A FOUNDATION TO ADDRESS EQUITY, GENDER AND HUMAN RIGHTS IN THE 2030 AGENDA:

PROGRESS IN 2014–2015
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## Abbreviations and acronyms

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AFRO</td>
<td>WHO Regional Office for Africa</td>
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<td>AMRO/PAHO</td>
<td>WHO Regional Office for the Americas/Pan American Health Organization</td>
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<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>DG</td>
<td>WHO Director-General</td>
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<td>ECHR</td>
<td>Ethiopia Commission on Human Rights</td>
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<td>EMRO</td>
<td>WHO Regional Office for the Eastern Mediterranean</td>
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<td>EURO</td>
<td>WHO Regional Office for Europe</td>
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<td>FWC</td>
<td>Family, Women’s and Children’s Health Cluster at WHO</td>
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<td>GBV</td>
<td>gender-based violence</td>
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<td>GER</td>
<td>Gender, Equity and Human Rights team at WHO</td>
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<td>HRuF</td>
<td>Human Rights up Front</td>
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<td>IASG</td>
<td>United Nations Inter-Agency Support Group for the Convention on the Rights of Persons with Disabilities</td>
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<td>IER</td>
<td>Information, Evidence and Research Department of WHO</td>
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<td>LGBT</td>
<td>lesbian, gay, bisexual, and transgender</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
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<td>OHCHR</td>
<td>Office of the High Commissioner for Human Rights</td>
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<td>RHR</td>
<td>WHO’s Department of Reproductive Health and Research</td>
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<td>RMNCH</td>
<td>reproductive, maternal, newborn and child</td>
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<td>SA</td>
<td>WHO Headquarters Staff Association</td>
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<td>SDG</td>
<td>United Nations Sustainable Development Goals</td>
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<td>SDH</td>
<td>social determinants of health</td>
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<td>SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNSWAP</td>
<td>United Nations System-Wide Action Plan</td>
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<td>UN Women</td>
<td>United Nations Entity for Gender Equality and the Empowerment of Women</td>
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<td>VAW</td>
<td>violence against women</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPRO</td>
<td>WHO Regional Office for the Western Pacific</td>
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Foreword

A HEALTHY FUTURE FOR ALL, WITH NO EXCEPTIONS

The era of the Sustainable Development Goals has begun. After years of planning, the “post-2015 agenda” is no longer just over the horizon, it is here and now.

If the public health goals of this new era could be captured in a single idea it would be: “leave no one behind”. Whatever their age, gender, ethnicity or lifestyle, or where they happen to live, no person should ever miss out on the chance for health and well-being. Our task as health professionals and policy-makers is to ensure that everyone, everywhere, is included.

Gender, equity and rights are central to this work. At the World Health Organization (WHO) we know from copious gender-oriented research that health outcomes for women are worse when they face discrimination, oppression, and lack of opportunity for education and employment. Their children’s health also suffers. Equity is a core objective within health policy because it enables improvements among the most disadvantaged and marginalized people. And all health programming should be underpinned by human rights – especially the fundamental right to the highest attainable standard of health.

These three themes come together at WHO within the Gender, Equity and Human Rights (GER) team. Formed in 2012 in my own area of Family, Women’s and Children’s Health, its aim is to embed GER approaches across WHO and its in-country partners. This is a collaborative effort that requires immense dedication and sustained work, and is absolutely vital if we are to create an enabling environment for lasting change.

This report highlights the advances of the global GER team over the 2014-2015 biennium. The accomplishments are a result of the quality of our staff, the support of generous donors, and – most important – fruitful partnerships with committed, thoughtful, energetic professionals in governments around the world who share our vision that no one should be left behind.

Dr Flavia Bustreo, WHO Assistant Director-General
Acknowledgements

Overall development of this report was by Joanna Vogel, WHO technical officer, Gender, Equity and Human Rights (GER), with support from Katharine Bagshaw, WHO communications consultant.

The progress reported was made possible by the dedicated work of WHO staff from the GER team at headquarters and at regional and country level.

Specific inputs by the following WHO staff are gratefully acknowledged: Hala Abou Taleb, Britta Baer, Anjana Bhushan, Benedicte Briot, Anna Coates, Alexander D’Elia, Sandra Del Pino, Rustini Floranita, Luiz A. C. Galvao, Sharifullah Haqmal, Ahmad Hosseinpoor, Theodora Koller, Fikir Melesse, Davison Munodawafa, Zainab Naimy, Aasa Nihlen, Hala Sakr, Alexandria San Jose, Anne Schlotheuber, Prakin Suchaxaya, Rebekah Thomas, Javier Vasquez, Anita Vitullo, and Isabel Yordi.

We particularly thank WHO HQ colleagues Anna Gruending, Marta Aguilo Seoane, and Shyama Kuruvilla for reviewing the report, and Ms. Erin Quibell, Policy Analyst/Gender Equality, from Global Affairs Canada, for her thoughtful comments on the draft.

The report was produced under the leadership of Dr Flavia Bustreo, WHO Assistant Director-General, Family, Women’s and Children’s Health (FWC), and Dr Veronica Magar, Team Leader, GER.

Editing of the progress report was conducted by Kay Bond and Plain Sense.

The work of GER over the course of 2014-2015 has been generously funded by Global Affairs Canada (formerly the Canadian Ministry of Foreign Affairs, Trade and Development (DFATD)), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), and the Norwegian Agency for Development Cooperation (Norad).
Executive Summary

In 2012, the Director-General of the World Health Organization (WHO) established the Gender, Equity and Human Rights (GER) team in the Family, Women’s and Children’s Health (FWC) Cluster. Drawing on the support of a network of committed staff at headquarters and at regional and country level, its purpose is to catalyse, support and coordinate institutional mainstreaming of equity, gender and human rights at all levels of WHO. The team’s corporate four year strategy, the *Roadmap for Action 2014-2019*, identifies three principal pillars of work: institutional mainstreaming; health inequality monitoring and data disaggregation; and country support.¹ This progress report highlights advances made in each of these areas during the 2014-2015 biennium.

With respect to institutional mainstreaming, GER initiatives have inspired several new organizational mandates that address equity, gender and human rights, including a dedicated chapter in the revised handbook on *Induction of Heads of WHO Offices in countries, territories and areas*. Programmatically, the team’s work has increased awareness and understanding of equity, gender and human rights, for example by developing a course on health equity and human rights in the Eastern Mediterranean Region and making equity, gender and human rights a standing item in the induction of all headquarters’ staff.

At country level, the capacity of Member States to monitor health inequality and integrate action on equity, gender, and human rights has been strengthened significantly. GER’s partnership with the Social Determinants of Health team (SDH, also located in the FWC Cluster) has helped countries to integrate social determinants in national health programmes.

Direct technical support to countries included the development of health action plans that are more equitable and gender responsive, as well as a health sector treatment protocol for gender-based violence (GBV).

Institutional mainstreaming mechanisms, capacity building, and direct country support led GER activities in the 2014-2015 biennium. Moving forward into 2016-2017, this foundational work will underpin GER’s efforts to assist countries to meet their targets under the UN 2030 Agenda for Sustainable Development and enable WHO to increase the number of health policies, strategies and programmes (in WHO and Member States) that are rights-based, sensitive to gender, and enhance equity.

INTRODUCTION
Introduction

Across the world, health outcomes are unequal, within countries and between them. Subpopulations\(^2\) can suffer many forms of disparity, due to gender inequality and differences in vulnerability, exposure to risk factors, and access to services, generating outcomes that include catastrophic expenditure, wide variations in illness, and stigmatization. Many of these differences in treatment and effect are avoidable and unacceptable.

WHO established the Gender, Equity and Human Rights (GER) team in 2012 to help close these health inequities. Several WHO programme areas already addressed equity, gender and human rights. The GER initiative consolidated this cluster of concerns in one team to strengthen their mainstreaming. The overall aim remains the same: to ensure that improvements in physical, mental and social well-being are enjoyed by all people everywhere.

The GER team draws on the support of a network of committed staff at headquarters as well as at regional and country level. Its corporate strategy, the *Roadmap for Action 2014-2019*, identifies three pillars of work:

- Institutional mainstreaming.
- Health inequality monitoring and data disaggregation.
- Country support.

The objective is to improve health, notably the health of population groups that are under-served, by strengthening institutional mainstreaming mechanisms, assisting Member States to monitor health inequalities, and providing technical assistance that promotes and supports national health policies, programmes and laws that are gender-responsive, enhance equity and fulfil the human right to health.

Advancing health equity, gender equality and the right to health requires the cooperation of a large and diverse group of actors inside and outside WHO. This report describes the progress that WHO has made in the last two years (2014–2015), lessons learned, and promising initiatives under each of the GER pillars and at each level of WHO. Text boxes highlight specific milestones. The variety of the examples underlines that attention given to equity, gender and human rights can add value in many ways and in many programme areas.

The experience we have gained in the last two years has laid the foundation for a stronger and more cohesive WHO approach to equity, gender and human rights. WHO should be more able to assist countries to develop health policies, strategies, programmes and laws that allow and encourage every person to be healthy without discrimination on grounds of race, sex, gender, ethnic origin, education, wealth or social status.

\(^2\) Subpopulations may be distinguished by age, sex, rural/urban status, education, income, ethnicity, migrant status, or in terms of other variables, according to the country or operational context.
Who we are

GER global staff work in all six WHO regions and some country offices, as well as in WHO’s headquarters in Geneva. In Geneva, the team includes a Team Leader and three technical officers. Elsewhere, mainstreaming is managed by a diverse group of staff in WHO’s regional offices for Africa (AFRO), the Americas (AMRO/PAHO), the Eastern Mediterranean (EMRO), Europe (EURO), South-East Asia (SEARO), and the Western Pacific (WPRO). WHO regional staff work part- or full-time on mainstreaming in different departments or divisions, depending on funding and availability. Figure 1 shows the departments, divisions or clusters in which GER regional and headquarters staff are located.

Figure 1. Where GER regional staff work
1.

INSTITUTIONAL AND PROGRAMMATIC MAINSTREAMING: CHANGING FROM WITHIN
1. Institutional and programmatic mainstreaming: changing from within

The test of organizational change is the degree to which WHO considers equity, gender and human rights at every step of its planning and operations - the extent to which mandates reflect GER concepts, senior managers are committed to and accountable for mainstreaming, and GER provides coherent technical support at every level.

Anchoring equity, gender and human rights in institutional mechanisms

Institutional mainstreaming of equity, gender and human rights implies that WHO structures, procedures and mechanisms should enable and facilitate the development, implementation and monitoring of health programmes and plans that are gender-responsive, enhance equity and promote rights, both in WHO and in its technical support programmes. To mainstream equity, gender and human rights successfully, an organization must transform its culture from within. One critical step towards doing this is to identify strategic entry points for mainstreaming.

Core actions for mainstreaming equity, gender and human rights: A successful WHO three level initiative

Most WHO staff understand the intrinsic value of addressing equity, gender and human rights. The challenge is to show how they can integrate actions on equity, gender and human rights practically and systematically in their programmes. To address this, in August 2014, GER staff across WHO met to agree practical actions that would have this effect. The meeting allocated core essential mainstreaming actions in three areas: analysis, action, and monitoring and reporting.3

To ensure the identified actions were feasible, acceptable and sustainable, GER mapped them into an assessment of 2014-2015 programme area deliverables and operational plans. This made it possible simultaneously to establish a baseline for WHO’s 2016-2017 Programme Budget, identify how many programme areas were implementing mainstreaming actions in 2015 (10 of 24 programme areas, 42%), and set a target for the end of 2017 (15 of 24 programme areas, 62%). In addition, after the Regional Office for Europe piloted the actions, a regional assessment was developed to guide priorities for the next biennium in 2016-2017.

Core mainstreaming actions are a mechanism for integrating equity, gender and human rights into programme areas. An e-learning series, to be launched in February 2016, will provide information on them to all WHO staff, helping to create conditions in which a shift in organizational culture can occur.

During 2014 and 2015 the GER team successfully integrated core mainstreaming actions for programming in several of WHO’s key institutional mechanisms. Guidance on integrating equity, gender and human rights was included in the WHO Handbook for Guideline Development4, the revised Guide for the formulation of a WHO Country Cooperation Strategy5, and in the Handbook for the induction of Heads of WHO Offices in countries, territories and areas6 (for inducting the

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3 The core mainstreaming actions are divided into three domains: analysis, action, and reporting and monitoring. Analysis includes data disaggregation, gender analysis, and equity analysis. Action includes gender responsiveness, equity enhancement, implementation of AAAQ (availability, accessibility, acceptability and quality), and use of participatory approaches to remove barriers to inclusion. Reporting and monitoring include gender, equity and rights data, and health inequality monitoring.


Heads of WHO offices). Equity, gender and human rights in programming was included in the induction of all new headquarters’ staff. Globally, WHO also instructed that equity, gender and human rights should be integrated in the 2016-2017 programme budget and operational planning.

Senior managers play a critical role in organizational change. During the 2014-2015 biennium, they strongly supported the mainstreaming of equity, gender and human rights. WHO’s Director-General (DG) endorsed GER’s Roadmap for Action 2014-2019 in 2015 and it was sent, with a request for support, to all Regional Directors and Assistant Directors-General.

WHO has made significant progress towards gender equality.

**Promoting gender equality in WHO**

In 2015, the DG joined ‘Geneva Gender Champions’. Led by the United Nations Office in Geneva (UNOG) and the U.S. Mission’s ‘Future She Deserves’, this initiative promotes gender equality in the workplace through executive leadership. The DG committed that, by September 2017, WHO will increase the number of female staff in its professional and higher categories by 3% (from 42% in 2015 to 45%). In 2015, the Headquarters Staff Association (SA) created a think tank on gender equality to promote women’s work and visibility. At the request of the DG, it aims to promote executive gender parity (Professional level 5 and above) at headquarters and in the six regions.

Progress has also been made at regional level. In May 2015, for example, the European Regional Coordination Mechanism (composed of the Regional Directors of all UN Agencies with European Regional Offices) established the European and Central Asia Working Group on Gender. WHO EURO is a member of this working group.

In parallel, WHO is making steady progress towards meeting the performance indicators of the UN-System-Wide Policy on Gender Equality and the Empowerment of Women (UNSWAP). UNSWAP, the UN’s first systematic accountability framework for gender mainstreaming, includes 15 performance indicators for monitoring progress towards gender equality and empowerment of women. The GER team works closely with relevant WHO departments to meet all indicators by the 2017 deadline.

The Human Resources Department, in particular, adopted several new initiatives designed to advance gender equality in staffing, especially at higher professional levels.

- The WHO Senior Management Accountability Compact now includes an indicator on gender equality in staffing.
- An enhanced Performance Management Development System (ePMDS+) requires supervisors and managers with recruitment responsibilities to set targets for gender equality in staffing.

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The WHO Programme Budget for 2016-17 (6.1.1) has an indicator for an approved and implemented up-to-date gender equality policy and plan, including gender mainstreaming and the equal representation of women.

In September 2015, the Under-Secretary-General and Executive Director of UN Women wrote to confirm WHO’s progress in advancing gender equality. In her letter, she congratulated WHO for its UNSWAP achievements in the area of gender-responsive performance management, noting that WHO’s presence of gender staff across the Organization provided a model for the UN system.

Programmatic mainstreaming in the 2014-2015 biennium

To successfully mainstream equity, gender and human rights into programmes, these approaches must be applied systematically in a manner that ensures that WHO’s normative guidance to Member States advances health equity, gender equality and the right to health. In addition, WHO staff must buy into and support the process, which requires evidence-based advocacy, clear guidance, technical support, and relationship building. Further, because the entry points for mainstreaming in WHO’s work are so diverse, staff and partners need to understand the concepts and framework and their practical application to health policy and programming.

Informed by data collected for Beyond the Mortality Advantage, an equity-driven, gender-responsive and human rights-based regional strategy for women’s health in Europe will be presented to the Regional Committee for endorsement in 2016.

Equity, gender and human rights have often been criticized on the grounds that they are ‘abstract’. In 2014-2015, GER began to make them practically applicable, by documenting country examples, preparing an e-training tool, and explaining the pragmatic implications of a ‘rights-based approach’. These initiatives are helping WHO staff and Member States to understand health equity, gender equality, and the right to health, and to promote them in health policies, programmes and strategies.

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8 WHO Regional Office for Europe, Beyond the mortality advantage: investigating women’s health in Europe (Copenhagen, 2015).
Translating human rights concepts into practice: two successful HQ initiatives

The UN set out what it meant by a human rights-based approach in 2003. For health organizations, nevertheless, the approach remains challenging and complex because they must fundamentally change the processes, principles and language they apply to programming.

To address this difficulty and to develop definitions that WHO can operationalize, the HQ GER team asked a diverse group of WHO programme staff in early 2015 to apply their understanding of human rights standards to various WHO functions. When doing so, staff were asked to draw on several generally recognized principles and criteria relevant to implementation of the right to health (including availability, accessibility, acceptability, quality, non-discrimination, participation, and accountability).

To support this exercise, the GER team commissioned New York University’s Global Justice Clinic to clarify the scope and application of these principles and criteria to health and human rights, and identify gaps, in consultation with experts and practitioners. For example, how is ‘accessibility’ to be measured? What proactive steps must be taken to ensure that the most marginalized obtain services? What degree of ‘participation’ qualifies a process to be described as ‘rights-based’?

In parallel, the team invited health practitioners and researchers to describe instances where the application of human rights standards has strengthened the impact of health programmes. A wide variety of initiatives emerged: a community-led advocacy campaign in Vermont, USA, to make health care a ‘human right’ in law; legislation on essential medicines in eight countries; the removal of ‘class’ wards in Indonesia; the involvement of males in preventing vertical HIV transmission in Tanzania, etc. GER is currently preparing a selection of these cases to illustrate how human rights can be applied usefully in health settings.

The 67th session of the Regional Committee for the Americas approved a ‘Strategy on health-related law’ (resolution CD54.R9). It will strengthen the technical capacity of health authorities to coordinate with the legislature and other branches of government. At the request of governments, AMRO/PAHO will assist Member States to draft or reform health-related national laws and regulations in line with UN and regional human rights standards.

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For mainstreaming to take hold, equity, gender and human rights must be considered across all stages of the programme cycle, including monitoring and reporting. Because every Member State has signed and ratified at least one human rights treaty relevant to health, requiring it to report periodically on the progress it has made in fulfilling its treaty commitments, reporting should consider human rights treaties. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, adopted in 1979) is one of several human rights treaties that include articles on health.

Reporting on the right to health: a successful initiative in Africa

The Ethiopia Commission on Human Rights (ECHR) is responsible for monitoring Ethiopia’s adherence to international human rights conventions and treaties.

In 2014-2015 GER staff in WHO’s Ethiopia office began working with ECHR to eliminate discrimination against women in the area of health care. In line with a UN system-wide effort to deliver programmes that take into account equity, gender and human rights, ECHR established a technical working group on women’s health rights that WHO, UN Women and the Joint United Nations Programme on HIV/AIDS (UNAIDS) joined.

In collaboration with WHO’s country office, ECHR developed a normative checklist for monitoring the public and private health sector which addresses gender, stigma, discrimination, and the quality of health service delivery. In 2016 the UN technical working group (led by WHO and funded by the Delivering Results Together Fund) will prepare a Joint Action Plan that will finalize the checklist and build the capacity of parliamentarians and ECHR to deliver it. WHO will then work with ECHR to turn its findings into actions that will improve the quality of health care and assist health workers to fulfil the right to health when they deliver services.

WHO’s partnership with ECHR helps it to promote the right to health of women and girls. WHO’s association with UN Women and UNAIDS has assisted it to apply policies on equity, gender and human rights. In general, collaboration with other actors enables WHO to advance principles of equity, gender and human rights in a practical manner that strengthens country health programmes.

Identifying strategic entry points is crucial to the success of mainstreaming. Doing so requires judgement and contextual understanding. Regional GER teams seek out opportunities for action and cooperation that can improve the health of marginalized or under-served population groups. For example, the world’s approximately 370 million indigenous people, living in at least 70 countries, have poorer access to health services, and use health services less, than the population as a whole. Indigenous women face additional health problems because they are particularly at risk from natural disasters and armed conflicts, and in many settings have less opportunity to acquire education, land and property, or other economic resources. The health inequities of indigenous people are a public health concern, but also a human rights concern - and both aspects need to be addressed if health standards are to be met.

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Increasing awareness of the health of indigenous people: a successful initiative in the Americas

In September 2014, the World Conference on Indigenous Peoples addressed the health inequities of indigenous populations. At the request of the UN Inter-Agency Support Group for the Convention on the Rights of Persons with Disabilities (in which WHO’s Regional Office for the Americas participates), GER staff in the Gender and Cultural Diversity Unit of AMRO/PAHO prepared a paper on the issue, in collaboration with other WHO regional offices. It found that:

- Indigenous women and young adults had less access to sexual and reproductive health services, with the effect that indigenous communities have a higher proportion of young mothers.
- Infant mortality among indigenous children is 60% higher than among non-indigenous children in Latin America.
- Social exclusion, discrimination, poverty, and limited access to health services, including mental health services, cause indigenous populations to suffer elevated levels of psychosocial stress, especially in rural areas.
- Poverty, poor housing, lack of access to medical care and drugs, cultural barriers, language differences, and geographic remoteness are responsible for a higher incidence of tuberculosis among indigenous people.
- Environmental degradation, contamination of the ecosystems in which indigenous communities have traditionally lived, and loss of land and territory, contribute to elevated rates of malnutrition in indigenous populations.

The report provides guidance on how the right to health of indigenous peoples can be promoted and protected and will assist WHO regions to develop remediable health policies and plans.

All regions and countries share certain entry points, notably universal health coverage (UHC). UHC asserts that all persons should have access to the health services they need and that these services should be of good quality and should not impose an undue financial burden on users. UHC covers health programmes and interventions that promote better health (such as anti-tobacco policies) and prevent illness (such as vaccinations), as well as access to services across the continuum of care (including treatment, rehabilitation, and palliative care). It is an essential element of the Sustainable Development Goals (SDGs) and underpins the efforts of Member States to strengthen their health systems.

WHO provides UHC guidance and support to Member States, adopting a holistic and multisectoral approach to ensure that outcomes are both equitable and sustainable.

11 Inter-agency support group on indigenous peoples’ issues, The health of indigenous peoples (paper for the 2014 World Conference on Indigenous Peoples, June 2014).
No Universal Health Coverage without health equity, gender equality and fulfilment of the right to health: a successful initiative in the Western Pacific

Responding to requests by Member States, WHO’s Regional Office for the Western Pacific developed an action framework to assist countries to achieve better health based on UHC. Universal Health Coverage: Moving towards Better Health identifies five essential attributes and fifteen areas of action. Priority recommendations for action include:

- Understand the impact of health financing and social protection schemes, especially on vulnerable populations such as the elderly, women, persons with disabilities, children and the poor.
- Improve the cultural competence and gender sensitivity of health staff. Instil people-centred values and practices in individual and general services.
- Develop policies that comply with international conventions, such as the United Nations Conventions on the Rights of the Child, the Rights of Persons with Disabilities, and the Elimination of All Forms of Discrimination against Women.

WHO’s Regional Committee for the Western Pacific endorsed the action framework in October 2015. The inclusion of equity, gender and human rights in the framework was facilitated by global acceptance that equity is a core dimension of UHC, by the leadership of WHO’s senior management, and the GER team’s ability to suggest specific, technically rigorous actions based on international commitments and tailored to the regional context.

The integration of equity, gender and human rights in WHO’s institutional mechanisms and programme areas is challenging partly because many staff believe they already implement these values and equate equity with ‘access’. These concepts (including the notions of availability, accessibility, acceptability, and quality) need to be better understood in the context of health. Skills need to be developed to support them. The principle of non-discrimination should be applied consistently to promote equity and equitable outcomes. Steps should be taken to ensure that those who are affected by decisions can participate in the decision-making process. Advocacy needs to be undertaken, finally, to secure international and national commitment.

Strengthening capacity to achieve health equity and the right to health: a successful initiative in the Eastern Mediterranean Region

WHO’s Eastern Mediterranean Regional Office partnered with the Social Research Center at the American University in Cairo, Egypt, to design and develop a multidisciplinary course titled ‘Health Equity and Human Rights’. It focuses on how health systems can improve the quality of care, and accountability, when integrating health equity and human rights in WHO programming. It also addresses key human rights principles, including non-discrimination. The course explains the roles and responsibilities of stakeholders, including parliamentarians, academics, and civil society, and the importance of laws and regulations to good health governance and accountability. The course was piloted in November 2014, with the participation of experts from Egypt, Jordan, Lebanon, the Occupied Palestinian Territory, and Tunisia. An adapted version is currently being rolled out in Pakistan, with national support and the assistance of multidisciplinary teams from four WHO regions. It is potentially relevant to many countries in the Eastern Mediterranean and other regions.

Lessons learned in institutional and programmatic mainstreaming

- The commitment of a key decision-maker makes it easier to integrate equity, gender and human rights in programmes and action.
- An enabling policy environment facilitates mainstreaming of equity, gender and human rights.
- Mainstreaming is more credible when supported by user-friendly operational tools.
- When creating such tools, it is important to take local and regional context into account.
- Before integrating equity, gender and human rights into WHO’s work, it is vital to
  - Strengthen staff understanding and awareness of basic concepts.
  - Strengthen the capacity of staff to integrate them in programme functions, including policy, planning and implementation cycles.
  - Develop staff skills in (inter alia) inequality monitoring, evidence-based planning, monitoring and evaluation, advocacy and communication skills, and legal action.
- Finding entry points requires judgement and an understanding of context. Equity, gender and human rights may not have the same entry points, and cannot always be addressed equally or at the same time. It is important to remain flexible and to take opportunities as they arise.
- When integrating equity, gender and human rights into policies and programmes, seek always to add value, take specific actions, and tailor guidance to the needs of the topic and the context.
- When identifying strategic entry points, consider the application of human rights instruments, especially to persons who are vulnerable and experience discrimination as a result of policies, laws or practices.
- Look for strategic entry points outside the UN system and ministries of health. Partnerships can create opportunities to mainstream and to initiate actions on equity, gender and human rights.
- Member States’ treaty obligations provide occasions to advance mainstreaming. Reports to UN treaty bodies create opportunities to collaborate practically with national health partners to promote equity, gender and human rights objectives.
- Resolutions at regional level (on the health of indigenous people, lesbian, gay, bisexual and transgender (LGBT) persons, or other under-served populations, for example) can advance mainstreaming.
- Inter-agency collaboration is fundamental to achieving an impact at global level.
2. MONITORING HEALTH INEQUALITIES
2. Monitoring health inequalities

To achieve health equity and gender equality, and fulfil the right to health, it is essential to identify health inequalities and what causes them. If we do not know which groups are disadvantaged or excluded, and why, evidence-based policies, programmes and practices cannot be designed and inequalities will not be tackled effectively.

To diagnose and treat differences of health outcomes, it is vital to identify inequalities within countries - between females and males, rural and urban populations, those with lower and higher incomes, those with and without education, those who are older and younger, etc. National averages are important for monitoring overall progress but do not provide information that makes it possible to understand differences in health outcomes at country level. Because equity-oriented health information systems are essential for monitoring health inequality, this work stream is dedicated to their national development and reinforcement.

35 countries received direct technical support from WHO to strengthen the collection and analysis of disaggregated health data.\(^{13}\)

WHO has promoted action to achieve health equity for many years and its importance has increasingly been recognized, notably in the post-2015 sustainable development agenda. Monitoring health inequality helps to measure progress towards health equity by disaggregating and analysing health data, taking account of social, demographic, economic and geographical factors. The information that monitoring generates can in turn sharpen efforts to remedy health inequalities through policies and programmes and other public and private action.

Within WHO, health inequality monitoring is led by the Information, Evidence and Research (IER) department. In 2014-2015, the HSI department in coordination with the GER team developed several tools that increase access to disaggregated data and assist health inequality monitoring. The tools enable WHO staff and Member States to run equity analyses, interpret equity data, and use the findings to set health priorities. They can also assist equity-oriented health information systems to develop strong global and national monitoring systems and evaluate their performance with a high degree of accountability and transparency.

\(^{13}\) Bahamas, Bangladesh, Belize, Bhutan, Cambodia, Chile, China, Colombia, Comoros, Costa Rica, Cuba, Egypt, Ethiopia, Honduras, India, Indonesia, Iran (Islamic Republic of), Iraq, Jordan, Lao People’s Democratic Republic, Malawi, Maldives, Mauritania, Mexico, Mongolia, Morocco, Myanmar, Nepal, Peru, Saudi Arabia, Sri Lanka, Thailand, Timor-Leste, Viet Nam, Zambia.
The National Institute of Public Health in the Republic of Macedonia has modified its monitoring system to include equity stratifiers.

The *Monitoring health inequality: an essential step for achieving health equity booklet*\(^4\) makes the case for health inequality monitoring and argues that resources should be invested to strengthen its development. The booklet has four main messages, with supporting examples; the video asks, and answers, key questions. Both are easily accessible to a general audience and to policymakers, health organizations and foundations that have no prior experience of inequality monitoring.

The *Health Inequality Monitoring E-Learning Module*\(^5\) is a four hour course of eight lectures that can be completed at the learner’s own pace. It discusses inequality monitoring in a range of settings and health contexts, touching on health indicators, equity stratifiers, data sources, and reporting, among other topics.

The *Health Equity Monitoring database*\(^6\) , *theme page*\(^7\), and *Equity Country Profiles* are platforms for supporting global and national health inequality monitoring. Updated annually, the database includes more than 30 reproductive, maternal, newborn and child (RMNCH) indicators from 94 countries as well as equity country profiles on 86 countries. The profiles allow disaggregated data from a country to be compared across indicators and over time, and can be customized (by dimension of inequality, indicator, and survey). The information can support efforts to evaluate the impact on disadvantaged subgroups of policies, programmes, and practices. The theme page highlights information generated by the database, using interactive visuals and featured stories, and provides entry points into the database for technical and non-technical audiences.

The availability of disaggregated data comparable across countries led WHO to prepare *State of inequality: reproductive, maternal, newborn, and child health*.\(^8\) This report showcases best practices in reporting health inequality in low- and middle-income countries, and innovative ways to explore inequality data, including interactive visuals and video clips. It was written primarily for those with basic skills in interpreting health-related data, but specialized knowledge about health inequality is not required. Its content and principles have relevance to all those interested in health inequality monitoring, health data communication, the novel application of interactive technologies, and RMNCH inequality.

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\(^5\) WHO, *Health Inequality Monitoring E-Learning Module* extranet.who.int/elearn/course/category.php?id=15
\(^6\) WHO, *Health Equity Monitoring data repository* apps.who.int/gho/data/node.main.HE-1540?lang=en
countries/en/
State of inequality: reproductive, maternal, newborn and child health

State of inequality explores RMNCH health indicator data from 86 low- and middle-income countries. It is unique in permitting the data to be compared across countries and over time. Inequality assessments should consider the current state of inequality and change over time. Highlighted health inequalities include:

- Women with no education use modern methods of contraception least.
- The proportion of births attended by skilled health personnel generally rises with economic status.
- Health care for children with pneumonia symptoms is sought more often in urban than rural areas in three quarters of low- and middle-income countries.
- Subgroups without education tend to have the highest prevalence of stunting in children under five.

The report disaggregates data in terms of economic status, education level, place of residence, and sex, revealing consistent differences between population groups along these dimensions. Without disaggregation, these inequalities would not be visible. Health data can equally be disaggregated along other dimensions, such as age, race/ethnicity, religion, subnational region, etc.

Ethiopia, Malawi and Zambia include gender indicators in their health management information systems.

To facilitate effective use of the tools, the IER department in coordination with the GER team organized regional workshops and four training-of-trainers events to build the capacity of Member States in health inequality monitoring. Hosted in four regions (the Americas, South-East Asia, Eastern Mediterranean, and Western Pacific), the workshops explored equity analysis and interpretation of equity data, developed skills relevant to health inequality monitoring systems at national level, and improved the participants’ capacity to monitor and address changes. Trainers were taught how to apply the workshop materials in their own workshops and educational events. The participants came from different countries in each region, and included officials from ministries of health.

To make it locally accessible, WHO’s regional offices for the Eastern Mediterranean and the Americas translated the handbook on health inequality monitoring\(^\text{19}\) into Arabic and Spanish.

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\(^{19}\) WHO, Handbook on health inequality monitoring with a special focus on low- and middle-income countries, (Geneva, 2013).
Health inequality monitoring is an essential step towards achieving health equity. Robust analysis of health data permits global and national stakeholders to understand the social contexts in which health programmes operate and what must change to achieve better health for all. Those responsible for health policies and programmes cannot establish whether any subpopulations are left behind unless they disaggregate health data, using a range of variables, and analyse the results in terms of equity.

Lessons learnt in health inequality monitoring

- Health inequality monitoring has broad application and is relevant to many aspects of health.
- It requires specific competencies and skills.
- To transfer skills sustainably, it is best to identify candidates for training who are in a position to apply the skills they learn directly in their work.
3. ASSISTING COUNTRIES TO LEAVE NO ONE BEHIND

WHO/Carlos Jasso
3. Assisting countries to leave no one behind

The UN 2030 Agenda for Sustainable Development (A/RES/70/1, adopted in 2015) outlines 17 Sustainable Development Goals (SDGs). Building on the Millennium Development Goals (2001-2015), it provides a new backdrop for WHO’s mainstreaming of equity, gender and human rights. Of particular relevance are WHO’s support to Member States to meet the targets of SDG Goal 3 (on health and well-being), and the role of equity, gender and human rights in achieving the targets of SDG Goal 5 (on gender equality) and SDG Goal 10 (on reducing inequality in and among countries).

As a result of WHO’s technical support, 46 countries in all WHO’s six regions have made their national health policies, plans and laws more equitable, gender responsive, and aligned with human rights.

National health programmes aim to ensure that no one is left behind. However, many struggle to identify the subpopulations that fail to benefit, the barriers that prevent people from remaining healthy or obtaining health care, the reasons for those barriers, or the actions that can be taken to remove them. As Member States advance towards the objectives of UHC and SDG health-related targets, WHO’s GER staff (at all levels) assist them to develop health policies, strategies, plans and laws that are gender responsive, enhance equity, and are human-rights focused. Country-level support works on disease and condition specific programmes as well as to strengthen health systems, reflecting the priorities and concerns of Member States.

The Maternal Mortality Commission in the Ministry of Health of Costa Rica now lists human rights violations and gender among the parameters that explain maternal deaths.
The provision of technical assistance to a Member State is led by the local WHO country office. It is supported by the regional office and can receive technical assistance from headquarters if required. The GER team in Geneva contributes to this work by developing methodologies for delivering planned technical assistance.

With technical support from WHO’s Regional Office for Europe, the Republic of Moldova began work in June 2014 to integrate gender, equity and human rights into its national child and adolescent health strategy.


During 2014-2015, GER and SDH teams jointly developed Innovat8, a methodology that assists national health programmes to analyse how far they address equity, social determinants of health, gender and human rights, and to fill any gaps found. The methodology has been piloted in several countries in partnership with regional and country offices.

The GER and SDH teams at WHO headquarters are assisting eight countries, territories and areas to review the degree to which their health programmes address equity, social determinants of health, gender and human rights.

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22 Albania, Indonesia, Kosovo, Morocco, Nepal, Romania, Slovakia, Ukraine.
The Innovat8 methodology and other tools that WHO is developing to support GER mainstreaming can be adapted and applied across regions, countries, and different technical programmes. This flexibility made it possible to apply the methodology in Albania, Kosovo23, Morocco, Nepal, Romania, Slovakia, and Ukraine. In these countries, national teams are currently reviewing their health programmes to make sure that no groups have been excluded.

Mozambique, Rwanda, United Republic of Tanzania and Zimbabwe have integrated equity, gender and human rights into their national health plans.

Moving towards health equity: a successful initiative in South-East Asia

In collaboration with WHO, the Government of Indonesia employed the Innovat8 methodology to review how national neonatal and maternal health action plans could better address equity, human rights, gender, and social determinants. With a GER team from all three levels of WHO, the Government formed review teams composed of staff from the Ministry of Health, subnational authorities, research institutes, nongovernmental organizations (NGOs), and multilateral agencies. Nearly 40 people were trained in the methodology.

After completing a diagnostic checklist, the teams identified equity, gender and human rights concerns and social determinants relevant to different aspects of care, and met again to review the findings, which showed that disadvantaged subpopulations (notably poor, uneducated families from the eastern provinces and residents of Papua) are less able to benefit from or access neonatal and maternal health programmes. The findings, and the review team’s emerging recommendations on how to overcome inequities, are being integrated in Indonesia’s neonatal and maternal health action plans.

Opportunities also exist to mainstream equity, gender and human rights in conflict and emergency settings. These drastically increase the vulnerability of populations to illness, injury and disease and, irrespective of the hazard, disproportionately affect poorer and marginalized groups. The Human Rights up Front initiative (HRuF) works to ensure that the UN respects its mandate to protect, promote and fulfil human rights and prevent serious violations of human rights and humanitarian law. A response to the UN system’s failings in Rwanda and Srebrenica, HRuF candidly informs national authorities, UN agencies and regional organizations of rights’ violations, leverages capacity and develops coherent strategies for remedial action, helps countries to implement strategies, and (importantly) publicly raises issues of concern.

Protecting the right to health during a crisis: a successful initiative in Europe

The GER team sponsored the participation of WHO’s Deputy Representative for Ukraine in a HRuF training in January 2014. More than one million people were internally displaced by the crisis in Ukraine, many of whom belonged to minority groups and were vulnerable to human rights violations, including violations of the right to health. Anxious to ensure that health services were maintained in affected and remote areas, WHO’s country office responded through the HRuF initiative, enabling it to navigate a passage between the different factions and reach those who were most at risk and in need.

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23 For the purposes of this publication, all references to ‘Kosovo’, including those in the reference list, should be understood to refer to ‘Kosovo’ (in accordance with Security Council resolution 1244 (1999)).
Protracted violence and conflict in Ukraine meant that many people were unable to access health care. Its overstretched health systems faced unprecedented constraints in terms of staff and medical supplies. Under HRuF, WHO trained health monitors, reported violations in conflict zones, contributed to casualty recording, and deployed mobile clinics and outreach programmes to reach affected populations. It shared information on violations with the Office of the High Commissioner for Human Rights (OHCHR) and the Office for the Coordination of Humanitarian Affairs (OCHA), strengthening the UN’s overall response. Human rights protection requires all UN entities to act collectively to prevent and respond to violations of all types of human rights, including economic and social rights.

Many GER regional staff also work on violence against women (VAW), in coordination and partnership with the Department of Reproductive Health and Research (RHR) at WHO headquarters. According to global estimates, more than a third of all women experience physical or sexual violence by a partner or sexual violence by a non-partner in the course of their lives. Countries are increasingly requesting technical support from WHO to strengthen the ability of their health systems to identify and address VAW.

Thirty-six countries strengthened the health sector response to violence against women with WHO support.24 Recognizing VAW’s impacts on physical and mental as well as sexual and reproductive health, the Sixty-seventh World Health Assembly adopted resolution WHA67.15, which calls on Member States to strengthen the capacity of their health systems to address VAW and provide effective and appropriate support to survivors. **Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines advises** health-care professionals on how to recognize signs of VAW and respond to it safely and appropriately.25

**WHO’s country office helps Afghanistan prepare VAW treatment protocols**

Although men and boys can also be victims of gender-based violence (GBV), research in Afghanistan shows that women are particularly affected. More than 80% experience at least one form of domestic violence and over 60% multiple forms of violence.26 VAW in Afghanistan includes domestic violence, sexual violence and rape, ‘honour’ killings and violence associated with other harmful traditional practices.

WHO’s Country Office in Afghanistan has worked closely with the Ministry of Public Health (MoPH) to strengthen the health system in this area. In 2014, Afghanistan launched the first country-specific health treatment protocol for VAW. Developed in collaboration with UN Women, it is derived from **WHO’s Responding to intimate partner violence and sexual violence against women.**

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The WHO Country Office gender focal point and MoPH have a strong record of successfully implemented gender initiatives and their relationship was vital to the protocol’s creation. Since 2006, Afghanistan’s gender in health and development programme has supported the development of MoPH’s gender policy, and integration of gender in health services and the health information system.

More than 6,000 health-care providers (including doctors, nurses and midwives) will be trained in GBV care in the next five years through a project supported by the United States Agency for International Development and the Italian Government. The protocol is a major step forward in building the capacity of the Afghan health sector to manage VAW effectively and will have a positive impact on the lives of women and girls.

**Lessons learned from cooperative efforts to leave no-one behind**

- To ensure that mainstreaming of equity, gender and human rights in the health sector is sustainable, Governments must own them. Activities should fit their structures.
- Identify ‘power brokers’ in health ministries and involve them from the start.
- The involvement of donors in undeveloped areas (such as VAW or gender inequality) can trigger institutional change at country level.
- Equity, gender and human rights mainstreaming is more likely to succeed when there is inter-departmental collaboration and ownership.
- UN efforts to end health and human rights violations are most credible and effective when all UN agencies adopt a consistent approach.
REFLECTIONS ON THE 2014–2015 BIENNINUM
Reflections on the 2014–2015 biennium

In 2014-2015, the GER programme significantly advanced institutional mainstreaming of equity, gender and human rights at all levels of WHO. It helped create and strengthen structures and mechanisms that enable programmatic mainstreaming to succeed. It provided technical support to countries that strengthened gender-responsive, equity-enhancing, and rights-based policies, strategies, plans and laws. 39 countries reformed their structures or processes as a result. These achievements reflect the hard work of WHO staff and partners. Their dedication, and the lessons learned during the biennium, will guide future work and provide a strong foundation for the next phase of action in the SDG era.

It is clear that the commitment and support of key decision-makers helped create the conditions for dialogue and integration of equity, gender and human rights. This is true at all levels of WHO, particularly at headquarters, where the support of decision-makers triggered a shift in organizational culture.

It is equally evident that a positive policy environment opened the way for equity, gender and human rights mainstreaming, notably at programme level. WPRO responded to the SDGs by creating an action framework to help countries realize universal health coverage, creating an opportunity for GER regional staff to contribute advice on how to include accountability, participation, gender, and equity. The framework was endorsed in 2015.

A third key lesson is the importance of recognizing opportunities and strategic entry points. The GER team has set a target: to increase from ten (2015) to fifteen (2017) the number of WHO programme areas that integrate equity, gender and human rights. To take advantage of opportunities, in addition, it is essential to be able to offer user-friendly and operational tools. The development of these was a major focus of the GER team’s work in the 2014-2015 biennium.

Resources and tools strengthen the technical support that WHO can provide; but they also create demands for capacity-building. GER staff at all three levels facilitated skill-building workshops this biennium. These confirmed that for both WHO staff and partners it is essential to reinforce the skills acquired by putting them quickly into practice. This was true in both Indonesia and Nepal, where GER teams trained health officials, research staff and NGOs in the Innovat8 methodology. Giving skills to the right people promotes sustainable change. The GER team will apply this insight in the next biennium, when it aims to increase from 63 (2015) to 84 (2017) the number of countries in which at least two WHO-supported activities promote equity, gender and human rights in health policies and programmes.

Most important, the GER team learnt in the 2014-2015 biennium that mainstreaming equity, gender and human rights is more successful when those involved coordinate in a spirit of partnership. AMRO/PAHO prepared a valuable thematic paper on the health of indigenous people after participating in the IASG on Indigenous Issues. WHO’s strong rapport with Afghan health officials underpinned the development of Afghanistan’s new VAW health treatment protocol. Coordination and collaboration - with Government counterparts, WHO departments, UN agencies, and partners outside the UN system - are crucial to the success of mainstreaming initiatives.

The GER programme is in a position to make an increasing impact at all levels of WHO and, most important, in countries on the ground. It can already show a number of accomplishments. It has mainstreamed equity, gender and human rights in several WHO institutional and programme mechanisms, has contributed to
health inequality monitoring and evidence-based health policies, and has influenced the direction of plans, laws and programmes in a number of Member States. As the focus shifts to the SDGs, where equity, gender equality and human rights are prominent, the GER team is well-placed to assist countries to meet their targets, so that no one is left behind.
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In 2012, the Director-General of the World Health Organization (WHO) established the Gender, Equity and Human Rights (GER) team in the Family, Women’s and Children’s Health (FWC) Cluster. Drawing on the support of a network of committed staff at headquarters and at regional and country level, its purpose is to catalyse, support and coordinate institutional mainstreaming of equity, gender and human rights at all levels of WHO. The team’s corporate four year strategy, the Roadmap for Action 2014–2019, identifies three principal pillars of work: institutional mainstreaming; health inequality monitoring and data disaggregation; and country support. This progress report highlights advances made in each of these areas during the 2014–2015 biennium.