Mainstreaming gender within the WHO Health Emergencies Programme

2022 -2026 strategy
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Acronyms

GBV   Gender Based Violence
GPW13 WHO Thirteenth General Programme of Work
GRAS  Gender Responsive Assessment Scale
GWG   Gender Working Group
IHR   International Health Regulations
IPPPR Independent Panel for Pandemic Preparedness and Response
PRSEAH Prevention and Response to Sexual Exploitation, Abuse and Harassment
WHE   WHO Health Emergencies Programme
Glossary of key terms


Gender

Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and workplaces. When individuals or groups do not “fit” established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health.

Gender analysis

The process of analysing how gender power relations affects women’s and men’s lives, creates differences in men’s and women’s needs and experiences, and how policies, services and programmes can help to address these differences. Gender analysis identifies, assesses and informs actions to address inequality that come from: 1) different gender norms, roles and relations; 2) unequal power relations between and among groups of men and women, and 3) the interaction of contextual factors with gender such as sexual orientation, ethnicity, education or employment status.

Gender analysis in health

Examines how biological and sociocultural factors interact to influence health behaviour, outcomes and services. It also uncovers how gender inequality affects health and well-being.

Gender-based Violence

Gender-based Violence (GBV) According to the Inter-Agency Standing Committee (IASC), GBV is defined as, “any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threat of such acts, coercion, and other deprivations of liberty.”

Gender blind

Level 2 of the WHO Gender Responsive Assessment Scale: Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. By ignoring differences in opportunities and resource allocation for women and men, such policies are often assumed to be “fair” as they claim to treat everyone the same.

Gender equality

Refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity – or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.

Gender equality in health

Women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality will require specific measures designed to support groups of people with limited access to such goods and resources.

Gender equity

More than formal equality of opportunity, gender equity refers to the different needs, preferences and interests of women and men. This may mean that different treatment is needed to ensure equality of opportunity. This is often
referred to as substantive equality (or equality of results) and requires considering the realities of women's and men's lives. Gender equity is often used interchangeably with gender equality, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.

**Gender equity in health**
Refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.

**Gender mainstreaming**
The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally, and inequality is not perpetuated.

**Gender responsive**
A policy or programme that considers gender norms, roles and inequality with measures taken to actively reduce their harmful effects.

**Gender sensitive**
Level 3 of the WHO Gender Responsive Assessment Scale: Indicates gender awareness, although no remedial action is developed.

**Gender specific**
Level 4 of the WHO Gender Responsive Assessment Scale: Considers women’s and men’s specific needs and intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs. Such policies often make it easier for women and men to fulfil duties that are ascribed to them based on their gender roles, but do not address underlying causes of gender differences.

**Gender transformative**
Level 5 of the WHO Gender Responsive Assessment Scale: Addresses the causes of gender-based health inequities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between women and men.

**Intersectionality**
Intersectionality is an analytical lens that examines how different social stratifiers (such as gender, class, ‘race’, education, ethnicity, age, geographic location, religion, migration status, ability, disability, sexuality, etc.) interact to create different experiences of privilege, vulnerability and/or marginalization (6). Intersectionality is not additive. It entails considering how human and social characteristics such as age, gender, sex, ability, disability, ethnicity, sexuality, etc. interact to shape individual experience at a given point or time. (Source: Incorporating intersectional gender analysis into research on infectious diseases of poverty: a toolkit for health researchers. Geneva: World Health Organization, 2020)

**Sex**
The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.

**WHO Gender Assessment Tool**
WHO Gender Analysis tool: basic check list aimed at rapid assessments of existing programmes and policies. Can be used in conjunction with the WHO Gender Responsive Assessment Scale.
Introduction

1.1. The mandate

WHO’s Constitution states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”(1). Seventy years after this Constitution was adopted, it is increasingly well recognized that there are differences in the factors determining health and the burden of ill-health across people with diverse gender identities and ages. The dynamics of gender in health emergencies are of profound importance and must be addressed.

Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health emergency risks, and in differential access to and utilization of health information, care and services – including during epidemic and pandemic events. The specific needs, capacities, and priorities of women, girls, men, boys, and people with diverse gender identities must be identified in public health emergencies, and health intervention approaches should be inclusive of the persons and groups most in need.

Gender equality is achieved when women and men can equally share power, resources, and influence. Inequalities are globally pervasive; women are known to experience disadvantages and often remain excluded from accessing opportunities and autonomy. These differences, in
turn, have clear impact on health outcomes and exacerbate the risk posed by health emergency threats.

The Sustainable Development Goals address global concerns, including health and well-being for all (Goal 3); gender equality (Goal 5); and the reduction of inequality within and among countries (Goal 10). As these goals indicate, to respond to multiple gender inequalities in the context of health emergencies, gender as a social and relational process must be better understood. An expanded grasp of gender and health emergency risks, as shaped by economic, political and cultural relationships, will provide a new starting point for progress on mitigating the differential impact that emergency events have on gender and it will support the broader advancement of sustainable development (2).

The WHO Thirteenth General Programme of Work (GPW13) reaffirms the relevance of gender for the work of the organization. “Gender-based differences between women and men, and girls and boys – in terms of health needs, risk behaviours, respective power and control over resources and information, and access to health services – continue to hamper improvements in health outcomes. Policies and programmes need to address gender as a determinant of health (among others) when tackling issues of access and risk.” The GPW13 places a heightened focus on gender, equity and human rights and underlines that “WHO commits, at all levels of engagement, to the implementation of gender equality, equity and rights-based approaches to health that enhance participation, build resilience, and empower communities. WHO commits to gender mainstreaming including not only sex-disaggregated data but also bringing a gender lens to needs analysis and programme design” (3).

In its efforts to implement the GPW13, and to achieve the goal of one billion more people better protected from health emergencies, the WHO Health Emergencies Programme (WHE) will implement a gender mainstreaming strategy across its policies, strategies, operations and capacity building as a priority. This also responds to specific recommendations included in the WHA Resolution 74.7 on Strengthening WHO Preparedness for and response to health emergencies (4), and other key documents.

1.2. Gender mainstreaming within the WHE programme

WHE is designed to deliver rapid, predictable, and comprehensive support to countries and communities as they prepare for, face, or recover from emergencies caused by any type of hazard to human health, whether disease outbreaks, natural or man-made disasters or conflicts. The programme has a common structure across the organization (in country offices, regional offices, and headquarters), reflecting WHO's major functions and responsibilities in health emergencies.

WHE aims to minimize the health consequences of outbreaks and emergencies by mitigating the risk of high threat diseases and infectious hazards; detecting and assessing emergency health threats and informing public health decision-making; responding rapidly and effectively to emergencies under a coordinated incident management system; and ensuring WHO’s work in emergencies is effectively managed, sustainably financed, adequately staffed and operationally ready to fulfil its mission.
This Strategy aims to provide guidance on how to systemically analyze and address relevant gender issues across WHE policies and programmes, to enable WHE work to contribute to gender equity and equality, which in turn will strengthen health emergency programming at all levels. It also provides strategic direction to facilitate how WHE can respond to the specific gender-based needs and risks that women, men, girls and boys and people with diverse gender identities experience as a consequence of health emergencies, in ways that improve the design and delivery of WHE policies and programmes, and contribute to reducing gender-inequalities including morbidity and mortality but also the medium and long term socio-economic effects of emergencies.

1.3. The context

1.3.1 The needs

There is a growing body of evidence showing the impact of health emergencies is not experienced in the same way by all genders (5). Gender norms, under-prepared health systems and barriers to accessing quality health care compound the risks and vulnerabilities that people face during emergencies including pandemic events. It is also well established that women are particularly vulnerable to the adverse effects of disaster—regardless of place of residence, age, income status, education, or ethnic group (6). During health emergency events, including epidemics and pandemics, the already unequal burden of unpaid care work in homes, including health care work, is exacerbated for women, often at the expense of their health (7). Estimates indicate that over 70% of women are at risk of, or have been a victim of, gender-based violence (GBV) in some crisis settings, with lifelong physical, emotional, social, economic and other consequences for survivors (8).

Evidence from past health emergencies, such as the Covid-19 epidemic, Zika and Ebola outbreaks, indicate that sexual and reproductive health services – including pregnancy care, contraceptives, sexual assault services and safe abortion – are scaled back during health crises. This can result in an increased risk of maternal mortality, unintended pregnancies and other adverse sexual and reproductive health outcomes among women and girls (9). As demonstrated during the Ebola outbreak in Sierra Leone, disruption in access to antenatal and labour support led to 3,600 additional maternal, neonatal and stillbirth deaths in 2014 and 2015. This number was similar to the total number of deaths due to the virus itself (10).

Women are estimated to represent 40% of the half a million humanitarian workers who provide frontline care during emergencies, wars and disasters (11). Concurrently, data show that women make up 70% of health care workers globally, yet they remain largely underrepresented in senior and decision-making roles in most national and global health settings (12). Health emergencies can also result in challenges to mental health and financial security (13), which affect individuals of diverse gender identities in different ways. The COVID-19 pandemic has further highlighted the urgent need to ensure that gender-sensitive preparedness and response measures are in place at all levels—from subnational, through to national, regional, and global levels.

Pervasive gender inequalities also leave specific groups outside decision making and consultation processes, ultimately further excluding large segments of the population from
receiving the care and assistance they need (12). The omission of women and people with diverse gender identities from these decision-making spaces is not only a reflection of gender inequalities which need to be addressed but is also to the detriment of the effectiveness and efficiency of emergency preparedness and response. There is mounting evidence of the direct, measurable, positive, and potentially transformative, impact of gender-equality programming on a wide range of humanitarian and health emergency interventions in a variety of contexts (14). Studies also point out that more attention is needed to better integrate gendered perspectives, expertise and skills in all aspects of health emergency preparedness, prevention, response, and recovery. There is a clear need for the systematic and consistent incorporation of gender in health emergency operations, from preparedness through response and recovery, and for WHO to collect and disseminate more widely gender disaggregated data and gender responsive guidance.

1.3.2 WHO actions

WHO Member States have recognized the need to “engage and involve women in all stages of preparedness processes, including in decision-making, and mainstream gender perspective in preparedness planning and emergency response” (15) as part of a landmark resolution on strengthening preparedness that was passed at the World Health Assembly in 2020. Recommendations made by the Review Committee on the Functioning of the International Health Regulations (IHR) (2005) and the Independent Panel for Pandemic Preparedness and Response (IPPPR) presented at the 74th World Health Assembly also emphasize the importance of health programmes to recognize and act upon gender, ethnic and other inequalities (16),

1 In this context, systematic means structured and repeated; consistent means in the according to certain defined criteria.
including to ensure that gender equality is integrated into IHR core capacity development and monitoring, and to adopt a gender-sensitive approach to health security data collection, analysis and response management (17).

Programming for health emergencies is closely linked to development and health systems strengthening. Working to address gender equality in emergency programming can therefore not be done in isolation but will be inextricably linked to areas of work throughout the continuum of preparedness, response, recovery, and transition to development.2

This Strategy builds on several workstreams that are ongoing across WHE/WHO which mainstream gender in health programmes including gender-based violence (GBV) prevention and response programming in emergencies, policy and advocacy with the Inter-Agency Standing Committee mechanisms, the collection and dissemination of sex-and-age disaggregated data, and the Prevention and Response to Sexual Exploitation, Abuse and Harassment (PRSEAH), among others. The Strategy is also aligned with and contributes to WHO-wide efforts to mainstream, including gender, equity and human-rights based approaches outlined in the Roadmap to Action (18), WHA’s resolution 60.25 Strategy for integrating gender analysis and actions into the work of WHO (19) and WHO’s Policy on gender equality in staffing.

1.4. WHE vision

The WHO Health Emergencies Programme (WHE) effectively addresses the causes of the differential impacts of health emergencies across people with diverse gender identities, particularly upon women and girls, and fosters policy changes to reduce harmful gender norms and promote gender equality across health emergency preparedness and response.

1.5. The scope

This Strategy is mainly for WHO and its WHE implementing partners, equipping them to provide Member States with a gender responsive support that would allow all health emergency guidance, operations, and capacity building efforts to fully reflect a gender perspective. While the Strategy recognizes the need for Member States guidance, it does not currently address that scope.

1.6. The target audience

This Strategy is intended to guide WHE programming across the local, national, regional, and global levels. It focuses on gender mainstreaming across programme design and implementation, as well as the institutional policies, frameworks, and functions that shape the work of the Programme. It is therefore addressed to all WHO staff within the WHE structure (country, regional and headquarters levels), responsible for the delivery of WHE functions, as well as relevant partners. This also targets all relevant WHO personnel working on the design, implementation and monitoring of WHE programmes, even if they are formally outside of the WHE structure or working on an ad hoc basis.

2 References to emergency programming or the health emergency cycle throughout this document should be considered to encompass all these phases.
The Strategic Framework

2.1. Goal

WHE policies, programmes and practice are responsive to the specific needs of all gender identities, particularly the most vulnerable and discriminated against, throughout the health emergency cycle.\(^3\)

2.2. Objectives

1. Address gender inequality across emergency preparedness, response and recovery policies, guidance and operations
2. Elevate the position of women in emergency preparedness, response operations and recovery

\(^3\) Refers to the continuum of preparedness, response, recovery, and transition to development.
2.3. The guiding principles

- Inclusive decision-making and implementation
- Institutionalization of gender responsive approaches in health emergencies
- Build on existing platforms and movements that address gender inequality and inequities in health emergencies
- Accountability in implementing strategy and measuring outcomes and impact
- A human-rights based approach

2.4. Key considerations

2.4.1. Building on past and ongoing achievements

Across WHE several initiatives to mainstream gender have been undertaken since 2016 when the programme was established, in accordance with the WHO Transformation Agenda. While there is some variability across WHO/WHE in terms of technical capacities and resources for gender mainstreaming, there is also richness in experiences, lessons learnt and best practices to date, which must be harnessed (see Annex 1a and Annex 1b for WHO/WHE gender related activities and resources). The present document, Mainstreaming gender within the WHO Health Emergencies Programme: 2022–2026 strategy, seeks to take stock of, and build on these initiatives and achievements, drawing also on the existing organization-wide frameworks and programmes on gender, equity, and rights.

2.4.2. Engaging key partners and stakeholders

Partner engagement is an integral part of this Strategy, founded in the belief that it crucial to work with, and consider the achievements, challenges and lessons learned from key stakeholders and partners to ensure a holistic and inclusive approach.

In alignment with the outlined objectives of this Strategy, specific partnerships will be identified to work with WHE in conducting gender-related assessments, identifying recommendations, delivering technical assistance, strengthening WHEs capacities, elevating the role of women in health emergencies, and strengthening accountability mechanisms for gender mainstreaming. To the extent possible, WHE will build on existing partnerships to advance these areas of work, including inter-agency partnership mechanisms and other consortiums which draw key relevant partners together. On a need-basis, new partnerships may be established for specific activities. More details on the partner engagement for mainstreaming gender can be found in Annex 2 and will be further outlined in the monitoring framework of the Strategy.

2.4.3. Re-iterative assessment of gender in policies and programmes

The WHO Gender Responsive Assessment Scale (GRAS) (20), proposes a classification framework for assessing gender in policies and programmes which can be instrumental in implementing this Strategy (Figure 1). The Scale includes five levels, where the gender transformative level is the goal. Gender unequal and gender blind are two undesired policy
types- and the third level, gender sensitivity, is the turning-point – when policies or programmes recognize the important health effects of gender norms, roles, and relations, without fully addressing them. The gender-specific level can focus exclusively on one sex with the aim of addressing specific gender norms, roles, or relations. The gender-transformative level seeks to address unfair gender norms, roles or relations which are the root causes of negative health outcomes and behaviour. This Strategy aims to achieve gender-responsive programmes, policies, operations, tools, and frameworks across WHE.

**Gender Responsive Assessment Scale**

- **Gender-unequal**: Reinforces stereotypes, perpetuates inequalities
- **Gender Blind**: Ignores gender roles, norms and relations
- **Gender Sensitive**: Shows basic awareness without really addressing issues
- **Gender-specific**: Targeted action to a specific group of women or men. Doesn’t challenge gender roles and norms
- **Gender Transformative**: Addresses the causes of gender inequality, transforms harmful gender roles, norms and relations, actively counters harmful stereotypes, promotes equality

Moving from concept to implementation

To achieve a fully gender responsive program, the present Strategy focuses on three areas of work, three outcomes and nine outputs. This section describes each of these elements, first presenting the outcomes and describing the work to be undertaken under each one, followed by the implementation framework (Table 1) and high-level indicators.

3.1. Expected outcomes

Outcome 1: WHE is gender responsive across programs and operations

WHE will review, update and produce new guidance and tools for Member States and partners to incorporate a gender analysis where relevant and in support of the delivery of a gender-responsive emergency preparedness and response programme. To this end, ways to strengthen the collection, analysis, use and dissemination of sex and age disaggregated data will be identified, including both qualitative and quantitative data. These efforts will be complemented with skills strengthening on gender analysis and gender responsive programming for WHE staff, as well as incorporation of new skills and expert profiles including from the social sciences. Increased female participation in WHE field operations and capacity building will also be a priority area of work.
Outcome 2: WHE is gender-balanced across staffing and organizational levels

To support the delivery of a gender responsive program and operations, the Strategy will also seek to raise the role of women in decision making within WHE, as this has been identified as a shortcoming in past staffing analysis (21). Geographic diversity and recruitment of younger professionals will be pursued, in alignment with broader WHE/WHO efforts to foster an organizational culture of diversity and inclusion which can draw on the expertise and contributions from varying perspectives. WHE will work with Human Resources to identify policies and practices which may need to be put in place to remove barriers for the equal and meaningful participation of all staff. This may include leadership training, measures to ensure gender-balanced representation in decision making committees, and in senior management roles, across organization levels; and conducting internal advocacy and awareness raising campaigns to facilitate understanding of the value of diversity inclusion and gender equality for the effectiveness of WHE’s programmes.

Outcome 3: WHE is accountable with systems effectively supporting a gender-responsive program

A final key element of this Strategy is the establishment of efficient systems to monitor progress towards gender-responsive programming, and to hold the organization accountable for its delivery. To this end, WHE will work to further integrate gender-related targets into performance appraisals, develop systems to track financial contributions to gender programming, and continue supporting the implementation and improvement of the GPW13 Output Scorecard dimension on the impactful integration of gender, equity and human rights.4 Moreover, WHE will engage with key stakeholders, networks, and partners at global, regional national and community levels (as relevant) and advocate for the adoption, implementation and monitoring of gender-responsive guidance and policies.

3.2. Implementation and Monitoring frameworks

The implementation framework below indicates the key areas of work, objectives, outcomes, and outputs that will guide the implementation of the present Strategy. The Monitoring Framework indicates high level indicators proposed to monitor progress.

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4 WHO’s output measurement system, requested by Member States, comprises a scorecard with six strategic dimensions, one of them being the “impactful integration of gender, equity and human rights” in the programmatic and corporate work of WHO. The scorecard is aligned with the technical requirements and recommendations of the United Systems-Wide Action Plan on Gender Equality and the Empowerment of Women (UNSWAP). See EB146/28 Rev.1 "WHO results framework: an update" for more details. (https://apps.who.int/ebwha/pdf_files/EB146/B146_28Rev1-en.pdf, accessed 1 June 2022)
<table>
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<th>Area of Work</th>
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| Technical support and delivery  | Address gender inequality across all emergency preparedness, response and recovery policies, guidance and operations.                                                                                       | WHE is gender responsive across programs and all operations.                                                 | WHE gender responsive frameworks, tools and guidance available and implemented  
Routine Gender analysis conducted across WHE programme, strategies, plans, messaging, at all levels  
Gender disaggregated data systematically collected, analysed and disseminated  
Human Resource capacities and skills for gender mainstreaming reinforced across all levels of the organization. |
| Gender representation and cultural diversity | Elevate the position of women in emergency preparedness, response operations and recovery                                                                                                                      | WHE is gender-balanced across staffing and organizational levels.                                                                                                         | Inclusive decision making instituted across WHE  
Enhanced attention to capacity building for women in the WHE Programme  
Strengthened culture of respect and inclusion in the WHE Programme on Health Emergencies |
| Accountability and monitoring   | Strengthen accountability for gender mainstreaming in emergency preparedness and response                                                                                                                   | WHE is accountable with systems effectively supporting a gender-responsive program.                                                                                 | WHE Gender mainstreaming monitoring and reporting system established and functional  
Advocacy to incorporate gender mainstreaming in health emergency policy, planning and operations systematized  
Relevant stakeholders and partners meaningfully engaged |
3.3. The Monitoring framework

**Outcome 1: WHE is gender Responsive across programs and all operations**

**Indicator 1.1**
Proportion of published guidance for MS and partners which is gender-responsive as per the GRAS scale.

**Indicator 1.2**
Gender-ratios across expert rosters and expert missions

**Indicator 1.3**
Proportion of funded emergency response plans that incorporate a gender-component.

**Outcome 2: WHE is gender balanced across organizational levels**

**Indicator 2.1**
% increase in proportion of female staff in the professional and higher categories across WHE

**Indicator 2.2**
Proportion of females included in WHE rosters; heads of mission; and as chairpersons of decision-making mechanisms.

**Outcome 3: WHE is accountable with systems effectively supporting a gender responsive program**

**Indicator 3.1**
Percentage increase in WHE financial resource allocations to gender, equity and rights activities.

**Indicator 3.2**
Proportion of increase in aggregate trend in gender equity and rights balanced scorecard for WHE Global Programme indicators

To the extent possible the indicators have been drawn from existing monitoring and reporting mechanisms in WHE, including those within the GPW13 Output Balanced Scorecard and data collection. As one of the 6 Output Scorecard Dimensions, the work on mainstreaming gender (and equity and rights) represents a strategic shift for the entire work of the Organization, across the 3 billion goals. This Strategy for mainstreaming gender within the WHO Health Emergencies Programme will support operationalizing these objectives and contributing to better performance on the six-output balanced scorecard dimension, in particular that related to gender.

The WHE Gender Working Group will be responsible for overseeing implementation of the Strategy, through measurement of the Monitoring Framework. Through its regular meetings it is expected to address any challenges that may arise towards the achievement of set targets, offer a knowledge sharing space to help units across organizational levels to learn from other experiences, and issue regular reports for senior management. Inputs from key partners would be regularly incorporated in the working group discussions. Full details on the roles and responsibilities of the Gender Working Group can be found on Annex 3.
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Annexes

Annex 1a. WHO/WHE gender related activities

This Annex provides information on ongoing initiatives and key resources led and produced by WHE/WHO, which address gender issues within emergency preparedness, response and recovery. Whilst not an exhaustive list, it showcases the variety of ways in which WHO/WHE is working to advance gender within the programme.

Programmes and Initiatives

♦ Disaster Risk Management Programme: WHOs Health Emergency and Disaster Risk Management Framework (EDRM) provides a common language and comprehensive approach that can be adapted and applied by all actors in Health and other sectors who are working to reduce health risks and consequences of emergencies and disasters with a focus on the differential vulnerabilities. This key guidance supports the for Member States towards fast-tracking implementation of the Sendai Framework for Disaster Risk Reduction (DRR) of Action in by the health sector through the whole-of-society approach. The Health EDRM accounts for both the relevance of integrating gender perspectives and of engaging women as leaders and accounting for their specific needs. Within the DRR portfolio, WHE/WHO is regularly engaged in advancing gender equality through a rights-based approach, providing support to the monitoring of the ‘Sendai Framework for DRR’ on health-related targets and
indicators emphasizing the importance of gender-disaggregated data, and participating in UN initiatives such as through the 2021 Joint UN Study on the Status of Gender Equality and Women's Leadership in Disaster Risk Reduction.

**Using MultiDimensional Poverty Index for emergency preparedness, response and recovery:** Jointly with Oxford University, WHE/WHO is working to use multi-dimensional poverty index to inform emergency preparedness, response and recovery. This tool provides a birdseye view of multiple overlapping deprivations; disaggregation to identify the poorest groups- including by gender; indicator detail to shape policy responses precisely; and provides flexibility to add indicators or analyze them alongside other datasets, adapting the model to local contexts.

For more information visit: [https://www.who.int/publications/i/item/9789240031852](https://www.who.int/publications/i/item/9789240031852)

**Health and Peace Initiative:** This WHO-led initiative is a key contribution to the Sustaining Peace agenda, exploring how health programmes can be used not only to work in conflict (achieving health benefits in conflict situations) but also to work on conflict. At a minimum, Health and Peace programmes seek to “do no harm”, while striving “do more good”: avoiding unintentionally fueling conflict and instead focusing on using health care to address some of a conflict's underlying causes. The Health and Peace handbook (for publication in late 2021) specifically points out how a gender-specific perspective needs to be included in conflict analysis- identifying where dividers and connectors affect different groups, including women and girls, sexual and gender minorities, and marginalised groups differently.

For more information visit: [https://www.who.int/initiatives/who-health-and-peace-initiative](https://www.who.int/initiatives/who-health-and-peace-initiative)

**Gender Based Violence in Emergencies:** This project aims at integrating prevention and response to gender-based violence (GBV) in WHO's response to health emergencies. It includes the deployment of GBV in emergencies advisors at regional, global and country-level, who provide ongoing technical support to health partners in the delivery of health services for GBV survivors in a number of countries. Through the Project, response to GBV is institutionalized, capacity of health actors is enhanced through service readiness assessment and quality assurance tool for CMR/IPV adapted for humanitarian settings, as well as updated guidance on clinical management of sexual violence and intimate partner violence survivors (CMR/IPV) guidelines and eLearning (French, Spanish, English, Arabic); and learning is promoted, by developing evidence-based adaptations of the RESPECT Framework for Prevention of Violence Against Women (2019) for humanitarian settings, and sharing learning related to GBV response to COVID-19 through GHC mechanisms.


**Strengthened Protection from Sexual Exploitation, Abuse and Harassment (PSEAH) across operations, including emergency response.** WHO continues to place high priority in this area of work. A PSEAH chapter has been included within the WHO Emergency Response Framework, which outlines the responsibilities of the PSEAH advisor as well as its key functions within emergency operations. WHO has also established a Director role on Prevention & Response to Sexual Exploitation, Abuse and Harassment and developed a WHO Framework on PRSEAH.

Global Health Workforce Network Gender Equity Hub: The WHO Global Health Workforce Network (GWHN) thematic hub on Gender Equity in the Health and Social Workforce (GEH) was launched in 2017. GEH is co-chaired by Women in Global Health (WGH) and WHO, and aims to accelerate large-scale gender-transformative policy change to address gender inequities in the global health and social care workforce.


Gender Equal Health and Care Workforce Initiative: 2021 has been designated as the International Year of Health and Care Workers (YHCW) in appreciation and gratitude for the unwavering dedication in the response to the COVID-19 pandemic that health and care workers have shown. The Gender Equal Health and Care Workforce Initiative sees the International Year of Health and Care Workers as an opportunity for the health and care sectors to drive policy action to achieve the visionary agenda for women’s rights and empowerment outlined in Beijing Declaration and Platform for Action.

For more information visit: https://www.who.int/initiatives/beijing25/gender-equal-health-and-care-workforce-initiative
Annex 1b. Other WHO Resources


**Inter Agency Gender responsive guidance, developed with WHOs contribution:**


**Relevant WHO resources:**

- WHO (2020). Incorporating intersectional gender analysis into research on infectious diseases of poverty: a toolkit for health researchers. World Health Organization. Available at: [https://apps.who.int/iris/handle/10665/334355](https://apps.who.int/iris/handle/10665/334355)


Regional guidance and briefs on gender and health:


Regional Office for the Western Pacific. (2014). Gender and health in the Western Pacific Region. https://apps.who.int/iris/handle/10665/208162


Annex 2. Partnership Engagement

For the development of this strategy, several external partners were requested to provide insight and suggestions. As the strategy is operationalized, specific activities and projects where the collaboration with partners is essential will be identified, in alignment with the 3 areas of work of the strategy (1) Technical support and delivery; (2) Gender representation and cultural diversity; and (3) accountability and monitoring. To the extent possible, WHE will build on existing partnerships to advance these areas of work, including inter-agency partnership mechanisms and other consortiums which draw key relevant partners together. On a needs basis, new partnerships may be established for specific activities.

Technical Support and Delivery

As WHE works to review and update past guidance to strengthen gender analysis and gender mainstreaming; and to develop new guidance, tools and protocols that adequately address gender issues, it is essential for WHE to work alongside recognized technical experts in the field. Academic institutions, WHO collaborating centers, civil society organizations, and UN specialized agencies will be part of these partnerships.

Another key component of this area of work is the strengthening of WHE’s operational capacities with relation to gender mainstreaming. For these, partnership with organizations experienced in the delivery and design of capacity building resources will be identified, including through IASC and other UN joint mechanisms with capacity building components.
**Gender representation and cultural diversity**

As described in the strategy, this area of work relates to WHE’s efforts to elevate the position of women in emergency preparedness, response operations and recovery. To this end WHE will work with advocacy organizations and stakeholders as well as experts in cultural change to identify catalytic actions through which women can be more strongly represented in decision making bodies within the organization, and a stronger culture of respect to cultural diversity and all genders could be implemented.

**Accountability and Monitoring**

WHE will work with partners to track and monitor progress in the implementation of this strategy. This will entail working alongside academic institutions and WHO Collaborating Centers to identify evidence-gaps and research areas, as well as in establishing platforms for knowledge sharing and advocacy. Partners can also assist WHE in its internal analysis and development of performance and programme indicators, and other key elements of its monitoring and reporting systems.

In addition, partners will be called upon to provide critical assessments of WHE’s work, providing instrumental recommendations that can be incorporated into annual work plans, and further advance the achievement of objectives.
Annex 3. WHE Gender Working Group: Terms of Reference

Context

There is a clearly identified need to consolidate gender mainstreaming work and efforts across the WHO Health Emergencies Programme (WHE). This also responds to a series of recommendations issues by the Independent Advisory Committee (IOAC), the International Health Regulations (2005) Review Committee, and the Independent Panel for Pandemic Preparedness and Response (IPPPR). Moreover, in 2020 the WHA adopted a key resolution indicating the need to “engage and involve women in all stages of preparedness processes, including in decision-making, and mainstream gender perspective in preparedness planning and emergency response” (4).

Purpose

The WHE Gender Working Group is a coordinating mechanism established to support the implementation and monitoring of the Mainstreaming gender within the WHO Health Emergencies Programme: 2022–2026 strategy. It is expected to encourage and sustain the prioritization of gender mainstreaming across levels of the organization.

Main priorities

1. Outline gender-inclusive measures for health emergency preparedness and response at national, regional and global levels.

2. Identify and review gender sensitive WHE guidance, tools, frameworks and training materials.
3. Define measures for greater inclusion and participation of individuals of all gender identities in leadership and decision making for support to health emergencies.

4. Support a robust gender-centred information, data and analysis of health emergency preparedness and response and capacity building at country, regional and global levels.

5. Recommend and support implementation of enhanced mechanisms for WHE to scale up gender inclusive approaches within all aspects of WHE work.

6. Conduct and support effective monitoring of national, regional and global progress in gender mainstreaming health emergency preparedness and response.

**Composition**

The WG is led by the WPE/Health Security Preparedness department and Core Members of the WG include representation from each of the six WHE HQ departments, all of the six WHO Regional Offices, country office focal points, and observers on a needs basis. Other relevant departments in WHO are engaged on an ad-hoc basis.

**Accountability**

The working group reports to the Director, Health Security Preparedness (WHE), who will regularly provide updates on the proceedings of the group to Regional Directors and WHE Senior Management as needed.

All core members are expected to attend the monthly meetings and share relevant information from their departments, and report back to their departments on key issues raised by the WG. If a Core Member is unable to attend the meeting, they are requested to identify an alternate representative from their department to attend on their behalf.

For the implementation of the monitoring framework, a Core Member is appointed as a Focal Point for each outcome and tasked with overseeing and guiding its implementation. With the support from the Secretariat, these Focal Points would be responsible for oversight and coordination of the relevant outcomes and are also expected to support monitoring of the relevant indicators and challenges associated with their activities.

**Outreach**

The Working group will reach out to other institutions, including civil society and academia, on an ad-hoc basis to inform its discussions on specific issues and seek technical guidance.

**Working arrangements**

The Working Group will meet virtually monthly to discuss priority issues and monitor implementation of the *Mainstreaming gender within the WHO Health Emergencies Programme: 2022–2026 strategy*. It will also offer a space for experience and knowledge sharing.

An agenda and relevant materials will be shared with participants prior to each meeting. When relevant, feedback and inputs may be sought from members of the working group, including engaging in ad-hoc TaskTeams to support specific deliverables.
References


4. Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme: A.74/16 and Looking Back to Move Forward (A.73/10)