

# Taking Stock and Moving Forward: Championing gender and health in the Western Pacific Region







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# Foreword

In 2019, Member States in the Western Pacific endorsed the Region's shared vision, *For the Future: Towards the healthiest and safest Region*. This vision articulates a strategy for WHO's work with Member States and partners in the coming years, which is based on a change agenda that focuses on acting today to address the health challenges of tomorrow.

This vision describes a future Region where health systems are resilient to climate change, disease outbreaks and natural disasters, where a healthier and equitable environment enables people to live long, healthy and productive lives, and where all people, especially those most disadvantaged and marginalized, have access to essential health services.

Our long-term vision of making the Western Pacific Region the healthiest and safest region will not be possible without applying a gender lens in our programmes and strategies. As gender affects health and creates inequities in health outcomes among and within countries in the Region, utilizing a gender lens will increase the effectiveness, reach and impact of our solutions by including diverse perspectives and recognizing social and cultural norms. Work on gender and equity is not a novel approach

and has historically been our priority. However, there is a need to strengthen work in this area to ensure regional progress towards better health while leaving no one behind. To accomplish this, WHO must make gender a part of its institutional DNA.

The *Taking Stock and Moving Forward: Championing gender and health in the Western Pacific Region* report provides an opportunity to reflect on how WHO has been applying a gender lens to its actions over the past three years. The report describes how considering differences in epidemiology, risk factors, access to services and response to interventions by gender helped different technical programmes achieve their objectives while promoting health equity by gender. Most importantly, the report highlights actions the Organization has taken to tailor-fit interventions.

As Acting Regional Director of the Western Pacific, I recognize that applying a gender lens to health is not only right in principle, but also in practice. Advancing health can only be achieved through attention to gender and equity, an approach we will apply in everything we do in the Region.

**Zsuzsanna Jakab**

Deputy Director-General

and Acting Regional Director for the Western Pacific

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# Introduction

There are different ways in which gender affects health. Gender can influence health burden and risk factors, an individual's access to health services, as well as their response to health interventions. Thus, in order to address gender inequities and improve the effectiveness of programmes, it is necessary to start by applying a gender lens.

- **Differences in disease burden and risks:**

As a social determinant of health, gender influences the extent to which women, men and gender-diverse individuals are exposed to risk and protective factors, and how they experience specific health concerns. For instance, traditional expectations of masculinity or “manhood” increase men's vulnerability to risky lifestyles, such as alcohol or tobacco use, and deter them from seeking health care when needed (1). As a result, men are at higher risk for both morbidity and premature mortality from communicable diseases and noncommunicable diseases (NCDs), as well as an increased risk of dying from suicides, homicides and injuries. The Western Pacific Region experiences a significant disparity in life expectancy at birth between men and women, with women living an average of 81 years compared to men who live approximately 75 years, resulting in a gap of six years.

- **Differences in access to services:**

Gendered differences create conditions that undermine efforts to expand coverage and improve the effectiveness of health interventions. As an example, although family planning services may be widely available and accessible to communities, gender norms that require women to seek permission from their partners to access services may cause women to either refrain from seeking or be denied services.

- **Differences in responses to health solutions:**

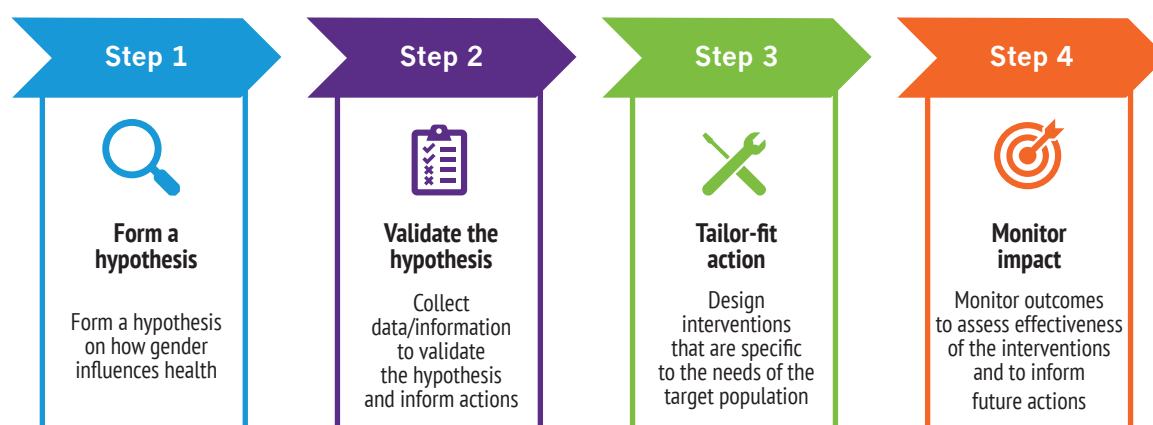
Blanket health interventions fail to address underlying gender-related barriers that play a role in the uptake of health services. In contrast, gender-responsive approaches may improve the outreach and effectiveness of health interventions. For instance, during the COVID-19 pandemic, a study among Organisation for Economic Co-operation and Development (OECD) countries revealed gender differences among men's and women's agreement on the implementation of measures to halt the spread of the virus. More women compared to men agreed and complied with measures such as wearing masks, closing schools, closing non-essential shops, prohibiting non-essential travel and imposing a curfew (2). Explanatory factors for this difference

included women being more risk averse and more favourable towards government intervention than men (2).

**Steps to apply a gender lens approach:** *For the Future: Towards the healthiest and safest Region* articulates a shared regional vision – acting today to address the challenges of tomorrow, to make the World Health Organization (WHO) Western Pacific Region the healthiest and safest

region. To realize this vision, actions should not only address present challenges but also anticipate and mitigate the effects of those challenges that will arise in the future. Applying a gender lens to everything we do is a critical tool to achieve a healthier and safer future for all by improving the coverage and impact of programmes while achieving gender equity in health (see Fig. 1).

**Fig. 1.** Gender lens framework



### **Step 1. Form a hypothesis on how gender influences health**

To ensure the effective implementation of health programmes, programme managers need to identify the possible impact of gender on the health burden and risk factors of the target population. Hypotheses on how gender influences health can be formed through community engagement or country case studies.

### **Step 2. Confirm or validate the hypothesis**

The hypothesis formed in Step 1 needs to be validated to confirm how gender impacts health programmes. This can be done by collecting sex- and gender-disaggregated data, conducting focus group discussions, surveying programme participants and observing

programme implementation in the field. This approach could give programme managers and implementers a better understanding of the experiences of the target population and further reveal nuances and details that affect the implementation of health programmes.

### **Step 3. Tailor-fit action**

By recognizing the specific health issues and challenges faced by the target population, programme managers can then design interventions that are specific to their needs. For example, outreach activities can be developed that target a specific gender that is known to face challenges in adopting a certain health intervention, such as smoking cessation targeting women.

#### **Step 4. Monitor impact**

Lastly, it is critical to monitor the impact of the programme on different genders to assess the effectiveness of the gender lens approach and make any necessary modifications. This could include collecting data on programme participation and health outcomes disaggregated by gender, conducting regular evaluations and soliciting feedback from programme participants and stakeholders. Monitoring and evaluation could also inform future actions such as scaling up the intervention or including new services to achieve the desired health outcomes.

### **Impact beyond individual programmes**

The application of a gender lens could have a positive impact on an individual programme, joint response efforts and solutions beyond the health sector, as described below.

#### **Applying a gender lens to the disease-specific programme as a strategy to improve effectiveness and outcome.**

The use of a gender lens in disease-specific programmes in the Western Pacific Region has been successful in reducing the burden of infectious diseases and improving maternal and child health outcomes. The application of a gender lens can help these programmes identify disease distribution among genders and gender norms and expectations affecting health behaviours, which improves the coverage and outcomes of interventions. For instance, in countries where men hold significant power over reproductive decisions for women and girls, the unmet need for family planning is high. Therefore, designing interventions that support both women's and men's choices and family planning needs may be able to effectively increase contraceptive use (3).

#### **Applying a gender lens to identify integrated solutions across multiple programmes and strengthen their joint approach and reach.**

The identification of unreached populations may highlight shared gender-related health concerns across multiple programmes. Policy-makers and programme managers can improve results by jointly designing and implementing gender-responsive strategies to address these common barriers and improve health interventions. For example, the management of HIV and mental health can have intersecting challenges. People living with HIV (PLHIV) or those at high risk are more likely to experience mental health concerns, which are associated with lower engagement in prevention services and retention in HIV care, as well as increased risk-taking behaviours (4). Thus, joint planning and/or programming enhances the reach and outcomes of individual programmes, such as integrating screening services for HIV and mental health disorders (5).

#### **Applying a gender lens to address the drivers of poor health through solutions that go beyond the health sector.**

Multisectoral collaboration is essential in tackling gender-related challenges across different sectors such as education, welfare, employment and health systems. As an example, road traffic crashes cause nearly 1.3 million preventable deaths and an estimated 50 million injuries. Men are three times more likely to die from road injuries than women. Bringing attention to the mortality and morbidity caused by road injuries can uncover the underlying reasons for poor health outcomes that are beyond the health sector, such as land-use planning, road safety regulations and safe road infrastructures (6). Overall, incorporating a gender lens into health interventions and



considering the intersections of health with other sectors can result in more effective, sustainable and equitable solutions that address the causes of poor health outcomes and drive sustainable development.

The *Taking Stock and Moving Forward: Championing gender and health in the Western Pacific Region* report provides an overview of how WHO is applying a gender lens to its work

with Member States, involving actors within and beyond the health sector to achieve a culture of gender equity in the Western Pacific Region. The report is intended to encourage public health programme implementers and managers to continue making progress in achieving a healthier and safer future for all in the Region, through gender-responsive interventions that promote gender and health equity.

# Health security and antimicrobial resistance



## Increasing the uptake of COVID-19 vaccinations for women experiencing homelessness in the Philippines



Addressing gendered barriers through targeted vaccine drives for people experiencing homelessness in Quezon City, Philippines.

People experiencing homelessness have a high risk of acquiring COVID-19 and are more likely to have negative health outcomes. Vaccination against COVID-19 is the most effective tool to protect oneself against the virus, and people experiencing homelessness have been prioritized in vaccine roll-outs in many settings (7,8). However, few studies have investigated the barriers to vaccination to inform outreach activities and the differences in response to intervention by gender within this minority group (9,10).

In the Philippines, there are approximately 4.5 million people experiencing homelessness, with 3 million people in Metro Manila (11). Many of these individuals are unable to adhere to public health directives such as physical distancing, isolation and practising hand hygiene due to precarious housing conditions that place them at an increased risk for COVID-19 infection and poor health outcomes. In Metro Manila, civil society organizations (CSOs) that were working to reach homeless populations with COVID-19 vaccine services found that women

were not accessing vaccine clinics at the same rate as their male counterparts. In response, the Department of Health, partner CSOs and the WHO country office in the Philippines sought to understand the barriers to vaccination that women in homelessness experience. There were three series of focus group discussions held, including community dialogues and key informant interviews with women experiencing homelessness living in Metro Manila, as well as with officials from established community networks working with the target population.

The results of these discussions revealed that women in homelessness are experiencing gender-specific barriers in accessing COVID-19 vaccines. Specifically, women's care-taking role hinders their ability to access vaccination services as children are unwelcome at vaccination sites. Women cited factors that dissuaded them from getting vaccinated, such as having no one to care for their children and potentially exposing their children to unsafe situations if left on the street or outside vaccination centres. In response, the Department of Health, along with the WHO Philippine country office and partner organizations, jointly developed a service delivery model that aims to reduce barriers

to vaccination for women experiencing homelessness. Specifically, a series of targeted vaccine drives were implemented. The programme included relaxed registration procedures and offered relevant services such as childcare, transportation and meals. Through these efforts, the programme can help improve vaccine access and uptake for women experiencing homelessness.

This approach has since been scaled up across different cities in Metro Manila. Further, lessons learnt from this intervention are currently informing a model for scaling up vaccination services to reach other vulnerable groups in the country.

The Philippines' experience underscores the importance of community engagement in recognizing barriers to vaccine access rooted in gender roles and norms and gathering data to tailor-fit interventions. Countries should include a monitoring framework to track vaccination rates and gather data on vaccine access disaggregated by gender and geography. This information can be used to identify any remaining barriers and assess the success of interventions in addressing them, which can help improve vaccination coverage.

## Engaging migrant women in the identification of ways to address their safety in quarantine centres in Cambodia

Quarantine centres are a type of collective site where people reside temporarily, often using shared facilities. Global experience has shown that in emergency contexts, women who are living in collective or camp settings can be at increased risk for gender-based violence (GBV), particularly near water points and water, sanitation and hygiene (WASH) facilities (12,13).

During the COVID-19 pandemic, Cambodia made preparations for repatriating migrants.

By August 2021, over 225 000 migrant labourers from Cambodia had returned from Thailand, with half of them (46%) being women (14). Women at quarantine facilities were exposed to a higher risk of GBV since there were no guidelines promoting safety and GBV prevention. This issue was raised by the quarantine facility management team, leading to the active involvement of the Government of Cambodia and the Ministry of Health to mitigate the risks of GBV in the





Migrant workers passing through Cambodian border to Thailand after completion of temperature checks by Cambodian health officials at Phnom Dey International Border Checkpoint.

quarantine facilities. The agencies conducted facility visits and key informant interviews with provincial health department staff and migrant women to understand safety risks and identify health service needs. The key informant interviews included questions on GBV risk perceptions within the facility. The research team's observations and information from the interviews showed that most of the quarantine centres did not provide a safe environment to prevent GBV.

The Government, in collaboration with the WHO country office in Cambodia and other United Nations agencies, utilized the information gathered from their observations and interviews to develop a package of policies and guidelines to restructure quarantine centres to ensure the safety of women. These were disseminated to

ensure that all quarantine centres nationally maintain a standard that ensures the safety of repatriating women. Specifically, the guidelines for quarantine centres included the following:

- **Integrating GBV prevention measures and practices**, such as having separate WASH facilities for men and women with private, well-lit toilets with internal latches; equipping sleeping rooms with locks; and ensuring that children and adolescents remain with parents or relatives and that unaccompanied children in quarantine centres had access to social worker support.
- **Promoting emotional safety and reporting mechanisms**, such as employing women security officers and providing information on how to report instances of GBV.

Through the facility visits and interviews conducted by the research team, the package of policies and guidelines captured the experiences of women in the quarantine facilities. By engaging the target population, the selected interventions would be more feasible and more acceptable to the women. This also allows for the attainment of GBV safety objectives for protecting women and children. However, there is a need to monitor the intervention to measure its effectiveness in addressing the needs of women in the quarantine facilities.

The Cambodian experience underscores the importance of anticipating gender-based health risks – for example, the GBV risk for women in quarantine centres – when tailoring actions during an emergency. For example, quarantine centres and other collective sites should consider safety and GBV prevention in their structures, design and operational policies to protect vulnerable populations at the outset, then adjust policies and actions based on the subsequent quantitative and qualitative assessment.

## Creating safe spaces for survivors of gender-based violence in Solomon Islands



A snapshot of a community member's journey to Verani clinic in East Guadalcanal, Solomon Islands.

GBV is a major public health problem that affects mostly women and is a violation of human rights. It is estimated that one in three (30%) women worldwide have experienced physical and/or sexual intimate partner or non-partner violence in their lifetime. GBV affects survivors'

physical, mental, sexual and reproductive health, and could have fatal outcomes (15).

According to the United Nations, Solomon Islands is one of 19 countries with the highest range (40–53%) for lifetime physical and/

or sexual intimate partner violence among ever-married/partnered women aged 15–49 years (16). The lifetime prevalence estimate of intimate partner violence for women aged 15–49 years in the country is 50% compared to the global average of 27% (17). Additionally, the COVID-19 pandemic affected the mobility of the population, decreased their access to basic services, and weakened social and protective networks. According to WHO (17), the pandemic environment exacerbated the risk of violence for women and children who found themselves in prolonged exposure to their abusers at home. Survivors of GBV in Solomon Islands also experience limited health services.

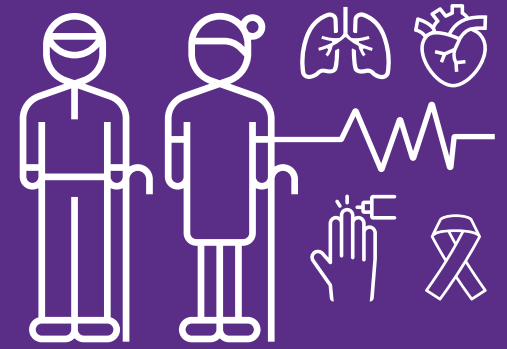
The GBV programme by the Ministry of Health & Medical Services was developed to address the health risks and burden that GBV survivors experienced in Solomon Islands. One area of focus is the creation of a safe space for GBV survivors, which follows the recommendation of the minimum care version of the WHO GBV Quality Assurance Tool. In the Good Samaritan Hospital in

Guadalcanal Province, provincial health authorities and WHO developed a safe space at the facility and ensured the availability of nurses trained in GBV counselling, clinical care and medical reporting. By providing a space where the needs of the survivors of GBV can be addressed while ensuring their privacy, the programme helps improve the health outcomes of women who seek care at the facility.

By using this gender approach, the disproportionate effect of GBV on women can be identified and tailored actions taken to address their health needs and the barriers to service they experience. However, there is a need to monitor the impact of the programme in addressing the health needs of GBV survivors through the collection of quantitative and qualitative data that measures the effectiveness of the intervention and informs future actions. The intervention can be scaled up in health-care facilities throughout the country to respond to the needs of GBV survivors.



# Noncommunicable diseases and ageing



## Tailored communication to increase engagement in tobacco cessation among women in Nauru



Leading by example – positive influence of tobacco cessation on healthy activities in children in Nauru.

In 2020, nearly a quarter of the world's population (22.3%) used tobacco. In general, smoking prevalence among men is higher compared to women (18). However, comparing the decline in smoking rates among women and men smokers, tobacco use among women has declined more slowly than in men, and women smokers also have lower cessation rates than men smokers (19–21). Determining and

addressing the underlying factors that influence smoking behaviours among women and girls may help to reduce health risks and increase cessation rates among them. For example, one of the factors associated with higher smoking prevalence among women is the advertising practices of tobacco companies that target women and change the social norm to make tobacco smoking more acceptable to them (22).

In Nauru, 43.5% of women aged 15 years and older smoke tobacco, which is comparable to the prevalence of tobacco use among men (44%) (18). The reason behind the higher rates of tobacco use among Nauruan women was unconfirmed as there have been no previous documented efforts to break down the issue. This led the Ministry of Health and WHO to conduct focus group discussions among women smokers in Nauru to understand their tobacco use initiation, behaviours and beliefs. The goal of the activity was to inform the development of materials specifically designed to encourage and support Nauruan women to quit smoking.

Findings from these focus group discussions revealed that stress and worry are common triggers for women to smoke. Women felt pressured to smoke when others in their social circles smoked. At the same time, barriers to smoking cessation include the limited availability and accessibility of cessation programmes. Women's willingness to participate in cessation programmes is also hindered by social norms and beliefs. Women shared that they are less inclined to participate in cessation programmes offered in a hospital setting since these facilities are typically only accessed when household members are sick. The discussions also revealed that women's desire to quit tobacco centred around money-

saving benefits and being a good role model for their children.

Insights from these discussions have helped to produce and tailor tobacco messaging and cessation service materials geared towards women under the Ministry of Health's *Stop and Take a Breath* initiative. A pocket guide was developed to support tobacco cessation targeting women. It contains practical tips on managing smoking triggers and peer pressure, along with a series of encouraging messages to avoid relapse. The Ministry of Health also identified locations outside of hospitals for their smoking cessation programme and made it available at convenient times, such as when children are in school, in response to women's concerns. The programme will continue to be monitored to determine its effectiveness in addressing tobacco cessation among women.

Nauru's Ministry of Health recognized the importance of understanding the high prevalence of risk factors in certain groups (in this case, smoking rates among women), which led them to investigate tobacco initiation, behaviours and beliefs among women in Nauru. As seen in this example, countries should keep monitoring tobacco use prevalence by gender and collect data to inform interventions that can address the underlying gender-related barriers to tobacco cessation.

# Climate change and environmental health



## Data-informed action to address gender-related risk from indoor air pollution in Mongolia



Exploring gendered risks – unveiling the impact of indoor air pollution across Mongolia.

Household air pollution remains a significant health issue around the world. Approximately 2.6 billion people worldwide are exposed to household pollutants by using polluting fuels such as charcoal, wood, animal dung and kerosene in open fires and inefficient stoves when cooking (23). Due to traditional gender roles associated with domestic work, such

as cooking and collecting fuel, women are at higher risk of adverse health effects from indoor air pollution than men (24,25).

In Mongolia, the proportion of the population with primary reliance on solid fuel resources is higher (50%) than the average in the Region (37%), and indoor air pollution contributes to

approximately 3010 deaths per year (26–28). Analysis indicates that men and women have different risk factors attributed to indoor air pollution. For women, mortality risk from indoor air pollution is more attributed to their reliance on polluting fuel for cooking than in men (28). To address this health risk and burden among women, in 2021, the WHO Mongolia country office launched a flagship programme that supported raising awareness of household air pollution among women who are considered to be more vulnerable to the negative health outcomes of cooking-associated indoor air pollution. This flagship programme has three priorities:

- **Advocacy and awareness raising:** The Mongolia country office facilitated conversations with women and supported women-focused advocacy actions. The BreatheLife campaign, organized by WHO and the United Nations Environment Programme, raised awareness of air pollution and identified gender-sensitive solutions.
- **Monitoring indoor air quality:** The country office supported the National Committee on Reduction of Environmental Pollution by developing surveys to monitor indoor air quality before and after the raw coal ban was implemented. It also worked

with partners to examine emissions from burning processed coal in 2021.

- **Translating findings into policy:** Results and lessons learnt from the flagship programme were shared with Ministry of Health officials to promote gender-responsive action towards their *Strategy on Indoor Air Pollution*. The findings inform a strategy to reduce the use of indoor air pollutants like raw and processed coal burning.

The Government of Mongolia was able to identify various health risks based on gender and took tailored actions. Engaging women who are more vulnerable to indoor air pollution would also help in the development of locally led and gender-sensitive solutions that are relevant, accessible and acceptable to them.

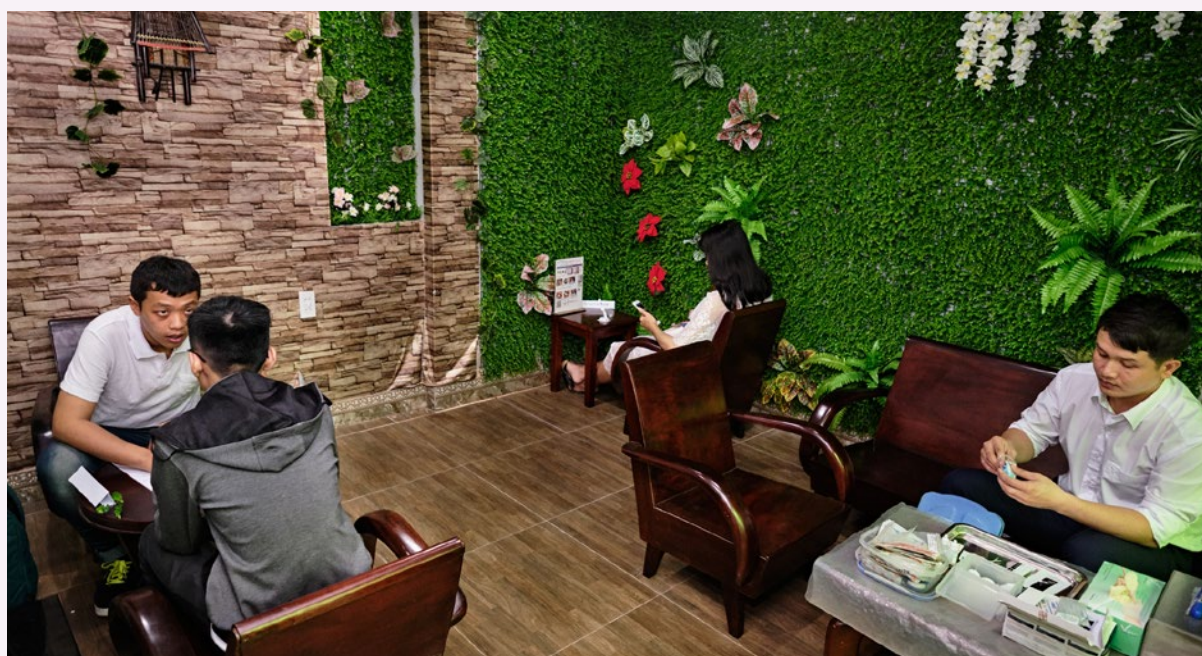
The Government of Mongolia is making further efforts to collect sex-disaggregated data to enable a better evidence base that can guide decision-makers in creating healthier environments in Mongolia, engaging vulnerable populations and evaluating the impact of the Ministry of Health's *Strategy on Indoor Air Pollution* to minimize the risk of exposure to indoor air pollution and in preventing its adverse effect on health.



# Reaching the unreached



## Implementing community-led HIV testing services to reach key gender and sexual minority populations in Viet Nam



Piloting community-led HIV testing through mobilizing peer educators in Can Tho, Viet Nam.

Globally, people who inject drugs (PWID), men who have sex with men (MSM), transgender individuals, sex workers and their partners are at the highest risk of acquiring HIV and hepatitis C virus (HCV) (29,30). High-risk groups are encouraged to undergo regular HIV testing to enable early diagnosis, treatment and care. However, HIV-related stigma and discrimination can impact their access to health services, preventing them from seeking HIV prevention, testing and treatment services (31). Therefore, designing and implementing approaches that

address stigma and discrimination among these vulnerable groups can facilitate the acceptance of HIV testing. An effective method for improving uptake of HIV testing services is through peer-led interventions, which have been successful in several countries (32).

In Viet Nam, there are about 240 000 PLHIV and nearly 1 million people living with HCV (33,34). Despite the importance of knowing one's HIV status to ensure appropriate care, access to HIV testing in a health facility remains low.

According to data from 2016, only 36% of PWID, 41% of MSM and 43% of female sex workers had ever been tested for HIV (35). Fear of stigma and discrimination, as well as perceived lack of confidentiality, are known barriers of HIV testing in facilities in Viet Nam (36). Recognizing the problem, the Government of Viet Nam has developed a national strategy to end the AIDS epidemic and move towards elimination of viral hepatitis by 2030, and has given top priority to improving access to testing services and fighting stigma and discrimination, particularly among PLHIV (37–39).

To achieve this priority, the Vietnam Administration for HIV/AIDS Prevention and Control (VAAC), in collaboration with WHO, implemented a pilot project that assessed the feasibility and effectiveness of strategies to increase the uptake of testing services among key populations. Interventions focused on addressing the barriers to testing services, including stigma and discrimination. The project was piloted in Can Tho city and Thai Nguyen province between 2017 and 2019. The following interventions were undertaken:

- **Mobilizing lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) peer educators who had experience with substance use and sex work to reach key populations:** MSM, PWID and sex workers without previous medical knowledge or experience in conducting HIV testing and outreach were recruited as peer leaders. They were trained on providing HIV, HCV and syphilis testing services, including counselling prior to and after testing, and support for linkage to care. Assisted partner notification (aPN) was also facilitated by the peer leaders. The aPN services were offered as direct assistance to PLHIV to contact their sexual or drug-injecting partners as facilitated by trained peer educators. The aPN services can help in case-finding and

facilitating the linkage to preventive care and treatment services.

- **Engaging key populations through demand creation and service provision:** Target populations were reached utilizing a combination of offline and online interventions using relevant community spaces and social networking groups while ensuring confidentiality and anonymity. Peer educators and clients often meet in coffee shops and drop-in houses to increase the comfort and accessibility of target populations. Trained peer educators disseminate information regarding the benefits of early testing, treatment and testing procedures. Testing services were offered to clients who agreed to be tested for HIV, HCV and/or syphilis.
- **Using gender-disaggregated data to inform programme planning and implementation of community-led services:** Monitoring and evaluation include tracking gender-disaggregated data on the utilization of HIV health services such as testing, treatment and linkage to care. The records were developed by WHO and provincial AIDS centres, allowing for the collection of information on the HIV cascade of care, with data collection facilitated by peer leaders.

The experience of Viet Nam in implementing key population-led and community-based HIV services among key populations underscored the effectiveness of employing a peer-facilitated approach, leveraging existing platforms and networks, and using gender-disaggregated data to inform programme design and implementation (35). As a result, 60% of all newly diagnosed HIV cases in Thai Nguyen and 30% of new cases in Can Tho were identified through community-based testing in 2017. In addition, among those who underwent the testing, 70% were first-time HIV testers (35). In the same time period, the annual proportion

of HIV-positive individuals among those tested in Viet Nam was only 2.7%. However, through community-based and peer-led intervention in pilot sites, a 5.8% positivity rate was recorded, which likely confirms improved outreach among key populations and their partners (40). The interventions also informed the national

guidelines for community-based HIV testing in Viet Nam and were approved by the Ministry of Health in 2018 and scaled up to other high-burden provinces (29,40). The HIV testing project can inform the delivery of other health services targeting key populations.

## Mobilizing young people through peer-to-peer approaches to reduce gender inequalities in health in the Marshall Islands



Nurturing the potential of adolescents and youth in Marshall Islands.

In developing nations, around 21 million girls between the ages of 15 and 19 become pregnant each year, with half of these pregnancies unintended. This results in about 12 million births each year. Adolescent pregnancy is a health concern as adolescents carry higher risks for health complications such as eclampsia, systemic infections, and

prolonged and obstructed labour. Additionally, infants born to adolescent mothers are at an increased risk of serious neonatal issues, low birthweight and preterm birth (41,42). Many adolescent girls who are pregnant face stigma and isolation as their pregnancy is often viewed as their sole responsibility.



The rate of adolescent pregnancy in the Marshall Islands is the second highest among all Pacific island countries and areas, with 60 births per 1000 adolescent girls recorded in 2021 (43). One of the factors contributing to the high rates of adolescent fertility in the country is the lack of access to youth-friendly sexual and reproductive health (SRH) services and comprehensive sex education, especially in rural areas (44).

Recognizing the impact of this health problem, the Ministry of Health and Human Services, the National Coalition of STD Directors, and WHO sought to develop a programme to support the prevention of adolescent pregnancy through peer-to-peer education, skill-building and engagement. Peer-to-peer education is an effective approach to improve knowledge, attitudes and self-efficacy in SRH (45). The programme aims to decrease risky sexual behaviour and improve reproductive health among adolescent boys and girls through the following interventions delivered through their peers:

- **Information and discussion sessions among the target population:** Using peer-to-peer delivery mechanisms, partners facilitated the implementation of 10 information and discussion sessions targeting young people between 7th and 12th grade on topics such as healthy relationships, the reproductive system, sex and sexuality, consent, pregnancy prevention, communication, sexually transmitted infections, HIV and other related areas.
- **Empowering young men and women on their reproductive health rights:** Through the workshops and interactive activities, the programme focused

on building resilience and improving adolescents' ability to make informed decisions about their health.

- **Breaking social norms on gender and sexuality:** Through engaging boys in the programme design, there was also attention brought to breaking down harmful masculinity norms held by many adolescent boys that encourage early sexual initiation and poor use of contraception, among other behaviours.

Peer facilitators observed the high engagement of students in the sessions through active participation in the activities and their topic-related inquiries. Some of the students also reported that the sessions increased their SRH knowledge and skills.

The case of the Marshall Islands highlights the importance of understanding the factors behind adolescent pregnancy and the involvement of both adolescent girls and boys, which enabled the Government to design effective interventions that can reduce risky sexual behaviour and increase SRH knowledge among the adolescent population. In the future, the programme should consider other factors that contribute to the high rate of adolescent pregnancies and develop a feedback mechanism and monitoring and evaluation framework with process (such as coverage, pre/post-workshop evaluations, participant interviews) and outcome indicators (for example, adolescent pregnancy rate) to evaluate the programme's impact on reducing adolescent pregnancy in the country. Results of the evaluation can inform next steps, including possible collaboration with the Ministry of Education to enhance the SRH curriculum and expand the peer-to-peer programme to the adolescent population nationwide.



# Applying a gender lens to our administrative work



## Creating a gender-equitable, inclusive and diverse workplace in the WHO Regional Office for the Western Pacific



Regional WHO representatives at the seventy-fourth session of the WHO Regional Committee for the Western Pacific in Manila, Philippines.

Gender diversity in an organization's human resources is important and has many advantages. A diverse workforce can lead to increased creativity and more effective problem-solving and decision-making due to an openness to a multiplicity of perspectives and ideas, which can spark creativity and innovation, and help the Regional Office challenge gender stereotypes. The advantages of a gender-diverse workplace

also include improved employee morale and a more positive organizational culture (46). Furthermore, Member States, stakeholders and beneficiaries are diverse, and it is important that WHO reflect its commitment to diversity, inclusive of gender. For these reasons, there is now greater attention being paid to creating a more gender-diverse and inclusive workplace among different organizations globally.

The WHO Western Pacific Region has a long-standing commitment to gender and equity. Over the past year, the Regional Office has worked to strengthen workplace culture and support organization reforms to make WHO more effective, efficient, transparent and accountable to better deliver on the needs and priorities of Member States. These reforms included prioritizing gender and equity within the Region to break down silos and improve ways of working together (47). The *Fit for the Future* stocktaking exercise was conducted to identify the most effective reform measures. The exercise revealed the significant role of workforce planning, an efficient recruitment process, and inclusive staff development and learning initiatives in improving organizational efficiency (48). In recent years, the *For the Future* vision strengthened the commitment of the Organization in achieving gender equity through actions aiming to institutionalize gender mainstreaming in all of WHO's policy and programme work.

Recognizing the importance of a gender-inclusive workplace where employees can effectively perform their roles and contribute to the Organization's goals, the WHO Regional Office for the Western Pacific implemented different gender-responsive interventions to stimulate professional growth, such as career counselling services, short-term development assignments and the Western Pacific Region mentorship programme. Additional actions to achieve gender parity within higher-level positions have also been undertaken. The Regional Office has implemented several measures and strategies, including regional

recruitment policy adjustments to eliminate bias during hiring processes, and provided training for staff representatives, hiring managers and all staff to reduce potential gender bias during participation in recruitment panels.

As a result of these combined efforts, positive outcomes can be observed in the interventions conducted, aiming to achieve gender parity and promote equal opportunities for career development and leadership. As an example, the share of women international staff in the WHO Western Pacific Region rose from 36% in 2014 to 50% at the end of 2019, and 56% by mid-2020. During the same time period, the proportion of women staff internationally and locally recruited in the professional category also increased from 32% to 54%. Regarding women staff holding P4 and above positions, this increased from 46% in 2019 to 55% in 2022. Further, in some offices, such as the Regional Director's Office and the Cabinet, gender parity has been achieved (49). In terms of career development and leadership intervention, in the Regional Mentoring Programme, women staff participation reached 66%.

WHO is committed to promoting gender diversity in the Western Pacific Region and has seen positive results from its efforts in creating a gender-equitable and inclusive workplace. Progress is noted on achieving gender parity in the workforce and increasing the number of women participating in career development programmes. The Organization needs to continue promoting programmes and initiatives that improve gender representation, and monitor their progress.

# Conclusion and recommendations

## Moving forward

Despite the improvements in health and development made at regional and country levels over the past few decades, differences in health outcomes remain at the local level. These differences are not only unjust and unfair, but they also threaten the advances made to date and put the potential achievement of the Sustainable Development Goals at risk. They also serve to remind us that achieving gender equality and health equity continues to be the “unfinished business of our time” (50).

The practices reflected in this report demonstrate the determination throughout WHO in applying a gender lens to every stage of our programmatic and administrative work. Member States across the Western Pacific Region have made progress towards driving gender-responsive action in different stages of operational, programme and policy-making processes, and as it relates to the four thematic priority areas: (1) health security and antimicrobial resistance; (2) NCDs and ageing; (3) climate change and environmental health; and (4) reaching the unreached.

By considering the differential risks, barriers and vulnerabilities faced by all genders, accessibility to quality essential health services has been strengthened. In some instances, sex-disaggregated data have been used to increase COVID-19 vaccine uptake among pregnant women and survivors of

GBV. A gender-responsive approach to health services has also increased access to timely services among survivors in Solomon Islands. These examples demonstrate that existing programmes can be used as an entry point for reducing gender inequalities in health.

Going forward, different health programmes should collect and analyse gender-specific data, conduct root cause analysis, and make adjustments based on the results of monitoring and evaluation. Prioritizing these elements in future health programmes can lead to improved programme delivery and greater health outcomes.

The stocktaking exercise also reiterated the added value of applying a gender lens in fostering a culture of equality within the workplace, as mentioned in the *For the Future* vision. This was demonstrated through various efforts, such as addressing gender balance and promoting diversity in the WHO workforce. These actions and others within the report highlight how applying a gender lens across the Organization has strengthened the Region’s commitment to new ways of working.

In conclusion, by taking a gender lens approach, health programmes can better address gender-specific differences and needs and achieve a more diverse workplace, ultimately leading to more inclusive and equitable health for all.





 **World Health Organization**  
Western Pacific Region



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