was 25%; by the end of 1996, it had increased to 27.1%. In 1997 the Health Assembly, by resolution WHA50.16, decided to raise the target to 50% and added the target of 50% for new appointments of women to professional posts by 2002. Resolution 56.17 in 2003 reaffirmed the target of 50% set by an earlier resolution in 1997 for appointments of women in professional and higher-category posts.

TABLE 8. GENDER PARITY IN WHO, DECEMBER 2017 TO JULY 2021

Indicator	2017 Dec	2018 Dec	2019 Dec	2020 Dec	2021 July
Percentage of women in the professional and higher categories holding long-term positions	44.4	45.4	45.8	45.9	46.4
Percentage of women at the P4 grade and above	41.9	43.4	43.5	43.5	43.7
Percentage of women as heads of country offices	33.3	35.8	37.4	37.1	38.7
Percentage of women at the P6, D1 and D2 grades	35.1	35.4	35.7	35.5	35.8

Source: WHO, 2021 [115].

Despite the commitments and measures, WHO has yet to meet the goal of gender parity in senior professional positions. WHO's report on the workforce as of 31 July 2021 shows that 46.4% of all professional and higher category staff are women (in headquarters and regional offices combined). This includes 43.7% in the grades P4 and above, and 38.7% as heads of country offices. Data for the past 4 years show small increases in each of the professional and higher-level positions (Table 8) [115].

In terms of creating an enabling work environment that fostered gender equality and family-friendly policies, flexible work hours and working from home become common during the COVID-19 pandemic. Staff were eligible for paid maternity leave, which can be availed from 6 weeks (but no later than 2 weeks) before the expected date of delivery. The duration of maternity leave is 16 weeks from the time it is granted. Nursing mothers are allowed 2 hours a day for breastfeeding[23].

Gender architecture

The history of WHO's gender architecture at headquarters may be broadly classified into four phases:

1. the period before the Beijing World Conference on Women (1982–1994), when there was a gender unit with one full-time position

2. the evolution into a department, and a conceptual shift from a focus on women's health to examining the role of gender on health in general and women's health (1994–2000)

3. the existence of a fully fledged department of gender, women and health (2000–2011)

4. the dissolution of the gender department and its replacement with a unit/team on GER (2011–present).

The present gender architecture of WHO is a component of the GER architecture, which is complex and diverse, and consists of three levels: (1) headquarters; (2) regional offices; (3) country offices. At headquarters, the GER team has been located within the office of the director-general since 2019. The Geneva team includes a team leader and three technical officers, one each for gender, equity, and human rights [116]. The technical divisions or programmes do not have a gender expert formally appointed on

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23 See World Health Organization 2014 Staff regulations and staff rules. https://www.who.int/employment/what_we_offer/EN_Staff_Regulations_and_Staff_Rules-2014.PDF

the team. However, there are two exceptions to this. The first one is the Special Programme on Research and Training in Tropical Diseases Research (TDR), which has a scientist who is responsible for gender and infectious disease research and is officially appointed as the GFP. The other exception is the Special Programme of Research, Development and Research Training in Human Reproduction Programme (HRP), which has had gender experts on staff for several decades.

The gender teams within regional offices go by different names and are located in different departments or directly report to senior management, and there have been many changes in names and locations over time.[24] For example, PAHO has the Office of Equity, Gender and Cultural Diversity, which reports to the director of programme management. Two senior professionals at P4 and P5 levels constitute a two-member team within the Gender and Human Rights Programme in the regional office for WHO/EURO This unit is located within one of the technical programmes. In the regional office for the Eastern Mediterranean region, the staff member responsible for gender is located within the Health Protection and Promotion Department. In each of the regional offices for Africa, South-East Asia and the Western Pacific, respectively, there is a single person serving as the GER regional adviser. Not all country offices have a GER focal point, and the focal points, where they exist, are not dedicated staff of the GER team but hold the portfolio in addition to their other responsibilities [116].

Staff capacity for gender mainstreaming

Various strategy and policy documents identify, as a key priority, building the gender mainstreaming capacity of WHO staff at all levels. Lack of capacity on gender was identified as a significant barrier in a 2011 review of gender mainstreaming. There was a lack of awareness of gender concepts among some and a lack of conviction regarding the importance of gender mainstreaming among others [117].

Scanning the WHO website identified two initiatives, neither of which were mandatory nor had been evaluated. The first is a 4-hour self-tutored virtual course *Gender and Health: Awareness, Analysis and Action* available to WHO staff across all offices. More recently, the GER team has made available a comprehensive e-learning series on equity, gender, and human rights (3.5 hours) on its iLearn online platform for all WHO staff. It is also mandatory for all WHO staff to undergo the course on prevention of sexual exploitation and abuse. The GER team also offers face-to-face training workshops, depending on the availability of financial resources and time [118]. Work is also ongoing to develop a stand-alone WHO Academy course on gender, equity and human rights mainstreaming in health.

Financial resources

According to the UN-SWAP report of 2019 for WHO, the organisation has not met the requirements either for putting in place a system for tracking financial resources or for making adequate financial allocations for gender mainstreaming [119]. Unlike several other UN agencies, such as the UNICEF, UNDP, and UNFPA, there is also no benchmark for minimum allocation to gender programming.

We attempted to get an idea of the magnitude of allocation of resources for gender, based on information from WHO's biennial programme budgets.[25] The allocation is subsumed under Outcome 4.2, on "strengthened leadership and advocacy for health," in which GER is a part

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24 There have been further changes since this information was gathered.
25 Since gender, equity and rights were integrated into a single programme in 2012, data are available for this combined category from the years 2012–13 to 2018–19, representing allocations for work done by the GER programme at all levels of the organisation. The programme budget 2020–2021 has not been included because it is no longer possible to identify a budget line item for GER.

TABLE 9. WHO BUDGET FOR THE GER PROGRAMME ACROSS THE ORGANISATION

	2012–13	2014–15	2016–17	2018–19 (GER and social determinants)
Approved budget for GER (US$ million) (proportion of total budget)	12.0 (0.3%)	13.9 (0.35%)	16.3 (0.38%)	50.5 (1.14%)
Total approved budget for WHO (US$ million)	3,959	3,977.2	4,340.4	4,421.5

Sources: WHO, 2011, 2014, 2015, 2017 [120–123].

of Outcome 4.2.6 – the leaving no one behind approach, which is focused on equity, gender, and human rights progressively incorporated and monitored. Table 9 summarises the data on approved budgets for GER during 2012–2019. The programme budget 2020–2021 has not been included because it is no longer possible to identify a budget line item for gender, equity, and rights.

From these data, it appears that less than 0.5% of the total budget was allocated for GER. In 2018–19, social determinants were added to the same budget line, and the allocation was 1.14%. We acknowledge that Table 9 provides only a partial picture of the spending on gender because it does not reflect the substantial investments made on gender work by special programmes. Nor does it reflect funds spent by other departments.

Accountability mechanisms

One key accountability mechanism for gender mainstreaming is the biennial progress report on the 2007 gender mainstreaming strategy by the director-general. Another includes routine evaluations of WHO's gender work. Three evaluations have been completed thus far. These include the baseline and midterm evaluations of the 2007 gender mainstreaming strategy in 2009 and 2011, and the evaluation of WHO's GER work in 2021.

The output scorecard, introduced as a part of the 13th GPW13 for 2019–2023, is another promising accountability mechanism[26]. It relies on self-assessment by teams responsible for various programmatic outputs of their overall performance across various domains, including "the meaningful integration of gender, equity and human rights"[27]. In this approach, the Secretariat proposes to measure each of the 43 outputs pertaining to 12 outcomes organised for the impactful integration of gender, equity and human rights. The criteria for scoring against each of these attributes combines GER. For example, one of the criteria is "technical assistance provided to reduce health inequities, gender inequalities and human rights-based and participatory approaches are included" [124]. Such an amalgamation of GER makes it difficult to assess progress on individual components, such as advancing gender equality in health.

Accountability mechanisms also ensure progress towards gender parity and that gender parity is sustained where it has already been achieved.

26 See World Health Organization Proposed programme budget 2020-21. 72nd World Health Assembly. Document A72/4. 10 May 2019. https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_4-en.pdf

27 The mid-term results of the Programme Budget 2020-2021 biennium Output Scorecard are available at: https://www.who.int/about/accountability/results/who-resultsreport-2020-mtr#output-scorecards.

Examples include the following:

- The WHO Senior Management Accountability Compact now includes an indicator of gender equality in staffing. However, this is not in place in regional offices [125].

- The enhanced Performance Management Development System requires supervisors and managers with recruitment responsibilities to report their performance on gender equality in staffing [125].

- The WHO programme budget for 2020–21 (4.3.2)[28] has an indicator for the equal representation of women among WHO staff.

- The Human Resources Management

Department also produces a 6-monthly report on the ratio of women to men among WHO staff by cluster and department at headquarters and in regional and country offices [118]. These reports are in the public domain.

- The Gender and Human Rights Advisory Panel of the Special Programme on Research, Development and Research Training (HRP) has had an external accountability mechanism in place since 1995. The panel has been effective in ensuring that gender equality concerns are central to the work done by HRP and the Department of Sexual and Reproductive Health, which houses it (see Box 3).

BOX 3. THE GENDER AND RIGHTS ADVISORY PANEL OF THE UNDP/UNFPA/WHO/WORLD BANK SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING (HRP) AND DEPARTMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND RESEARCH (SHR)

Under Dr Mahmoud Fathalla's leadership, the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) established a gender advisory panel of external experts in 1995. The purpose of the panel was to facilitate the integration of gender concerns in its work. In 2007, the panel's scope was expanded to include human rights, and it was renamed the Gender and Rights Advisory Panel.

An external evaluation of the panel's contributions over the period 2002–2012 reported that "in the years since the panel's inception, RHR/HRP has moved from vague awareness towards formal acceptance of the need to address gender equality systematically and human rights within RHR/HRP" [a]. In a recent evaluation of HRP's work (2012–2017), 73% of informants reported that the panel had been either "effective" or "highly effective" in fulfilling its objectives. While the evaluation noted that the integration of gender and rights was uneven across activities and products of HRP/RHR for various organisational reasons, it observed that the panel adds "substantial value as a critical voice to the programme for ensuring that important gender and human rights are kept on the agenda and are effectively addressed"[b].

a World Health Organization (2014). External evaluation. Gender and Rights Advisory Panel (2002-2012). https://www.who.int/about/resources_planning/HQPRP14.1_PBPA2012-2013.pdf?ua=1
b HERA (2019). External evaluation of the UNDP-UNFPA-UNICEF-WHO World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) 2013-2017. https://www.who.int/reproductivehealth/about_us/hrp/HRP-Evaluation-Report-Vol-2.pdf

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28 See World Health Organization Proposed programme budget 2020-21. 72nd World Health Assembly. Document A72/4. 10 May 2019. https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_4-en.pdf

6.2.2 Programmatic gender mainstreaming

WHO's work consists mainly of developing norms and guidelines and setting standards, and providing technical support to countries. It is not generally involved in programme implementation. Programmatic gender mainstreaming in WHO may, therefore, play out differently from agencies involved in programme planning and implementation.

This sub-section aims to provide an overview of programmatic gender mainstreaming in WHO. It starts with describing where gender features in WHO's overall priorities through an examination of WHO's 13th (2019–2023) general programme of work. It then looks at selected examples of gender mainstreamed programming at different levels of WHO, based on the scattered and scant literature on WHO's gender mainstreamed programmes and projects.

Gender in WHO's 13th General Programme of Work (GPW13) (2019–2023)

Until recently, gender has not featured prominently in WHO's programme priorities. Although there is more on gender in the current GPW 1334, gender is not mainstreamed into all pertinent programme areas, and not represented adequately in programme outcomes and outputs.

GPW13 has three strategic priorities and goals: 1 billion more people benefiting from universal health coverage (UHC), 1 billion more people better protected from health emergencies, and 1 billion more people enjoying better health and wellbeing[29].

Gender is addressed as one of many determinants of health under the third priority area, and two indicators may be counted as gender indicators – one on the prevalence of GBV, and the second on the proportion of women who can make independent reproductive decisions. Detailed scanning of GPW13 helps identify a few additional gender commitments. One of these supports Member States to develop UHC policies that address the impact of gender inequalities and ensure access to essential medicines, vaccines, diagnostics and devices for primary health care. The second is citizens' participation in health decision-making and gender equality. The third is about disaggregation of data by sex and at least two other social statistics, such as age and educational level34.

Examples of programmatic gender mainstreaming

WHO's work in programmatic gender mainstreaming falls under three broad categories:

1. strengthening the evidence base on gender and health

2. developing tools and guidelines and setting standards

3. capacity-building and technical support to Member States

The first two of the above are carried out at the level of headquarters and regional offices. At the headquarters level, the GER team, (and the GWH team before that) have been the main actors, often in collaboration with other technical departments. However, other departments, such as SHR, and Special Programmes for Research, Development and Research Training on HRP and TDR, among others, have also made significant independent contributions. Technical support to Member States is provided by the GER (and, earlier, GWH) teams at all three levels of the organisation.

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29 See World Health Organization Thirteenth General Programme of Work, 2019–2023. https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf.

Strengthening the evidence base on gender and health

During the period from its inception in 2000 to 2011, the GWH department produced a large number of useful knowledge products. These included a series of information sheets on gender issues in health as it relates to specific programme areas, such as TB, malaria, HIV/AIDS, mental health, ageing, tobacco use, alcohol use, road traffic injuries, disasters, and climate change, among others. These information sheets synthesised available evidence in a succinct format [126]. There were relatively few knowledge products on gender published over the period 2010–19.[30] The most recent, produced by the GER team, have been about gender issues within the health system, and about challenges to the health of female migrant workers and a chapter on gender and UHC in the latest UHC monitoring report[31].

In addition to the collation and synthesis of existing evidence, the GWH team, in collaboration with a range of partners, engaged in evidence generation as well. WHO's multi-country study on women's health and domestic violence against women represents a major contribution to the evidence base on how gender impacts a person's health. A series of knowledge products emanated from this study over the period 2005–2010 [127]. With the dissolution of the GWH Department in 2011, the team working on GBV moved to the Department of SRH and has been continuing this work from that location.

The Special Programme for Research and Training on TDR has been involved in strengthening the evidence base on gender and tropical diseases for the past three decades. During 1991–1997, TDR's gender and tropical diseases award for the best paper that addressed sex differences in the determinants and consequences of tropical diseases made a major contribution to the evidence base in this area. In 1995, TDR constituted the Gender and Tropical Diseases Task Force, and funded research that examined the gender aspects of tropical diseases. In the process, it built capacity for research with a gender perspective among many researchers from low and low-middle income countries [128, 129]. After a gap of several years, work on gender seems to have been revitalised over the past decade [130]. A review of research on gender concerns in neglected tropical diseases helped identify evidence gaps, develop a gender agenda for research on neglected tropical diseases, and produce publications on the topic.

The Department of Reproductive Health and Research (RHR) and the HRP have, with the advice of the panel, integrated gender and rights-based approaches in all of their social science research about diverse SRH issues, ranging from FGM to adolescent sexual and reproductive health. Research proposals submitted for funding by HRP are required to indicate how gender concerns have been addressed.[32]

A few other departments have produced occasional publications on gender. These include recent publications on gender equity in the health workforce by the Department of Health Workforce [131, 132], publications by the Department of Mental Health and Substance Use on women's mental health from a gender perspective [133] and the mental health aspects of women's reproductive health [134], and by the Vaccine Research Initiative on Gender and Immunisation [135].

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30 This is to some extent the result of the diminished gender architecture in WHO headquarters, and also because some of the technical departments have been producing knowledge products on gender. Moreover, work on gender-based violence, which accounts for a large number of knowledge products is now undertaken by the Sexual and Reproductive Health Research Department.
31 See World Health Organization Publications by topic. Gender. https://www.who.int/gender-equity-rights/knowledge/gender-topic/en/.
32 These details are based on the author's first-hand interaction with RHR.

Of the regional offices, PAHO produces a regular periodic compilation (2007, 2009, 2011, 2013 and 2016), of statistical information on gender, health and development, and a recent assessment of progress in gender mainstreaming in health in its Member States [136]. Other knowledge products by regional offices include overviews of the gender and health situation in the regions (including how gender affects men's health in the European region), GBV in specific countries or regions, and on how gender impacts specific health conditions such as non-communicable diseases [113, 114, 137]. The Western Pacific regional office has also produced several programme-focused technical publications [137]. Knowledge products by other regional offices (African, Eastern Mediterranean, and South-East Asia) are far fewer [109].

Developing tools and guidelines and setting standards

WHO's various offices have produced an impressive array of tools, guidelines, and standards. These include guides on carrying out health situation analyses and research informed by a gender analysis, as well as reviewing and redesigning programmes and policies to make them gender-responsive. The erstwhile GWH department produced six tools as part of the *Gender Mainstreaming for Health Managers* manual; these tools continue to be useful [138].

For example, the GER team produced a template for integrating gender, equity, and human rights within country cooperation strategies (CCS), so that WHO country offices may then work with Member States to help with GER mainstreaming in policies and programmes [116]. Earlier products included a tool for making HIV/AIDS programmes gender-responsive (2005), and a review of all available gender and health analysis tools (2003)[33]. WHO/TDR is currently field-testing a gender research tool kit, which provides

guidance for implementation research on tropical diseases and programmes informed by a gender and equity perspective [139].

The Department of RHR has produced the most comprehensive set of tools on a single thematic area, GBV and sexual violence. The tools range from clinical and policy guidelines to ethical standards for research and framework for policymakers [127].

In 2009, PAHO produced a series of useful guidance documents. These include: guidance on why and how to design gender-responsive health programmes; how to carry out a gender analysis of health data to aid decision-making; how to develop a population-based gender and health profile; and how to monitor gender equity in policies and programmes [136]. Contributions from the Western Pacific regional office have included a series of six modules intended as resources for health professionals on integrating gender and poverty into health programmes (produced in the early 2000s), an analytical framework for integrating gender into emerging infectious diseases programmes (2013) and, more recently, a "how-to" guide with illustrative case studies on integrating gender, equity and human rights into health programmes (2017) [137].

Technical support to countries, including capacity-building

WHO's technical guidance to countries in the area of gender (equity and human rights) have included: assisting countries in developing national health policies, strategies, and action plans that have integrated a gender (gender, equity, and rights) perspective; assisting country statistical offices to develop guidelines for disaggregating health data by sex and other social strata (only PAHO); disseminating information on the latest clinical standards and programme protocols, especially in the area of

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33 See World Health Organization. Publications by topic. Gender. https://www.who.int/gender-equity-rights/knowledge/gender-topic/en/

GBV; and providing training on health equity assessment (including gender).

WHO's gender departments and units have, in the past, made a significant contribution to building Member States' technical capacity on gender and health. The period 2000–2011 witnessed intensive investments in building Member State capacity, through two key training initiatives. The first of these was by the then Department of RHR called *Transforming Health Systems: Gender and Rights in Reproductive Health* [140], and the second was the training programme for health managers on gender mainstreaming in health [138]. Currently, PAHO's virtual course, *Gender and Health: Awareness, Analysis and Action* is available for health managers in health ministries of English-speaking Caribbean countries [141].

Currently, TDR is collaborating with universities in Ghana and South Africa to build the capacity of researchers on the gender dimensions of vector-borne diseases under climate change. Researchers from Africa learn how to carry out gender analysis and produce papers with a gender lens. The tool kit on intersectional gender analysis is also being used for gender capacity-building of researchers and programme staff from Member States [130, 139].
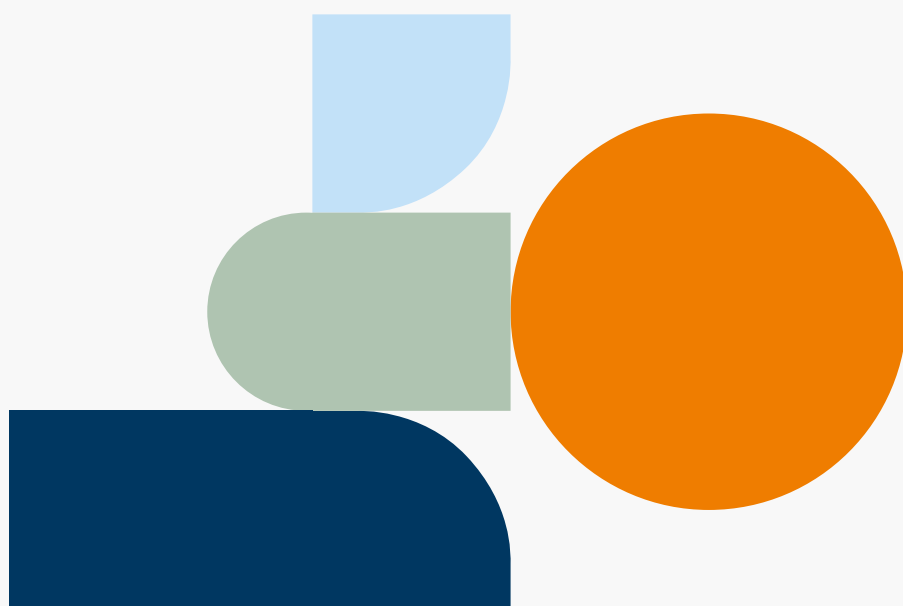
7. CONCLUSION

This compilation of gender mainstreaming histories across five UN agencies with a health mandate has drawn on a wide range of disparate and fragmented sources to document, in a single place, the sustained efforts over decades to advance gender-equitable institutional norms, policies, and programmes. We sought to capture gender mainstreaming efforts against the backdrop of each agency's history, including cases of evolving mandates, and identify the actors and factors that may have influenced gender mainstreaming. What this compendium reveals is a chequered history of gender mainstreaming within the agencies, with setbacks often following modest advances.

Although each agency has distinguishing features, based on their collective histories the following lessons can be leveraged to advance gender equality in health:

- investing in high-quality, strategically positioned gender experts at headquarters, regional and country office level, with these positions being core-funded to ensure sustainability

- securing well-crafted organisational mandates that include objectives for institutional and programmatic gender mainstreaming and institutional structures for governance and coordination of implementation, together with indicators for monitoring and evaluation, including expenditure tracking

- sustaining robust in-house and external accountability mechanisms that enforce answerability.

External accountability mechanisms that can be fostered include independent advisory groups and committees, as well as leveraging external networks of CSOs and women's and youth health advocates to produce periodic progress reports.

Experience tells us that programme prioritisation does not occur in a vacuum but is rooted in the prevailing and evolving institutional social, cultural, political, and economic contexts that frame and drive investment in gender equality in health programmes [142]. This compendium is a modest attempt at providing the kind of historical evidence that can be analysed as part of future research to enable a better understanding of the current scenario and take stock, revise, and revitalise the movement for gender mainstreaming.

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