Washington D.C.,

 February, 2009

**STRATEGY ON INTEGRATING GENDER ANALYSIS AND ACTIONS INTO THE WORK OF THE PAN AMERICAN HEALTH ORGANIZATION/ WORLD HEALTH ORGANIZATION**

**Monitoring and Evaluation Baseline Assessment**

**Prepared for the Pan American Health Organization,**

**Regional Office of the World Health Organization**

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**Executive summary**

 The **purpose** of this baseline assessment was to collect a minimum data set which reflected the current status for implementing the four strategic directions (SD) of the World Health Organization (WHO) Gender Strategy (2009-2013). The assessment forms part of a long term plan for evaluating the progress of mainstreaming gender within all the offices of WHO: Headquarters (HQ), as well as its four regional offices: of the Americas (AMRO/PAHO), Europe (EURO), Africa (AFRO), Asia Pacific (APRO), and Western Pacific (WIPRO). The evaluation includes three phases: the baseline to be finalized in 2009, a midterm assessment in 2010, and the final evaluation in 2013. This baseline will also apply to monitoring the progress on implementing the Pan American Health Organization’s (PAHO) Gender Equality Policy (2005) and its Action Plan (2009-2013), as part of the WHO strategy, and is expected to contribute to identifying actions needed to strengthen the implementation of the WHO and PAHO gender policy and strategy.

 The **specific objectives** of this baseline were the following:

* Assess the institution wide capacity for gender analysis and actions (SD1).
* Gauge the extent to which PAHO/WHO’s management has integrated gender (SD2) in: strategic and operational planning and programme cycle processes; Country Cooperation Strategy (CCS) and country work plan documents; and achievement of sex parity in staffing.
* Map the extent to which key PAHO/WHO publications promote and use sex-disaggregated data (SDD) and gender analysis (SD3).
* Weight-up senior management (Director General/Regional Directors) commitment to the promotion of gender equality, by examining their speeches (SD4).

 The **scope** of this document is limited to the assessment of the current situation of gender mainstreaming in PAHO, the WHO Regional Office for the Americas which was founded in 1902, is composed of 46 Member States and territories, and has approximately 889 staff members. The report is **intended** to support the WHO and PAHO Directors to report on the progress on implementing the gender policies and strategies to the Governing Bodies, while providing direction to all those accountable for the implementation of these mandates, including all managers, the global WHO Gender, Women and Health (GWH) network, and the PAHO Gender, Ethnicity and Health (GE) network in HQ and countries. In the interests of transparency and of sharing its informative results, this report will be made available to all WHO and PAHO staff.

The **methodology,** shared by all WHO Regions and HQ, employed a mix of qualitative and quantitative methods including an all-staff E-survey, interviews with planning focal points from selected departments, review of staffing data, and content analysis of selected countries CCS and BWP, key PAHO/WHO publications, and Director’s speeches. All these methods were pretested in PAHO on February 2008. The interviews and analyses were carried out by regional consultants during 2008, and the report was finalized in 2009, after consultations with representatives of each region.

 **Key findings**

 **1. Staff capacity for gender mainstreaming (SD1):** The assessment tool was an email survey sent to all WHO staff, to which the PAHO *response rate* was44%, well above the 25% average reached by all WHO staff. Approximately, **nine** **out of each ten PAHO** staff members were aware of WHO and PAHO gender policies**, six** had knowledge of basic gender concepts**, six** felt that gender was relevant to their work, **four** applied this knowledge to their work, and **four** acknowledged having received institutional support for doing so. Statistically significant differentials were recorded between professional **(P)** and general service **(G)** staffregarding perceived gender relevance, application of gender concepts, and institutional support received for gender mainstreaming. Differentials by WHO Region were also significant, with PAHO ranking 1st and 2nd among all Regions for most indicators.

A primary determinant of the gap between gender knowledge and its application to work was reportedly the **lack of specificity** of this knowledge with respect to staff’s current work areas. Respondents identified the availability of information and hands-on technical collaboration **tailored** to specific areas of work as the main ***facilitating factors*** of gender integration. PAHO staff responses coincided with those from the other Regions***.*** Accordingly, the types of ***institutional support* pointed out *as most needed*** to advance gender mainstreaming referred to facilitating the development of *knowledge* and skills, the creation of ***area-specific*** *gender data/evidence,* and the s*ustained technical collaboration from the* ***Gender unit and country focal points.***

 **2. Gender integration into the mainstream of PAHO’s programme management (SD2):**

 **(a) Operational programming cycle:** Twenty one planning officers selected from PAHO/HQ and CO were interviewed on the extent that gender was integrated into theplanning, implementation and monitoring/evaluation phases of this cycle. 39% reported that gender was **strongly integrated** in the **planning** phase, a proportion slightly above the WHO overall average (37%). However, no strong integration was reported in PAHO for the implementation and evaluation phases, whereas the WHO respective proportions were 6% and 2%. **Moderate** scores were reported by 65% and 19% of PAHO planners for the **implementation** and **evaluation** phases, respectively.

 **(b)** **Country cooperation strategies (CCS) and corresponding biennial work plans (BWP):** The CCS and BWP of two countries were selected for content analysis: Honduras and Trinidad and Tobago: the former had a long collaboration history with the PAHO Gender network, the latter had none. Both countries’ CCS and work plans scored only **medium** values of gender integration. In both CCSs Gender related policy statements were too broad to have empirical footing, whereas in the BWPs, gender actions were too restricted to permeate the mainstream of technical cooperation in the countries. The effect of having had a direct collaboration with the PAHO Gender network (that included national gender focal point), was reflected in the Honduras work plan with specific expected results. Gender-based violence was the issue most visibly mainstreamed in both countries.

 **(c)** **Sex parity in PAHO staffing:** The analysisdealt with two broad dimensions: all active staff at December 31, 2007, and new appointments that occurred during the same year. Among**all staff,** women comprised **60%** of the total, **41%** of International Professionals, **70%** of National Professional Officers, **80%** of General Service staff, **59%** of long-term appointments, and **60%** of temporary recruitments. In other words, women outnumbered men in all examined categories, except one*: international professionals (P).* Within Ps, women outnumbered men in the two extremes of the scale: in the two lowest grades (P1 and P2) and in the top managerial positions (UG) - Regional, Assistant, and Deputy Directors—all occupied by women. However, women were underrepresented at professional ranks higher than P2, among Ds and long-term professionals. Regarding **new appointments,**women predominated in all categories except P at the country level and long- term contracts. Although overall **professional** **sex parity was reached at PAHO/HQ,** women made up only 30% of P staff at country offices (CO). P4 stood out as the rank with the lowest female representation both, among all active staff and new appointments in 2007.

 **3. Promoting or using sex-disaggregated data and gender analysis (SD3):** Two of thefour types ofsampled documents promoted/used SDD and strongly promoted/used gender analysis. Acontent analysis of the four types of publications indicated a wide variation in this respect among the selected documents, and even among sections of the same document. The overall scores fluctuated between *high* for the **“evidence”** type publication and the Regional Volume 1 of the **“seminal”** PAHO’s flagship publication “*Health in the Americas 2007;* *medium* for the Countries Volume 2 of the same publication; and *low* for two very important “**policy”** and **“normative”** documents.

 **4. Establishing accountability from the Senior Management (SD4):** The selected indicator was reflection of gender in selected speeches given by the PAHO Director in 2007. The content analysis indicated that eight of the nine sampled speeches/presentations included references to gender. These references were more frequent in wide-scope than in issue-specific presentations.

**Conclusions**

 1. The analysis revealed two major types of gaps: ***first,*** between knowledge and actual application regarding the promotion of gender equality in the work of PAHO; and ***second,*** between HQ and CO with respect to gender integration in key documents, and sex parity among professional staff. A third gap was inferred between P and G staff in matters of application of gender concepts to work. Although the E-survey did not directly address G staff functions and responsibilities, the significantly lower response from Gs to the survey, coupled with the fact that the official PAHO planning guidelines explicitly excluded administrative entities from having to integrate cross-cutting issues (gender equality among them) into their work, warrant further consideration.

 2. The planning phase was reportedly, the most strategic for gender integration within the programming cycle process. “Genderless” implementation and evaluation, particularly the latter, were linked to genderless indicators, guidelines and situation analysis at the planning stage. The absence of official feedback and, particularly, the perceived **lack of** **accountability** regarding gender integration were highlighted as critical challenges throughout the programming process. Clearly, gender integration in the accountability processes of monitoring/evaluation was deemed the weakest phase of the cycle in PAHO and all of WHO.

 3. Although gender equity concerns played a role in the CCS and BWP documents of the two sampled countries, these documents did not reflect WHO and PAHO directives on gender as a **cross-cutting issue** in country programming. Aside from lacking a gendered situation analysis providing base to related actions, these documents revealed a disconnect between broad-spectrum policies and concrete activities in the mainstream of technical cooperation in the country.

 4. While PAHO had achieved sex parity in P staffing at HQ level, challenges remain in attaining parity at country level and in some P categories. **P4 stands out as the most unequal P grade,** issue of utmost importance for sex parity since this P4 grade comprises half of all P staff and represents the main pool for promotion at managerial levels.

 5. The wide variation in the use and promotion of SDD and gender analysis in the key sampled documents and Director’s presentations, constitutes a reflection of the varying degrees of gender integration in the managerial and technical work of the different regional units and country offices.

 6. The role of the PAHO Gender network (Regional Unit and country focal points) appeared central to the mainstreaming process. Not only it was explicitly acknowledged by surveyed and interviewed staff, but its influence was evident through the analyzed CCSs, work plans and key documents in whose preparation this network collaborated.

 7. Overall, the results of this assessment (in PAHO and of the other regions) coincided to indicate that awareness and even “knowledge” of wide-ranging gender mandates and concepts--of the type transmitted through one-time workshops or a set of tools and guidelines--, seemed to act as “entry points”, at best, but not as drivers of gender mainstreaming. A need was made clear for **sustained and tailored** **technical collaboration** tobuild and apply knowledge that emphasized the use of participatory, **bottom-up** rather than conventional **top-down** approaches.

 8. Most importantly, the results confirmed that while knowledge is obviously necessary, the commitment and active support of managers is essential to drive the mainstreaming process and ensure its sustainability and accountability.

**Main recommendations**

 1. Build capacity through processes that go beyond *across-the-board* gender “training”, towards **participatory** assembling of conceptual frameworks, evidence and toolsthat are **focused** onspecific work areas. Collaborative work with the other PAHO six cross-cutting themes should have a multiplier effect. Specific training for managers in HQ and CO seems critical.

 2. Strengthen collaboration between the Gender Network and key PAHO Offices, among them, *Planning and Program Budget, Country Support, Human Resources Management, Governing Bodies, Health Analysis,* and the *Assistant* and *Deputy Director’s,*for the purposes of designing and applying gender-sensitive **guidelines** to planning, evaluation and document production, as well as effective **incentives, feedback** and **accountability mechanisms** for gender integration.

 3. Ensure the active participation of the GE network (regional and country focal points) in the planning and monitoring/evaluation phases of the programming cycle. And aim--through different avenues-- to broaden the availability of gender expertise throughout the Organization.

 4. Engage the Staff Association in placing gender mainstreaming in the context of administrative concerns and internal human resources policies.

 5. Give special consideration to the recruitment and promotion of women into the P4 grade within the context of Career Development in the Human Resources Development Plan.

  **I. INTRODUCTION**

This report presents the baseline assessment of the extent to which gender is integrated into the work of the Pan American Health Organization (PAHO). This assessment was carried out as part of the World Health Organization (WHO) coordinated effort to set evaluation and monitoring parameters for its recently approved Gender Integration Strategy (2008-2013). The assessment forms part of a long term plan for evaluating the progress of mainstreaming gender within all the offices of WHO: Headquarters (HQ), as well as its four regional offices: of the Americas (AMRO/PAHO), Europe (EURO), Africa (AFRO), Asia Pacific (APRO), and Western Pacific (WPRO). The evaluation includes three phases: the baseline to be finalized in 2009, a midterm assessment in 2010, and the final evaluation in 2013.

For PAHO, this baseline has the added value of providing the evaluation and monitoring basis for the implementation of its own Gender Equality Policy, approved by its Member States in 2005, as well as key elements to guide its proposed action plan (2009 – 2013). This policy forms part of the WHO gender policy and mainstreaming strategy.

PAHO, founded in 1902, is the oldest international public health agency in the world. It performs the double role of serving as the Regional Office for the Americas (AMRO) of the World Health Organization within the United Nations system, and the specialized agency for health within the Inter-American System.

The PAHO Region is composed of 46 countries and territories encompassing North, Central and South America as well as the Caribbean Islands. As of December 31, 2007, the total number of all PAHO staff was 889, of which 527 were women. From its headquarters in Washington, D.C., PAHO directs the scientific and technical efforts of experts in 27 country offices and in seven scientific centers. PAHO's annual budget for its core programs totals about $180 million, largely from assessed contributions paid by Member Governments. In addition, PAHO receives financial support from WHO/Geneva, other contributing countries, foundations and the private sector. PAHO’s Governing Bodies comprise [the Pan American Sanitary Conference](http://www.paho.org/english/gov/csp/govbodies-CSP.htm), [the Directing Council](http://www.paho.org/english/gov/cd/govbodies-CD.htm), and the [Executive Committee](http://www.paho.org/english/gov/ce/govbodies-CE.htm), all composed by representatives of its 46 Member States.

**1. Purpose and objectives of the Baseline**

The purpose of the baseline assessment is to collect a minimum data set which reflects the current status for implementing the four strategic directions (SD) of the WHO Gender Strategy (2008-2013).

SD 1: Building the capacity for gender analysis and planning

SD 2: Bringing gender into the mainstream of WHO’s programme management

SD 3: Promoting the use of sex-disaggregated data and gender analysis

SD 4: Establishing accountability

It is the preliminary step in identifying where strategic actions to strengthen the implementation of the Gender Strategy are needed and for measuring progress throughout the strategy period. Its specific **objectives** are:

1. To assess the institution wide capacity for gender analysis and actions (SD1).
2. To determine the extent to which PAHO/WHO’s management has integrated gender (SD2) in the following areas: (a) strategic and operational planning and programme cycle processes; (b) Country Cooperation Strategy (CCS) documents and country work plans; and (c) achievement of sex parity in staffing in 2007.
3. To map the extent to which key PAHO/WHO publications-- including tools and guidance documents, Governing Bodies publications, and evidence-based publications-- promote and use sex disaggregated data (SDD) and gender analysis (SD3).
4. To assess the accountability of senior management (e.g. Director General/Regional Directors) in PAHO/WHO to supporting gender equality, by examining whether their speeches reflect commitment to gender equality (SD4).
5. **Intended audience of the report**

This report is intended to support the Director General to report back on the WHO Gender Strategy to the World Health Assembly in May 2009, as well as to provide baseline information for those who are accountable for the implementation of the WHO Gender Strategy, that includes the PAHO Gender Equality Policy and its Plan of Action. This pertains to the Regional Directors, ADGs, Managers of WHO and PAHO programmes and units, the global Gender, Women and Health (GWH) network, and the PAHO Gender network at regional and country levels--to help them take appropriate actions. In the interests of transparency, as well as of providing general information, this report will be made available to all WHO and PAHO staff.

**II. METHODOLOGY**

1. **Assessment design**

The baseline assessment measures where PAHO/WHO currently stand in integrating gender analysis and actions into their work, with respect to the four strategic directions outlined in the WHO gender strategy. The methodology employed a mix of qualitative and quantitative methods including an all staff E-survey; interviews with planning focal points from selected departments; and content analysis of key PAHO/WHO publications, work plans and Director’s speeches. A summary of the sampling methods and instruments used to gather and analyze data are summarized below by each strategic direction and detailed in the report’s annexes, along with the ethical considerations and methodological limitations of the methodology,

The tools for data collection and analysis were pre-tested in the PAHO regional office in January-February 2008 and the results of the pre-test were used to refine them. The consultants participated in a week long orientation workshop held at WHO Headquarters, with members of GWH network and Gender Regional Advisors (RA) who played a key role in helping the consultants understand the role and contributions they make to facilitating gender mainstreaming in their region, how they collaborate with the various technical areas and country offices.

**SD 1: Building the capacity for gender analysis and planning:**

An online survey was conducted to measure SD1 with indicators: 1.1, 1.2, 1.3 described below. This survey included questions to assess staff knowledge, awareness and practice of gender analysis and actions in their daily work, and was sent to all PAHO/WHO staff in countries, headquarters and special programmes or inter-country team offices via email notifications sent from the PAHO Director.

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|  | **Indicator** | **Definitions & notes** |
| 1.1 | Level of staff **understanding** of gender*Overall indicator*: Percentage of all PAHO/WHO staff (by sex, WHO category (P, D, G), WHO level (HQ, Regional Office, Country Offices[[1]](#endnote-2)) who have a basic understanding of gender and health;*Sub Indicators:*  i. Percentage of all PAHO/WHO staff who report awareness of **at least one** WHO gender policy or strategy ii. Percentage of all PAHO/WHO staff who report **good knowledge** of gender concepts.iii. Percentage of all PAHO/WHO staff who says **yes that gender is relevant to the work of unit**.iv. Percentage of all PAHO/WHO staff who says **yes that gender is relevant to their own work.**  | **Basic understanding** of gender and health is defined along three dimensions:**a.** **Awareness** of at least one WHO gender policy or strategy of at least one of the four WHO gender policies or strategies identified in the all staff survey questions (see annex 1 for details).**b. Knowledge of gender concepts** classified as no knowledge, some knowledge and good knowledge based on scores to the 4 knowledge questions in the all staff survey. A score of 3 or 4 (i.e. correctly answering at least 3 out of 4 knowledge questions) is considered as having good knowledge. **c. Relevance of gender** to their own work and to the work of their unit classified into yes, no and don't know in response to two questions in the all staff survey. |
| 1.2 | Application of gender analysis and actions to staff work *Indicator:* Percentage of all PAHO/WHO staff who is **at least moderately applying gender analysis and actions** in their work (disaggregated by sex, WHO grade, WHO level & WHO region).  | Application of skills in gender analysis to his or her work is measured on a scale of none, some, and moderately strong application. These are based on 11 questions (see annex 1 for more details) with scores ranging from 0 to 11. Those who score 6 to 11 points are classified as at least moderately applying gender analysis. |
| 1.3 | Level of Institutional support for gender mainstreaming *Indicator:* Percentage of PAHO/WHO staff who **reports at least some institutional support** for integrating gender into their work (disaggregated by sex, WHO grade, WHO level & WHO region).  | Institutional support is measured on a scale of none, some, and strong institutional support. This is based on 4 questions (see annex 1 for more details) with scores ranging from 0 to 4. Those who score 1 to 4 points are categorized as reporting at least some institutional support. |

(See Annex 1 for details)

***SD 2: Bringing gender into the mainstream of PAHO/WHO’s programme management***

To gauge to what extent Planning Staff included gender in planning instruments, face-to-face and phone interviews were conducted with 21 selected planning focal points[[2]](#footnote-2) . These 30 – 60 minute interviews were conducted to measure indicators 2.2 and 3.3 below, and focused on how gender was incorporated during the operational planning for the Medium Term Strategic Plan (2008-2013), the implementation of the 2006-2007 biennial work plan, and the monitoring and evaluation of work plans for 2006-2007. PFP were selected among PAHO managers at HQ and two were selected PAHO Country Representatives (PWR).

Indicators for sex parity in staffing are detailed in 2.4 and 2.5 in the table below. Data to measure sex parity was provided by WHO Department of Human Resources and Development (HRD); PAHO also obtained additional data its own HRD. Data on sex parity was considered until December 31 2007.

To understand how gender was reflected in Country Cooperation Strategies (CCS) and country work plans, content analysis of these two documents was conducted, as described in Annex 4. The CCS serves as the framework to guide collaborative planning between PAHO/WHO and its Member States. The country work plans were included as a proxy to capture the extent to which the planning framework is translated into joint operational plans at the country level. These documents were randomly selected from CCS that had been completed since the approval of PAHO’s Gender equality Policy in 2005, and among countries that did and did not receive regular technical collaboration from the Gender Unit. In PAHO, Honduras was selected as the former and Trinidad and Tobago as the latter.

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|  | **Indicator** | **Definition and Notes** |
| 2.1 | Extent of gender integration into the operational planning and programme cycle processes.*Overall indicator:*  Percentage of planning focal points whose responses reflect "strong" integration of gender during the operational planning and programme cycle, disaggregated by sex, WHO category (P, D, G), WHO level (HQ, Regional Office, Country Offices) and by whether or not there was collaboration with the GWH network. *Sub-indicators:* **i.** Percentage of planning focal points whose responses reflect "strong" integrating gender during the **operational planning process** disaggregated by sex, WHO category (P, D, G), WHO level (HQ, Regional Office, Country Offices) and by whether or not there was collaboration with the GWH network. **ii.** Percentage of planning focal points whose responses reflect "strong" integrating gender during **programme implementation** for 2006-2007 biennium disaggregated by sex, WHO category (P D and G), WHO level (HQ, Regional Office, Country Offices) and collaboration with GWH network.**iii.** Percentage of planning focal points whose responses reflect "strong" integrating gender during **programme monitoring and evaluation** for 2006-2007 biennium disaggregated by sex, WHO category (P D and G), WHO level (HQ, Regional Office, Country Offices) and collaboration with GWH network. | Gender integration into **operational planning process** is measured on a scale of weak, moderate, and strong, The values for classifying into these three categories are derived as an index score based on questions 11 to 18 in the planning officers interview (see annex 3 for details), which ranges from 0 to 8 points. Those who score 7 or 8 are classified as indicating strong integration of gender in the operational planning process. Strong integration of gender in the **programme implementation process** is measured on a scale of weak, moderate and strong. The values for classifying into these three categories are derived as an index score based on questions 21 to 25 in the planning officers interview (see annex 3 for details), which ranges 0 to 12. Those who score 10-12 are classified as indicating strong integrating gender in the programme implementation process. Strongly integrating gender in the programme monitoring and evaluation is measured on a scale of weak, moderate and strong. The values for classifying into these three categories are derived as an index score based on questions 28 to 33 from the planning officers interview (see annex 3 for details), which range from 0 to 25. Those who score 19-25 are classified as having indicated strong gender integration for programme monitoring.  |
| 2.2 | Number of post-2005 Country Cooperation strategies (CCS) out of those sampled, that strongly integrate gender.  | As part of the document review, a series of criteria are applied (see annex 4 for details). A score of one is given to each criterion met by the document and a zero for each that is not. These scores are tallied as a simple index. A maximum score would be 9 and a minimum, 0. CCSs categorized as having strongly integrated gender would be those with a score of 7-9.  |
| 2.3 | Number of (2006/2007) Biennial Country Work Plans out of those sampled that strongly integrate gender. | Applying similar criteria (see annex 4 for details) to the review of biennial country work plans, country work plans categorized as having strongly integrated gender are those with a score of 5 or 6 |
| 2.4 | Percentage of all professional and administrative long-term and temporary posts, by sex and grade-level, cumulative at Dec 31 2007 | i.) Long-term posts or appointments refer to positions that are longer than 12 months. Temporary posts or appointments refer to positions that are 12 months or less. ii.) Grades-levels refer to: Professionals including P1-P6, D1, D2, UG; National Professional Officers - NPO including A, B, C and D; and General Service including G1-G7.  |
| 2.5 | Percentage of all long-term and temporary new appointments in 2007 by sex and category (Professional, National Professional Officers and General Service). | Explanations as above (2.4i) |

(See Annexes 2, 3 and 4 for details)

***SD 3: Promote the use of sex-disaggregated data and gender analysis***

The indicators for measuring SD3 correspond to indicators 3.1 and 3.2 that include a content analysis of selected PAHO/WHO publications and tools selected for each of the following categories: a. seminal institution-wide publications (e.g. World Health Report or Health in the Americas). b. Policy/World Health Assembly, or PAHO Governing Bodies documents. c. Evidence type (research) publication. And d. Tools/normative guidelines

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|  | **Indicator** | **Definition and Notes** |
| 3.1 | Number of new PAHO/WHO publications out of those sampled that promote or use sex disaggregated data (SDD). | Publications that promote or use sex disaggregated data are based on a series of criteria for document review that are detailed in Annex 5. These criteria are scored on the basis of a yes or no response and a tally is compiled into an index score ranging from 0 to 3. If the publication scores either 3 or 2 then it is to be considered as promoting or using SDD; if it scores 0 or 1, then it is not considered promoting or using SDD. |
| 3.2 | Number of new PAHO/WHO publications out of those sampled that strongly promote and use gender analysis in health. | Publications that promote or use gender analysis in health were compiled from a tally of yes or no responses to a series of criteria detailed in Annex 5. The scores range from 0 to 7. Documents that score 5 to 7 were classified as strongly promoting or using gender analysis. Documents that score 2-4, somewhat promoting or using gender analysis and those that score 0-1, as not promoting or using gender analysis in health.  |

 (See Annex 5 for details)

***SD 4: Establishing Accountability***

Senior management accountability was measured through indicator 4.1. which reflected the content analysis of selected speeches presented by the PAHO Regional Director in 2007.

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|  | **Indicator** | **Definition and Notes** |
| 4.1 | Number of speeches by the DG and the Regional Directors of those sampled which include at least one reference to gender. | Speeches by the DG and Regional Directors in which there is at least one reference to gender using a word search criteria of 13 words or phrases (see annex 6 for details). Speeches are to be classified as those in which there is at least one reference to gender. |

(See Annex 6 for details)

The tools for data collection and analysis were pre-tested in the PAHO regional office in January-February, 2008, and the results of the pre-test were used to refine them.

The consultants participated in a week long orientation workshop held at WHO Headquarters, in Geneva, in April 2008, attended by the Gender Regional Advisors (GRA) and members of the WHO Gender network (GWH), where the tools and methodology for the baseline were discussed, and consultants were provided with a basic understanding of WHO’s position on gender equality.

1. **Sampling and data collection tools**

 **2.1. Staff capacity on gender analysis and actions (SD1)**

An online survey was conducted to measure indicators: 1.1, 1.2, 1.3 described above. This survey included questions to assess staff knowledge, awareness and practice of gender analysis and actions in their daily work. (See questionnaire in Annex1). Since PAHO/ WHO sees gender equality as a cross-cutting issue that is the responsibility of all staff, the e-mail survey was sent to all staff at all levels of the Organization in countries, headquarters and special programmes. The questionnaire was internet accessible to PAHO staff between May 27 and June 20, 2008. The PAHO Director, Dr. Mirta Roses, sent a communication to all staff requesting their response and providing the corresponding link. This communication was followed by two e-mail reminders sent by the PAHO Gender, Ethnicity and Health Unit (GE) on June 5 and June 16.

WHO was in charge of the statistical processing of the results, prepared a standard set of tables to be analyzed by each region and ran the corresponding statistical tests of significance. The accorded level of significance was 0.05, which meant that only those associations whose probability of occurrence could be stated with a level of confidence equal or greater than 95% were to be considered statistically significant. Significance judgements were further weighted by the sample sizes falling in individual cells (Detailed information on Confidence Intervals can be found in the corresponding tables in Appendix 1).

 **2.2. Integration of gender in PAHO/WHO management: strategic and operational**

 **planning (SD2)**

Face-to-face and phone interviews were conducted with planning focal points[[3]](#footnote-3) involved in the strategic and operational planning in PAHO/WHO in 2006 and 2007. These interviews were conducted to measure indicator 2.2 and 3.3 above.

In 2006/2007, WHO transitioned to a new strategic and operational planning framework in which what was previously known as Areas of Work were consolidated into 13 Strategic Objectives (SO) for the organization. Each SO was facilitated with SO facilitator with participation of relevant departments or divisions or units at regional and headquarters level. Therefore, planning focal points also included the SO facilitators. Since the sampling frame of SO facilitators was small (in most regions and headquarters no more than 12-15), all SO facilitators were included in the sample. In addition, departments or divisions were stratified into two: those that collaborated with the gender focal points or unit in their region and those that did not collaborate in 2006-2007. Departments or divisions were randomly selected from these strata and their planning focal points (director or coordinator or designated planning focal point) were selected. In addition, two to four PAHO/WHO country offices were selected and planning focal points from the selected offices were included in the sample. In PAHO, a geographical sub regional criterion of representativeness was added in the selection of the country representatives. In each region the target sample size was 20-25 and the expected response rate was 80%.

Twenty one interviews, out of a sample of twenty nine, were conducted by the regional consultant in PAHO. Interviews were face-to-face in HQ, and by telephone in the field; they lasted 50 to 70 minutes. The interviewer used structured and open-ended questions (see Annex 3 for detailed questionnaire) that focused on how gender was incorporated into the operational planning for the Medium Term Strategic Plan (2008-2013), the implementation of the 2006-2007 biennial work plan, and the monitoring and evaluation of this 2006-2007 work plan. The selected officers to be interviewed were contacted trough e-mail by the PAHO Gender and Ethnicity Unit Chief who requested their collaboration and included the PAHO Director’s letter written in support of this initiative. The interviews were recorded on paper by the consultants, and data was entered in Datacol, an online data entry software.

 **2.3. Integration of gender in PAHO/WHO management: Integration of gender in country**

 **Cooperation Strategies (CCS) and country work plans (SD2).**

To understand how gender was reflected in Country Cooperation Strategies (CCS) and country work plans, content analysis of these two documents was conducted. The Country Cooperation Strategies serve as the framework to guide collaborative planning between PAHO/WHO and its Member States. The country work plans were included as a proxy to capture the extent to which the planning framework is translated into joint operational plans at the country level (i.e. a proxy measure, even if somewhat imperfect, to capture implementation of joint PAHO/WHO and Member States plans).

In each region, the sampling frame included CCS documents developed after 2005 that were stratified into two. The two strata for CCS included those countries where there was some collaboration with the gender focal point or unit in the PAHO/WHO country or regional office and those where there was no collaboration. From each stratum, one CCS was selected for a total of two CCS documents. The selection criteria included those that were developed after 2005 because in 2005, there was a WHO framework document guiding the development of these CCSs that explicitly mentioned gender as one of the considerations. Therefore the baseline assessment measured integration of gender in only those CCS documents that were developed after this guiding framework came into effect. The two countries selected in the PAHO Region for this analysis were: **Honduras** and **Trinidad & Tobago.** The first countryhad sustained collaboration with the gender network (country focal point and regional unit), the second had none.

**The CCSs** were analyzed using word search criteria that are detailed in Annex 4. The analysis of the CCS facilitated an examination of whether the document:

* Explicitly mentioned promotion of gender equality;
* Consulted with women’s groups and/or involved the Ministry of women’s affairs;
* promoted sex disaggregated data;
* Analyzed/interpreted the different outcomes for men and women
* Specified actions to address gender inequalities.

These criteria were coded based on a yes or no response and a score was calculated adding all the yes responses (which received a score of 1). A threshold was determined for the scores to be classified into none, weak, moderate or strong level of gender integration in the CCS (see annex 4 for details). Interpretation of how strongly the CCS integrated gender was based on these scores as well as qualitative interpretation of the content of the CCS.

**The country work plans** were analyzed using word search criteria that are detailed in Annex 4. The analysis examined whether the work plans included:

* a statement on gender equality or equity;
* specified an action, product or service for collaboration with a women’s group;
* disaggregation of data by sex;
* at least one OSER, or product, or activity, or service that specifically mentioned addressing gender.

The criteria were coded yes or no and a score was calculated by adding all the yes responses (which received a score of 1). A threshold was determined for scores to be classified into none, weak, moderate or strong level of gender integration in the country work plan (see annex 4 for details). Interpretation of how strongly the country work plans integrated gender was based on the scores and qualitative interpretation of the content of the country work plans.

 **2.4. Integration of gender in PAHO/WHO management: Sex parity in staffing (SD2)**

Indicators for sex parity in staffing are detailed in 2.4 and 2.5 in the table above. Data was considered until December 31 2007. At the global level, the information to measure sex parity was provided by the WHO Department of Human Resources and Development (HRD) that compiles this information every year for submission to the World Health Assembly. In PAHO’s case,however, the analysis was based on the PAHO Human Resources Data Base, which more accurately reflects the actual sex-distribution of PAHO staff. This decision was based on three reasons: *First* and most critical was the fact that the WHO Annual Reports covered only WHO centrally (Geneva) funded staff, thus excluding staff funded by PAHO Member States and other external sources. And, according to PAHO data base, **WHO funded staff represented less than one fourth of all PAHO personnel**: the total number of all PAHO staff, irrespective of funding sources, was **889,** while the number for the WHO funded personnel within PAHO was **211**. *Second,* WHO reports centered on long-term staff, offering insufficient information for temporary staff. PAHO data base, on the other hand, provided similar kind of information for both, long-term and temporary personnel. *Third,* substantial discrepancies between the WHO and PAHO data sets were found regarding WHO funded personnel in reference to the total and some staffing categories.

 **2.5. Promoting sex disaggregated data and gender analysis (SD3).**

The indicators for measuring this strategic direction correspond to indicators 3.1 and 3.2. The indicators were measured through a content analysis of selected PAHO/WHO publications and tools from each region. For the baseline, a sampling frame with a list of all PAHO/WHO publications in English and Spanish was given to the consultants. Then a random sample was selected from this list that covered four broad categories of types of publications:

a. Seminal institution wide publications (e.g. World or Regional Health Report).

b. Policy/World or Regional Governing Bodies document.

c. Evidence type (research) publication

d. Tools/normative guidelines

In each region including headquarters, the consultants selected one document from each of the four categories for a total of 4 publications per region for review. Furthermore, each document also reflected a different health topic or disease category in order to ensure as diverse a set of publications as possible. The consultants selected the publications, which were made available to them as pdf or doc formats and conducted a content review as per criteria developed for this purpose (see annex 5 for the analysis tool)

 **2.6. Establishing accountability: reflection of commitment to gender in senior**

 **management speeches (SD4).**

To measure senior management accountability, indicator 4.1 was developed and measured through a content analysis of senior management speeches. While there are several other ways to measure senior management accountability to gender equality, none of the other measures were found to be feasible to measure at the time of the baseline assessment.[[4]](#footnote-4) The most feasible way of measuring this was considered to be through a content review of speeches and presentations of the Director General and the Regional Directors that were made in 2007. The sampling frame consisted of all speeches made by these Directors in 2007. The consultants randomly selected four to nine speeches from this list and conducted a review according to a set of criteria developed for the analysis (see annex 6 for the analysis tool). In PAHO, four (4) speeches and five (5) power-point presentations given by the PAHO Director, Dr. Mirta Roses Periago, were included in the sample. All were posted on the Director’s Corner Internet site [www.paho.org/English/D/director\_paho.htm](http://www.paho.org/English/D/director_paho.htm) under the headings of “events”, “speeches” and “presentations”. Considering that the 2007 available speeches/ presentations were few and short, the decision was to include all rather than some of them. The only criteria for exclusion referred to speeches made specifically on gender or women's issues, e.g. the speech on International Women's Day.

1. **Ethical considerations**

For the online survey, the link was made available on the WHO intranet website, which can be accessed by all WHO staff from a WHO computer anywhere in the world without having to log in. This protected their usernames or any way of identification when they accessed the online survey form and submitted their responses.

For the planning officer’s interview, the interviews were conducted by consultants face-to-face privately in the office of the respondent with no other person present or separately or over the phone again from a place where the interview could not be overheard by anyone else. Once again no names were recorded in the database. Access to the database for both interviews was only made available to the administrator of the project and the consultants who were conducting the baseline assessment.

The consultants were provided with information on WHO’s harassment policy in case any such reports were made to them during the course of the interviews. When reports were made and the consultants were advised to provide information about PAHO/WHO’s harassment policy and actions the person could take to report it. The identities of the persons who reported such incidents were kept confidential. The content review of documents was based on published documents and publicly made available speeches.

All respondents to the survey and in-person interviews were provided clear information about the baseline assessment, its purpose, the use of the data and how it would be reported. Senior management in all departments, units, divisions in all regions were sent memos about the baseline assessment and asked to inform their staff about the assessment. They were advised that they or their staff would be asked to participate in the baseline assessment as respondents through a random selection process.

1. **Methodological limitations**

Several limitations emerged in developing the methodology for the baseline assessment. These methodological limitations constrain the ability to measure integration of gender in PAHO/WHO in several ways. Some of these limitations can potentially be addressed with methodological adjustments in the assessments to be conducted for mid-term review and final evaluations. However, other limitations will stay

* The questions in the all staff survey on gender knowledge and application (SD1) were not tailored to adequately measure G staff’s knowledge and participation in gender integration. During the process of developing the questionnaire itself, G staff was not systematically involved. This has likely affected the participation of the G staff.
* A key area of measurement related to integration of gender in PAHO/WHO management in terms of operational planning could not be measured at the time of the baseline assessment. This measure captures the extent to which gender is integrated as an outcome of the operational planning process in PAHO/WHO OSERS[[5]](#footnote-5) and Products[[6]](#footnote-6), which form the concrete operational planning outcomes on the basis of which PAHO/WHO conducts its work. At the time of the baseline WHO was transitioning from an old administrative system to a new oracle-based system. In the old system, the list of WHO OSERS and Products was not consolidated, was available only as short statements, and there were far too many (90,000 Products) to do a content review to assess gender integration. In the new system, it is envisaged that this list will be consolidated and available across headquarters and regions, and also include a classification code of OSERS and Products that address gender in order to easily enumerate the percentage of total OSERS and Products that address gender. Therefore, it is expected that for the mid-term and final evaluation, it will be possible to collect this information and measure integration of gender in the outcomes of the operational planning process.
* Another key area of measurement that remains weak in terms of its indicators is the one to establish senior management accountability. The selected indicator is reflection of gender in senior management speeches and only holds the very top level of senior management (i.e. DG and RDs) accountable through speeches, but there is no measure to hold the next few layers of senior management such as Assistant Director Generals, Directors, Coordinators, and Deputies to the Regional Directors accountable. Furthermore, a reflection of gender in speeches also does not capture the extent to which verbal commitment is translated into action in terms of greater devotion of resources and actual institutional outputs. Alternative areas of measurement including whether gender was reflected in the Terms of Reference and the Performance Management Evaluation and Development (PMDS) of the individual senior management as well as all PAHO/WHO staff, and measures related to allocation of budgets to work on gender were also considered (please see annex 7 for a detailed list of additional measures). However, because the PMDS is a confidential document between the staff member and his or her supervisor and not accessible, it was not feasible to measure accountability to gender through the PMDS. There are ongoing efforts to identify other feasible ways of establishing senior management accountability.
* In examining the data on sex parity obtained from headquarters, it was noted that disaggregated data for staff by sex, grade and grade level is only available for long-term staff and not for temporary appointments. The lack of availability of sex parity data for temporary appointments limits the conclusions that can be drawn about the overall sex parity in the organization. In addition, in PAHO, there is a number of staff that is not funded by WHO sources, but through contributions to PAHO directly from its Member States. This situation is unique to PAHO, and that staff is not included in the data available through the headquarters HR report.
* Data collection method selected for assessing staff capacity – all staff online survey sent via email is limited by the low response rate expected from such email surveys which are completed on a voluntary basis. Typically surveys sent via email tend to receive around 20% response rate and also have selection bias.
* Due to financial, administrative and other logistical constraints, delays and the labour/time intensive nature of the data collection methods, there was a time constraint in terms of number of days that could be allocated for data collection. This limited the sample size for several of the data collection methods including planning focal point interviews, content analysis of PAHO/WHO documents, number of countries that were included in the interviews and document review.

**III. FINDINGS OF THE BASELINE ASSESSMENT**

The presentation of the baseline results is organized around the four WHO Strategic Directions for gender mainstreaming. They will be preceded by a contextual and followed by a general discussion of all the findings and the ensuing recommendations.

**Background /context of gender mainstreaming in PAHO**

For 26 years, from 1980 until 2006, PAHO had within its Governing Bodies, an auxiliary advisory body to the Executive Committee, [the Subcommittee on Women, Health and Development](http://www.paho.org/english/gov/ce/spba/govbodies-SPBA-e.htm) which can be credited with promoting and bolstering most of PAHO’s current policies on gender equality. Among these policies was the creation in 1987 of a Women, Health and Development Unit, under the Assistant Director’s Office, today the Gender, Ethnicity and Health Unit (GE); and most importantly, the PAHO Gender Equality Policy approved by the Executive Committee (June 2005) and adopted by a Directing Council Resolution on September 30, 2005.

The Senior Gender Regional Adviser, also Chief of the Gender, Ethnicity and Health Unit, is Dr. Marijke Velzeboer-Salcedo. She has been in this position since January 2008, but also had occupied it before between 1998 and 2003. Her role as Unit Chief is that of coordinating, supervising, monitoring and providing technical support to the mainstreaming of two major themes into the Organization: Gender and Ethnicity. The GE Unit continues to be located within the PAHO Assistant Director (AD) and reports directly to AD.

The GE Unit Chief works with the offices to promote gender mainstreaming along three lines: (a) Building gender analysis /planning capacities among PAHO staff, Ministries of Health, and gender advocate partners; (b) coordinating the Gender internal Working Group and the External Gender Advisory Group for planning and executing the strategy to implement the PAHO Gender Equality Policy; (c) Setting up a knowledge platform for the purpose of building capacity and providing continued information to the different technical areas.

PAHO has a 15 year-history of promoting gender mainstreaming with the external support of Governments like Sweden, Norway, Canada and Spain, and Foundations like Rockefeller and Ford. An important milestone in this process was marked by the above mentioned Government Bodies Resolution adopting the PAHO Gender Equality Policy (September 30, 2005). At present, as expressed by Dr. Velzeboer, there is a **medium/high** commitment to this process. The **challenges** lie on people understanding the meaning of integrating a gender perspective in all of their work, and putting information into action in order to reduce inequities and increase efficiency in providing health care and implementing health policy. “*We have moved from low priority to confusion. People are really confused on what to implement, and continually bring up time and resources limitations, without realizing that including a gender perspective will actually improve their work efficiency, but does require a new way of thinking and doing things. Since we are facilitators, this is very intensive and extensive work. We have to work intensively with partners over a long period of time”.*

The **facilitating factors** for promoting gender, according to the GRA, are the following**:** the Director’s declaration of gender as a priority; numerous staff members who are gender-sensitive and willing to incorporate gender into their programming; Gender Equality being one of the six cross-cutting themes of PAHO’s work; a good gender team in HQ and the field; WHO support; small but faithful donor support; and receptivity from Area Managers. A key assumption concerning what can be done to promote gender that outsiders may not be aware of, is the fact that PAHO has a Gender Equality Policy that includes the Organization and its partners.

The GRA has been involved in the work related to the following **Strategic Objectives (SO**): SO2: HIV/AIDS, malaria and TB; SO4: Sexual and reproductive health; SO5: Disasters Relief; SO7: Other than the gender-specific Regional expected Result (RER) 7.5, with RER 7.3, Social and economic data; and SO16: Human resource policies and practices

Regarding **financial and human resources:** GE regular budget for the 2008-2009 biennium is the following: general operating funds: US$ 223.200; and staff salaries (AAA): 1’648.600. Approximately two thirds of this budget goes to gender mainstreaming. In terms of staffing, the HQ/GE Unit has six professionals who also devote two thirds of their time to gender mainstreaming. In the field, the GE has 21 focal points that spend variable portions of their time in gender-related activities. These portions depend, to a great extent, on the funding provided by PAHO/GE in HQ. The GRA networks with all focal points; with some has a more direct work relation, but the PWRs are ultimately responsible for their work.

|  |
| --- |
| STRATEGIC DIRECTION 1: BUILDING THE CAPACITY FOR GENDER ANALYSIS AND PLANNING |

The information to map the institution-wide capacity for gender mainstreaming was collected through an email survey sent to all staff. The main findings in this respect are summarized in the following chart:

|  |
| --- |
|  **SUMMARY INDICATORS**  |
| 1. **Level of staff understanding in gender in all PAHO staff**

***Overall Indicator:***Percentage of all PAHO staff who have a ***basic*** ***understanding*** of gender and health.  ***Specific sub indicators:***i. % who reported awareness of **at least one** gender policy or strategy... 92.6 ii. % who reported **good knowledge** of gender concepts.......................... 63.3 iii. % who said **yes, gender is relevant to the work of their offices**......... 67.2iv. % who said **yes, gender is relevant to their own work**.......................... 64.6**2. Application of gender analysis and actions to their work**  ***Indicator:*** Percentage of all PAHO staff who are **at least moderately applying** gender analysis and actions in their work. .............. .... 42.1**3. Institutional support for gender mainstreaming** ***Indicator****:* Percentage of all PAHO staff who report **at least some institutional support** for gender integration into their work...................... . 42.9 |

***Sample size and distribution:*** PAHO’s staff response to the online survey was **44%,** amply surpassing the low expectation of 20% and the average response for all WHO staff which was 25%. The response rates by sex and grade appearing in Table 1 show that the sex difference was negligible. The grade difference, on the other hand, was considerable and favoured professionals whose percentage of response more than doubled that of the general service staff.

**Table 1.** Composition by sex and grade of the sample of PAHO staff members that answered the E-mail survey. June 2008

|  |  |  |  |
| --- | --- | --- | --- |
|  **Sex & Grade categories**  | No.Staff  | No.Respondents | %Response |
| All WHO staff (for comparison) | 8032 | 2160 |   26.89 |
| All PAHO staff | 889 | 390 | 44.32 |
| Sex | Men | 362 | 161 | 44.48 |
| Women | 527 | 229 | 43.45 |
| Grade | Professionals (including Directors) | 459 | 272 | 59.26 |
| General Services | 397 | 104 | 26.20 |
| Others (presumably National Officers) | 33 | 14 | 42.42 |

The main findings of this E Survey are presented in relation to two aspects: ***First,*** the relative standing, of PAHO staff on three measurement areas: knowledge level, knowledge application, and institutional support received to integrate gender into their work. ***Second,*** the staff perceptions on factors that have facilitated or inhibited gender mainstreaming in their work; and on types of institutional support needed for that purpose. The first type of indicators will aid the tracking progress over time; the second will contribute to identify the actions needed to move the gender strategy in the right direction.

**1. Basic understanding of gender and health**

Three dimensions or sub indicators were considered in this overall indicator:

* Awareness of WHO gender policies or strategies classified according to which particular WHO gender policy or strategy they know and if respondent does not know of any
* Knowledge of gender concepts classified as no knowledge, some knowledge and good knowledge
* Relevance of gender to their own work and to the work of their unit
	1. **Awareness of WHO gender policies or strategies**

93% of PAHO staff respondents, reported awareness of **at least one** WHO gender policy or strategy. As expected, the PAHO Gender Equality Policy was the policy piece most frequently acknowledged. 88% of respondents recognized the existence of the PAHO Gender Equality Policy, while 63% and 42%, respectively, acknowledged the WHO Gender Policy and WHO Gender Strategy.

* *Differentials by sex and grade*

There was no statistically significant difference by sex regarding awareness of **at least one** WHO gender policy/strategy and, more specifically, of the PAHO Gender Equality Policy. Directors and professionals tended to be more aware of **at least one** policy, but the difference by grade was not statistically significant either. However, when individual policies were considered separately, a statistically significant difference by grade was observed regarding awareness of both the WHO Gender Policy and Strategy (Table 2).

**Table 2.** Percentages of PAHO staff members reporting awareness of WHO gender policies or strategies, by sex and grade. 2008.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  **Staff** **Categories** | N | **WHO Gender Policy** | **PAHO Gender Equality Policy** | **Other Regional Gender Policy** | **WHO Strategy on Integrating Gender**  | **Dont' know of any of these Policies/ Strategy** |
| n | % | n | % | n | % | n | % | n | % |
|  **All AMRO/**  **PAHO Staff** | 390 | 244 | 62.6 | 343 | 88.0 | 33 | 8.5 | 165 | 42.3 | 29 | 7.4 |
|  **By Sex** |  |  |  |  |  |  |  |  |  |  |  |
|  Male Staff | 161 | 108 | 67.1 | 141 | 87.6 | 20 | 12.4 | 72 | 44.7 | 12 | 7.5 |
|  Female Staff | 229 | 136 | 59.4 | 202 | 88.2 | 13 | 5.7 | 93 | 40.6 | 17 | 7.4 |
|  p-value |  | 0.1223 | 0.8503 | 0.0184 | 0.4187 | 0.9912 |
|  **By Grade** |  |  |  |  |  |  |  |  |  |  |  |
|  D | 10 | 7 | 70.0 | 10 | 100.0 | 0 | 0.0 | 5 | 50.0 | 0 | 0.0 |
|  P | 262 | 177 | 67.6 | 235 | 89.7 | 26 | 9.9 | 130 | 49.6 | 15 | 5.7 |
|  G | 104 | 53 | 51.0 | 86 | 82.7 | 4 | 3.9 | 25 | 24.0 | 13 | 12.5 |
|  Other | 14 | 7 | 50.0 | 12 | 85.7 | 3 | 21.4 | 5 | 35.7 | 1 | 7.1 |
|  p-value |  | 0.0190 | 0.1792 | 0.0564 | 0.0001 | 0.1221 |

* *Differentials by WHO Region*

The inter-regional differences in awareness of **at least one** WHO gender policy/strategy were statistically significant at the 0.0001 level (Table 1, Appendix 1). PAHO’s awareness score (93%) was well above WHO’s average (79%), **ranking first** among all Regions and WHO/HQ. PAHO was followed distantly by WPRO (80%); and EURO & WHO/ HQ (78%) (See Figure 1).

**Figure 1:** Percentage of WHO staff members who reported awareness of at

least one of WHOs Regional Gender Policies and Strategies, by Region, 2008. 

* 1. **Knowledge of gender concepts**

The level of knowledge in gender was categorized in terms of “none”, “some” and “good knowledge”, according to the scores assigned to the responses given to four questions in the E- Survey dealing with the concepts of sex, gender, and gender mainstreaming. The proportion of PAHO staff with “good knowledge” of gender concepts was **63%.** And in the more encompassing category of “some + good knowledge”, the corresponding proportion was 97.4%.

**Table 3.** Percent distribution of PAHO/WHO staff according to level of knowledge of gender concepts, by sex and grade. 2008

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender Knowledge**  | N | **No Knowledge** | **Some Knowledge** | **Good Knowledge** |
| n | % | n | % | n | % |
|  **All AMRO/PAHO**  **Staff** | 390 | 10 | 2.6  | 133 | 34.1 | 247 | 63.3 |
|  **By Sex** |  |  |  |  |  |  |  |
|  Male Staff | 161 | 4 | 2.5 | 53 | 32.9 | 104 | 64.6 |
|  Female Staff | 229 | 6 | 2.6 | 80 | 34.9 | 143 | 62.5 |
|  p-value |  |  0.9101 |
|  **By Grade** |  |  |  |  |  |  |  |
|  D | 10 | 0 | 0.0 | 5 | 50.0 |  5 | 50.0 |
|  P | 262 | 4 | 1.5 | 80 | 30.5 |  178 | 67.9 |
|  G | 104 | 6 | 5.8 | 42 | 40.4 |  | 56 | 53.8 |
|  Other | 14 | 0 | 0.0 | 6 | 42.9 | 8 | 57.1 |
|  p-value |  |  0.0656 |

* *Sex and grade differentials*

A higher percentage of males (65) than of females (63) fell in the category of “good knowledge” but the sex difference was not statistically significant (Table 3). A larger proportion of professionals (68%) than of General Service staff (54%) or Directors (50%) were categorized as having “good knowledge”, but the grade differences were not statistically significant either (Table 3).

* *Differentials by WHO Region*

The differentials in knowledge levels between regions were statistically significant at the 0.01 level. In the specific category of ”good” knowledge of gender concepts, PAHO’s percentage of 63 was above the WHO’s average of 59. PAHO **ranked second** among all WHO Regions and WHO/HQ in terms of good knowledge, closely after EURO with 65 (See Figure 2). In the more general category resulting from the addition of the “some” and “good” knowledge categories, the percentage of PAHO staff was 97%, which represented the highest proportion of all regions.

 **Figure 2.** Percentage of WHO staff members with “good knowledge” of

gender concepts, by Region. 2008. 

* 1. **Relevance of gender to PAHO/ WHO work**

More than 6 out of 10 PAHO staff members declared that gender **was relevant** to the work of their offices and/or to their own work.

* *Sex and grade differentials*

Men, more often than women, tended to report that gender was relevant both to the work of their offices and to their own work. This sex-difference was statistically significant (Table 4)[[7]](#footnote-7).

Regarding grade**, all Ds** and, approximately, **8 out of 10** **Ps** and **4 out of 10 Gs** declared that gender was relevant to the work of their offices. The corresponding proportions were slightly lower regarding individual’s own work, but statistically significant in both instances (Table 4).

|  |  |  |
| --- | --- | --- |
|  **Staff**  **Categories** | **N** |  **Relevance of gender to work** |
|  **Work of their offices Their own work**  |
| No | Yes | Don't Know | No | Yes | Don't Know |
| n | % | n | % | n | % | n | % | n | % | n | % |
|  **All AMRO/**  **PAHO Staff** | 390 | 109 | 27.9 | 262 | 67.2 | 19 | 4.9 | 127 | 32.6 | 252 | 64.6 | 11 | 2.8 |
|  **By Sex** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  Male Staff | 161 | 33 | 20.5 | 124 | 77.0 | 4 | 2.5 | 39 | 24.2 | 120 | 74.5 | 2 | 1.2 |
|  Female Staff | 229 | 76 | 33.2 | 138 | 60.3 | 15 | 6.6 | 88 | 38.4 | 132 | 57.6 | 9 | 3.9 |
| p-value |  |  0.0018 |
|  **By Grade** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  D | 10 | 0 | 0.0 | 10 | 100.0 | 0 | 0.0 | 0 | 0.0 | 9 | 90.0 | 1 | 10.0 |
|  P | 262 | 50 | 19.1 | 205 | 78.2 | 7 | 2.7 | 56 | 21.4 | 201 | 76.7 | 5 | 1.9 |
|  G | 104 | 52 | 50.0 | 40 | 38.5 | 12 | 11.5 | 66 | 63.5 | 33 | 31.7 | 5 | 4.8 |
|  Other | 14 | 7 | 50.0 | 7 | 50.0 | 0 | 0.0 | 5 | 35.7 | 9 | 64.3 | 0 | 0.0 |
| p-value |  |  0.0001 | 0.0001 |

 **Table 4**. Percentage of WHO/PAHO staff members who reported that gender was relevant

tothe work of their offices and to their own individual work, by sex and grade. 2008.

* *Differentials by WHO Region*

The proportions of PAHO staff reporting that gender was relevant to both the collective work of their offices (67%) and to their own individual work (65%) were higher than the respective averages for all of WHO (64 and 60%). Compared to individual regions and WHO/HQ, PAHO ranked second on both dimensions of work relevance, but the regional differences were statistically significant (at the 0.0005) only for the category of individual own work (See Appendix 1).

**2. Application of gender skills to PAHO’s work**

The level of application of gender skills was measured on a scale from *none, some, moderate*, to *strong* application. The proportion of PAHO staff ***at least* *moderately applying*** gender skills in their work (the sum of moderate + strong)was **42%** (See Table 5).

* *Sex and grade differentials*

More males than females were applying their gender knowledge to their work in “moderately strong” to “strong” fashion: 53% of men and 34% of women (See footnote 6).

Table 5 shows that gender skills application was more frequently reported at higher occupational grades: approximately **8 of 10 Ds**; **5 of 10 Ps**; and **1.5 of 10 Gs** said they were applying gender skills to their work in a ‘moderately strong’ to ‘strong’ fashion. The differences between these categories proved to be statistically significant at the confidence level of 0.0001 (see Table 5). Figure 3 further illustrates the vast difference between grades by which the reported **no application** of gender concepts to work was eight times higher for Gs than Ps (56% for Gs, 7% for Ps, and 0% for Ds).

## Table 5. Percent distribution of PAHO staff members according to level of application of gender skills to current work, by sex and occupational grade. 2008

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Staff categories** | **N** | **Not Applying**  | **Some Application** | **Moderately Strong Application** | **Strong Application** |
| n | % | n | % | n | % | n | % |
| **All AMRO/PAHO Staff** | 390 | 79 | 20.3 | 147 | 37.7 | 85 | 21.8 | 79 | 20.3 |
| **By Sex** |  |  |  |  |  |  |  |  |  |
|  Male Staff | 161 | 22 | 13.7 | 53 | 32.9 | 47 | 29.2 | 39 | 24.2 |
|  Female Staff | 229 | 57 | 24.9 | 94 | 41.1 | 38 | 16.6 | 40 | 17.5 |
| p-value |  | 0.0009 |
| **By Grade** |  |  |  |  |  |  |  |  |  |
|  D | 10 | 0 | 0.0 | 2 | 20.0 | 2 | 20.0 | 6 | 60.0 |
|  P | 262 | 19 | 7.3 | 108 | 41.2 | 72 | 27.5 | 63 | 24.1 |
|  G | 104 | 58 | 55.8 | 30 | 28.9 | 10 | 9.6 | 6 | 5.8 |
|  Other | 14 | 2 | 14.3 | 7 | 50.0 | 1 | 7.1 | 4 | 28.6 |
| p-value |  | < 0.0001 |

**Figure 3.** Percent distribution of PAHO staff according to level of application of gender knowledge to their work, by grade. 2008

7.3

55.8

20.0

41.2

28.9

20.0

27.5

9.6

60.0

24.1

5.8

0

20

40

60

80

100

D

P

G

%

Not applying

 Some application

 Moderate strong application

 Strong application

* *Differentials by WHO Region*

PAHO was well above the WHO average (33%) and ranked first among all regions and WHO/HQ in terms of its percentage (42%) of staff reporting moderate to strong application of gender knowledge to their work. This difference was statistically significant at the 0.0001 level (See Figure 4; Table 4, Appendix 1).

**Figure 4.** Percentage of WHO staff reporting a “moderately strong” to “strong” application of gender concepts to their work, by Region. 2008

%

42.1

41.0

36.4

34.4

24.7

25.7

32.5

**33.1**

0

10

20

30

40

50

AMRO/PAHO

SEARO

AFRO

WPRO

EMRO

WHO/HQ

EURO

Region

All WHO Staff

**3. Institutional support given to gender mainstreaming**

The responses to the E survey questions regarding having received institutional support to undertake gender mainstreaming were scored in terms of three categories: None, some, and strong institutional support. The proportion of PAHO staff members reporting **“at least some institutional support”** [[8]](#footnote-8)for gender mainstreaming was **43%.** The corresponding percentage for“good” support was **15.4**.

**Table 6.** Percent distribution of PAHO staff members according to reported level of institutional support for gender mainstreaming, by sex and occupational grade. 2008

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Staff categories** | **N** | **No Support** | **Some Support** | **Good Support** |
| **n** | **%** | **n** | **%** | **n** | **%** |
| **All AMRO/PAHO Staff** | 389 | 222 | 57.1 | 107 | 27.5 | 60 | 15.4 |
| **By Sex** |  |  |  |  |  |  |  |
|  Male Staff | 161 | 77 | 47.8 | 50 | 31.1 | 34 | 21.1 |
|  Female Staff | 228 | 145 | 63.6 | 57 | 25.0 | 26 | 11.4 |
| p-value |  | 0.0038 |
| **By Grade** |  |  |  |  |  |  |  |
|  D | 10 | 3 | 30.0 | 5 | 50.0 | 2 | 20.0 |
|  P | 261 | 128 | 49.0 | 81 | 31.0 | 52 | 19.9 |
|  G | 104 | 83 | 79.8 | 17 | 16.3 | 4 | 3.9 |
|  Other | 14 | 8 | 57.1 | 4 | 28.6 | 2 | 14.3 |
| p-value |  | < 0.0001 |
|  |  |  |

* *Differentials by sex and grade*

A higher proportion of men (53%) than women (36%) reportedly had received “some” to “good” institutional support for gender mainstreaming (Table 6), and the difference was statistically significant at the 0.004 level. Reported institutional support clearly varied with grade. **Seven** out of ten directors, **five** of every ten professionals, and **two** of every ten general service staff members reported having obtained “some” to “good” institutional support for gender mainstreaming. This difference was statistically significant at the 0.0001 level. It bears noting that the reporting of “good” support was five times higher among Ps than among Gs, further suggesting the existence of a corresponding institutional gap which was corroborated by the fact that the official PAHO guidelines for planning and monitoring the 2008-2009 BWP, excluded administrative entities from integrating crosscutting issues into their work (See SD3 findings, section 3.4 in this report).

* *Differentials by WHO Region*

PAHO exceeded the WHO average on percentage of staff reporting having received institutional support for gender mainstreaming. As Figure 5 indicates, PAHO with 43%, ranked first among all regions on this indicator, being followed by SEARO (39%) and EMRO (35%). This regional difference was statistically significant at the 0.0001 level.

**Figure 5.** Percentage of WHO staff reporting some to good institutional support for gender integration into their work, by WHO Region. 2008.

%

42.9

39.3

35.3

23.0

27.4

30.0

30.5

**31.9**

0

10

20

30

40

50

AMRO/PAHO

SEARO

EMRO

WPRO

AFRO

WHO/HQ

EURO

Region

All WHO Staff

**4. Facilitating factors for gender integration**

The factors that PAHO staff members most often identified as facilitators of gender integration into their work were, in order of frequency, the following (See Table 7):

## 1st: Colleagues with gender expertise to collaborate ……….……………………..39%

## 2nd Discussions on gender in one’s area of work during office-staff meetings… 32%

3rd Information sharing on gender in one’s area of work......................................31%

4th Having designated Gender Focal Points………………………………………..29%.

## Table 7. Facilitating factors for gender integration as identified by WHO/PAHO staff members. 2008

|  |  |  |
| --- | --- | --- |
| **Facilitating Factors or Opportunities** | **All WHO** | **AMRO/PAHO** |
| **n** | **%** | **n** | **%** |
| Colleagues with gender expertise to collaborate with | 610 | 28.2 | 151 | 38.7 |
| Information sharing on gender in your area of work | 630 | 29.2 | 125 | 32.1 |
| Discussions on gender in your area of work in office staff meetings | 551 | 25.5 | 120 | 30.8 |
| Designated Gender Focal Point | 466 | 21.6 | 114 | 29.2 |
| Linkages with Countries/Regional/HQ Gender Focal Points/Units | 339 | 15.7 | 89 | 22.8 |
| Information sharing on upcoming seminars/meeting on gender | 351 | 16.3 | 85 | 21.8 |
| Information sharing on gender training opportunities | 320 | 14.8 | 64 | 16.4 |
| Interdepartmental Task Force on Gender | 161 | 7.5 | 38 | 9.7 |
| All of the above | 151 | 7.0 | 34 | 8.7 |
| Other | 70 | 3.2 | 13 | 3.3 |
| None | 469 | 21.7 | 53 | 13.6 |
| Don't know | 383 | 17.7 | 40 | 10.3 |

The relative importance assigned by PAHO staff to these four factors matches closely the priorities expressed by WHO staff as a whole. Other factors relating to training opportunities, formal seminars, and Task Force provisions received considerably fewer mentions. Training, for instance was mentioned half as often as the first four factors. These findings highlight the priority assigned by staff to being able to access information and rely on technical collaboration tailored to their ***specific*** work areas.

1. **Inhibiting factors or institutional barriers for gender mainstreaming**

Regarding the existence of inhibiting factors or institutional barriers for gender mainstreaming, the most frequent response among PAHO staff members (28%) was that there were “none”. This type of response was given by 20% of all WHO staff.

The factors most often identified by PAHO staff as challenges or barriers for gender mainstreaming, in nearly 1 of every 4 cases, were the following: (Table 8)

1st Insufficient knowledge or skills on gender to apply it to my work ...........26%

2nd Lack of appropriate data / evidence on gender in my area of work..,......24%

3rd Lack of appropriate tools to help me address gender in my work............24%

These three factors were also the same ones pointed out most frequently by **all** WHO staff and again attest to the need for tailored support. The options alluding to lack of appropriate resources—financial or human— and insufficient technical follow-up after training, received intermediate ratings (18, 14, and 18%, respectively) among PAHO staff. Among all WHO staff the intermediate percentages corresponded instead to lack of interest and time to pursue gender integration (16 and 14%, respectively). The latter inhibiting factors, lack of time or interest for addressing gender, indicated the lowest frequency of mentions among PAHO staff (11%), lower than for WHO staff as a whole.

## Table 8. Inhibiting factors or institutional barriers for gender integration into WHO/PAHO’s work, as identified by WHO/PAHO staff members. 2008.

|  |  |  |
| --- | --- | --- |
|  **I Inhibiting factors or institutional barriers**  | **All WHO** | **AMRO/PAHO** |
| **n** | **%** | **n** | **%** |
| Insufficient knowledge or skills on gender to apply it to my work | 618 | 28.6 | 100 | 25.6 |
| Lack of appropriate data / evidence on gender in my area of work | 507 | 23.5 | 94 | 24.1 |
| Lack of appropriate tools to help me address gender in my work | 538 | 24.9 | 94 | 24.1 |
| No budgetary resources available for work on gender | 367 | 17.0 | 71 | 18.2 |
| Insufficient technical follow-up after training to address gender in my work | 262 | 12.1 | 69 | 17.7 |
| No human resources available for work on gender | 302 | 14.0 | 56 | 14.4 |
| Work schedule is too busy to accommodate work on gender | 310 | 14.4 | 44 | 11.3 |
| Not interested in gender / Not relevant to my work / Not a priority | 348 | 16.1 | 42 | 10.8 |
| All of the above | 86 | 4.0 | 17 | 4.4 |
| Other | 140 | 6.5 | 22 | 5.6 |
| None | 438 | 20.3 | 108 | 27.7 |
| Don't Know | 178 | 8.2 | 25 | 6.4 |

1. **Types of institutional support needed for the future**

In correspondence with the above findings on facilitating and inhibiting factors for gender mainstreaming, the three types of institutional support that higher proportions of PAHO staff members deemed most needed were: (Table 9)

1st Opportunities to learn or further develop skills in gender …….…………………..…. 49%

2nd Access to data or evidence on gender in the individual’s specific area of work….….42%

3rd Technical support from the Gender Focal Point(s) or the Gender Unit……….……. ..35%

 4th Resource materials……………….…………………………………………………………32%

PAHO’s choices in this respect were the same ones manifested by WHO staff as a whole. This affinity reinforced the overall importance ascribed by staff members to a learning process based on **evidence** relevant to their **specific** areas of work and catalyzed by a **continued** technical support from experts within the organization.

**Table 9.** Types ofinstitutional support considered necessaryfor the futureby WHO/PAHO staff members forthe integration of gender into their work. 2008

|  |  |  |
| --- | --- | --- |
|  **Types of Needed Institutional Support Identified by Staff** | All WHO | AMRO/PAHO |
| n | % | n | % |
| Opportunities to learn or further develop skills in gender | 1116 | 51.7 | 191 | 49.0 |
| Data/Evidence on gender in my area of work | 801 | 37.1 | 163 | 41.8 |
| Technical support from Gender Focal Point(s)/Unit(s) | 756 | 35.0 | 137 | 35.1 |
| Resource material | 759 | 35.1 | 126 | 32.3 |
| Funds to be allocated for work on addressing gender | 565 | 26.2 | 110 | 28.2 |
| Regular discussions with my supervisor on addressing gender in my work | 420 | 19.4 | 82 | 21.0 |
| Adjustments in my other responsibilities so that I can give more time to work on gender | 325 | 15.1 | 62 | 15.9 |
| Additional human resources to work on gender | 394 | 18.2 | 70 | 18.0 |
| All of the above | 243 | 11.3 | 47 | 12.1 |
| Other | 41 | 1.9 | 5 | 1.3 |
| No support needed | 190 | 8.8 | 28 | 7.2 |
| Don't Know | 211 | 9.8 | 26 | 6.7 |

**7. Limitations of the findings**

As already stated, the sample –although reasonable in size--, may not be representative since in this type of surveys, respondents are self-selected.

The analysis was constrained by the non availability of cross-tabulations by **location,** i.e., HQ and Country Offices. The data provided by WHO to the Regions was disaggregated only by two variables: sex and grade. And regarding sex, a further limitation was experienced, since this variable was disaggregated only for the total staff, not for grade categories. This circumstance did not permit sound inferences about **sex differentials** along selected indicators and staff groups, since these differentials were biased by the large share of Gs among the total staff and the female predominance (80%) in this G category, traditionally not a priority target for gender mainstreaming actions. To arrive at non spurious conclusion in this respect, sex differentials would have to be calculated within grades.

|  |
| --- |
| STRATEGIC DIRECTION 2: BRINGING GENDER INTO THE MAINSTREAM OF PAHO’S MANAGEMENT |

The extent of gender integration into the mainstream of PAHO’s management was assessed in terms of three dimensions: (a) operational planning and programme cycle processes; (b) Country Cooperation Strategies (CCS) and their corresponding two-year work plans; and (c) level of sex parity among staff. Each dimension will be analyzed separately in this section.

1. **Gender integration in the operational planning and programme cycle process**

The tool chosen for this component was an interview with Planning Focal Points (PFP) aimed to assess the extent to which the programming cycle processes facilitate gender integration, and the institution supports this integration. While other tools in this baseline assessment were intended to measure gender integration in products, this tool examined the *processes* in which these products were developed. The selected indicators and their corresponding values are presented in the following chart.

**Level of Gender Integration into the PAHO Operational Programming Cycle.** **Summary of Selected Indicators**

|  |
| --- |
| Percentage of Planning Focal Points (PFP) whose responses reflected **STRONG** gender integration during the recent programming processes of:   |
| Operational Program Program  Planning Implementation Monitoring(2008-2012)(2006-2007) (2006-2007) |
|  **PAHO PFP sample**  | **38.9** | **0.0** | **0.0** |
|  By sex |  |  |  |
|  Female Staff  | 40.0 | 0.0 | 0.0 |
|  Male Staff  | 38.4 | 0.0 | 0.0 |
|  By Grade |  |  |  |
|  D | 60.0 | 0.0 | 0.0 |
|  P | 30.8 | 0.0 | 0.0 |
|  By collaboration with GE |  |  |  |
|  Yes | 50.0 | 0.0 | 0.0 |
|  No | 25.0 | 0.0 | 0.0 |

**Description of the sample:**  The initially selected PAHO sample included twenty nine (29) planning focal points. The number actually interviewed was twenty one (21). However, due to some “don’t know’ answers, this total was respectively reduced to 18, 17, and 16, when gender integration scores were calculated for the different stages of planning, implementation and monitoring. The analysis of six open-ended questions on inhibiting and facilitating factors for gender integration into each of these stages did include all twenty-one interviews.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | N | Females | Males | GE Collab. | GE Non-Collab.. |
|  Managers acting as SO Coordinators  | **6** | 1 | 5 | 2 | 4 |
|  Country Representatives  | **3** | 3 | -- | 2 | 1 |
|  Unit Chiefs, Team Leaders and  Regional Advisers  |  **12** | 4 | 8 | 5 | 7 |
|  **Total**  | **21** | **8** | **13** | **9** |  **12** |

The composition of the sample of interviewed PFPs was the following:

**1. Level of gender integration in the programming cycle**

Sharp differences in the reported extent of gender integration into the programming process were registered in regards to the planning, implementation and monitoring phases of this process. Planning registered the highest reported levels, and monitoring, the lowest.

**1.1. In the operational planning process**

Gender integration in this phase was measured on the basis of affirmative responses given to questions on whether or not consideration was given to gender inequalities in the definition of objectives, activities and resources corresponding to the most recent five-year (2008-2012) operational planning process.

**Table 10.** AMRO/PAHO: Percent distribution of sampled planning focal points according to reported level of gender integration in their 2008-2012 operational planning processes, by sex, grade, and previous collaboration with PAHO/GE. 2008

|  |  |  |
| --- | --- | --- |
|  Planning  | **N** | **Level of Gender Integration** |
| None or weak  | Some or moderate  | Strong  |
| **n** | **%** | **n** | **%** | **n** | **%** |
| **WHO planners sample** | **131** | **45** | **34.4** | **37** | **28.2** | **49** | **37.4** |
| **PAHO planners sample** | **18\*** | **4** | **22.2** | **7** | **38.9** | **7** | **38.9** |
|  By Sex |  |  |  |  |  |  |  |
|  Female Staff | 5 | 0 | 0.0 | 3 | 60.0 | 2 | 40.0 |
|  Male Staff | 13 | 4 | 30.8 | 4 | 30.8 | 5 | 38.4 |
|  By Grade |  |  |  |  |  |  |  |
|  D | 5 | 1 | 20.0 | 1 | 20.0 | 3 | 60.0 |
|  P | 13 | 3 | 23.1 | 6 | 46.2 | 4 | 30.8 |
|  By GE Collaboration |  |  |  |  |  |  |  |
|  Yes | 10 | 2 | 20.0 | 3 | 30.0 | 5 | 50.0 |
|  No / Don't Know | 8 | 2 | 25.0 | 4 | 50.0 | 2 | 25.0 |

\* 3 respondents on this subject were excluded due to ‘don't know’ answers

A strong level of gender integration was reported by seven out of the eighteen PFP with complete answers on this respect. The corresponding PAHO proportion (39%) was above the average for all WHO regions (37%).

*Variations by sex, grade, and GE collaboration:*  The proportion of PFPs reporting strong gender integration in their planning processes was higher among women, Ds, and GE collaborators. However, the small size of the sample, did not warrant definite conclusions about associations in this respect

 **1.2. In the implementation of work plans**

The level of gender integration in program implementation referred to the extent to which gender inequalities in health were addressed in the implementation of the past **2006-2007** biennial work plan through specific actions and use of resources.[[9]](#footnote-9)

Table 11 indicates that **none** of PAHO interviewed PFP acknowledged a strong level of gender integration in the implementation of their work plans, while the corresponding figure for the entire WHO sample was 5.5%. Two thirds of the respondents (11 out of 17) declared a moderate level of gender integration in their program implementation while the remaining third (6) reported weak or no integration.

**Table 11.** AMRO/PAHO: Percent distribution of sampled planning focal points according to reported level of gender integration in the implementation of their 2006-2007 work plans, by sex, grade, and previous collaboration with PAHO/GE. 2008.

|  |  |  |
| --- | --- | --- |
|  **Implementation**  |  | **Level of Gender Integration** |
| **N** | **None or Weak**  | **Some or Moderate**  | **Strong**  |
| **n** | **%** | **n** | **%** | **n** | **%** |
| **WHO planners sample** | 127 | 47 | 37.0 | 73 | 57.5 | 7 | 5.5 |
| **PAHO planners sample** | 17\* | 6 | 35.3 | 11 | 64.7 | 0 | 0.0 |
| **By Sex** |  |  |  |  |  |  |  |
|  Female Staff | 5 | 1 | 20.0 | 4 | 80.0 | 0 | 0.0 |
|  Male Staff | 12 | 5 | 41.7 | 7 | 58.3 | 0 | 0.0 |
| **By Grade** |  |  |  |  |  |  |  |
|  D | 4 | 1 | 25.0 | 3 | 75.0 | 0 | 0.0 |
|  P | 13 | 5 | 38.5 | 8 | 61.5 | 0 | 0.0 |
| **By Collaboration with GE** |  |  |  |  |  |  |  |
|  Yes | 10 | 1 | 10.0 | 9 | 90.0 | 0 | 0.0 |
|  No / Don't Know | 7 | 5 | 71.4 | 2 | 28.6 | 0 | 0.0 |

\* 4 respondents on this subject were excluded due to don't know answers

Although the small sample size did not allow for statistically significant inferences, variations in the level of this integration were evident according to sex, grade and history of GE collaboration. As in the planning stage, the proportion integrating gender in the implementation of work plans was higher among women, Ds, and those PFP that had collaborated with GE.

**1.3. In monitoring and evaluating work plans**

Scores on gender integration in monitoring and evaluation were assigned to respondent’s assessments of the extent to which the process of monitoring and evaluating 2006-2007 biennial work plans addressed gender inequalities in health[[10]](#footnote-10).

None of the interviewees acknowledged having strongly integrated gender in the monitoring and evaluating process of their 2006-2007 work plans, while the corresponding figure for the WHO sample was 1.6%. Over 80% (13 out of 16) reported none or a weak level of gender integration in their monitoring & evaluating process, and only 3 of the 16 PFPs indicated some or a moderate level, thus illustrating the near absence of gender considerations at this stage of the programming cycle (Table12).

As in the preceding programming stages, the few respondents reporting any gender integration in the monitoring phase of their work plans clustered around the staff categories of females, Ds, and GE collaborators (Table12).

**Table 12.** AMRO/PAHO: Percent distribution of sampled planning focal points according to reported level of gender integration in the **monitoring & evaluation** of their 2006-2007 work plans, by sex, grade, and previous collaboration with PAHO/GE. 2008

|  |  |  |
| --- | --- | --- |
|  **Monitoring**  **& Evaluation** | **N** | **Level of Gender Integration** |
| **None or Weak**  | **Some or Moderate**  | **Strong Level of**  |
| **N** | **%** | **n** | **%** | **n** | **%** |
| **WHO planners sample** | 127 | 87 | 68.5 | 38 | 29.9 | 2 | 1.6 |
| **PAHO planners sample** | 16\* | 13 | 81.3 | 3 | 18.7 | 0 | 0.0 |
| **By Sex** |  |  |  |  |  |  |  |
|  Female Staff | 5 | 2 | 40.0 | 3 | 60.0 | 0 | 0.0 |
|  Male Staff | 11 | 11 | 100.0 | 0 | 0.0 | 0 | 0.0 |
| **By Grade** |  |  |  |  |  |  |  |
|  D | 4 | 2 | 50.0 | 2 | 50.0 | 0 | 0.0 |
|  P | 12 | 11 | 91.7 | 1 | 8.3 | 0 | 0.0 |
| **By Collaboration with GE** |  |  |  |  |  |  |  |
|  Yes | 10 | 8 | 80.0 | 2 | 20.0 | 0 | 0.0 |
|  No / Don't Know | 6 | 5 | 83.3 | 1 | 16.7 | 0 | 0.0 |

 \* 5 respondents on this subject were excluded due to don't know answers

1. **Perceived facilitating and inhibiting factors for gender integration in the programming cycle**

**Summary results of the** responses to the interview’s six open-ended questions on perceived f**acilitating and inhibiting factors\* to gender integration in the operational programming cycle**

|  |
| --- |
|  **Overall tendencies of Gender integration in the *different phases* of the**  **programming cycle*** Weaknesses of gender integration in the **planning stage** were seen as hampering integration prospects in the subsequent stages of implementation and monitoring.
* Significant advances in gender integration were identified in some cases in relation to the **implementation** stage. However, these advances were attributed to particular gender-focused initiatives rather than to enhanced gender sensitivity/ competencies.
* Gender-sensitive monitoring & evaluation were considered almost non-existent.
* Gender awareness was seen as widespread, nor so the needed competencies to integrate gender into operational programming.

 ***Challenges* for gender mainstreaming perceived as most significant** * Deficiencies in/ lack of understanding of gender issues in **specific** areas of work
* Gaps in the institutional environment referring to formal guidelines, accountability mechanisms, and incentives
* Severe limitations of enabling resources, particularly gender-skilled human resources

 ***Internal facilitating factors* reported as most decisive**  * Proactive support from the Director and some senior managers (in HQ and CO), as well as institutional pro-gender equality policies
* Advances in awareness, understanding, competencies, access and use of information on the part of technical teams
* Presence and collaboration of the Gender team in HQ (GE Unit) and in some countries, through GE focal points

 ***External facilitating factors* characterized as most influential**  * Financial and political support received from progressive donors;
* Alliances & partnerships with other UN and Inter American Systems’ agencies
* Multi-sector work involving National Ministries of Women’s Affairs.
 |

The responses to the open-ended questions on challenges and facilitating factors affecting the programming cycle were classified under the following analytical categories: (1) staff understanding of and technical capacities for gender mainstreaming; (2) enabling institutional environment: resources and mechanisms; (3) external partnerships and alliances; and (4) collaboration with the PAHO Gender Network . Although the latter is a subcategory of institutional environment, it will be analyzed separately given the fact that it was a sampling criterion. The analysis of these responses aimed to provide a context for the broader discussion about the extent to which gender is integrated into the mainstream of WHO/PAHO programming cycle, and the degree to which the Organization is facilitating that integration.

While examining the findings, the reader must keep in mind that the information on the planning, implementation and evaluation processes does not refer to the same chronological programming cycle: the questions on implementation and monitoring corresponded to the 2006-2007 period, while the questions on planning dealt with the cycle beginning in 2008. Therefore, the inhibiting or facilitating factors that played a factor in the implementation and monitoring stages of the 2006-2007 Biennial Work Plan could not be causally linked to the factors mentioned in relation to the planning phase that took place at a later time.

* 1. **Challenges and obstacles**

The challenges most often and emphatically mentioned fell under the above first two analytical categories: limited understanding and capacities for gender analysis and planning on the part of respondents (and their teams); and constraints in the institutional environment. These challenges were also considered most critical during the planning phase. Given the almost total absence of gender criteria or indicators at the planning stage, gender integration was reported weak during the implementation phase and gender monitoring was perceived as practically non-existent.

A cross-classification of the responses by types of challenges and programming stages indicated the following general tendencies:

**The limited understanding and technical capacity** challenges were seen as the most important for each and all programming stages. All twenty-one interviewees acknowledged both, the existence of a PAHO Gender Equality Policy, and the Senior Management declaration of Gender Equality as one of six cross-cutting themes in the Organization’s work. This policy awareness, bolstered in some cases by a personal commitment to the elimination *of all forms of inequity*, was not paired by knowledge of the ***what* is there to rectify** in matters of gender, let alone of the***how* to do it**.The most cited obstacle was the poor understanding of gender issues **in relation to *specific* areas of current work*.*** Critical importance was assigned to the following weak or missing elements : (a) *shared* conceptual framework on gender and health; (b) evidence, indicators and research on the relation of gender with the problem at hand; (c) practical tools, guidelines and indicators; and (d) opportunities to exchange ideas on specific areas of concern. These elements were reported as relevant for all the programming cycle, although their individual weight and expression varied according to the different stages of this cycle. **The Institutional environment** challenges were the second most frequently identified. They alluded to limitations in, or absence of, (a) managerial support; (b) enabling resources and mechanisms; and (c) accountability.

More specific challenges, classified by analytical categories and programming stages, were the following:

1. **In planning**
* *Understanding and technical capacities*

**Shared conceptual framework:** The emphasis placed on **“shared”** referred not only to a collective but to a **“bottom-up”** rather than a **“top- down”** approach. A difficulty was signalled for advancing a gender equity approach in the face of an appearing weakening of **“Equity”** as the structuring principle of the Organization’s work. The need was expressed for this framework to elucidate the role of gender factors in relation not only to disease, but very importantly, to **health promotion** and **human resources** in the health system. And in this context, understanding the nature and impacts of ***‘women’s empowerment’*** --as promoted by the third MDG--, was seen critical.

It was noted that the **focus on gender**, particularly at the country level, was restricted to either, ‘Family and Community Health’ (FCH) themes, or to gender-specific issues such as gender-based violence. Respondents emphasized the need to broaden the understanding of **gender as a** **determinant of health inequality** in interaction with other inequality determinants. Particular weight was also given to integrating men more fully in the gender framework.

Due to the noted weakness or absence of a pertinent conceptual framework, gender was not integrated in the pre-planning **situation analysis.** It was argued that if gender was not to become an integral part of the situation analysis, it was unlikely that it could play a part of the planning, implementation and evaluation stages. The situation analysis that served as basis for the work plans was recognized as the “*Achilles heel”* of gender mainstreaming in programming.

The need to support theoretical knowledge with **empirical evidence** was underscored. Noted obstacles in this regard were: scarcity of sex-disaggregated information to detect problems, and non availability of documented “good practices” to guide strategies to address these problems.

Finally, the lack of both **internal dialogue** in PAHO involving the Gender Unit, and formal discussion fora on the relevance of gender to specific areas of interest, was seen as a key obstacle to the development of knowledge and of effective programming strategies.

* *Institutional environment*

Gender themes were perceived as having limited or no visibility in the **manager’s agendas**, and the view of gender integration as “*an added burden to programming, and added layer of thinking” was* considered widespread among staff.

Resources, both financial and human, for engendering work were reportedly limited. One third of respondents underscored the need for **human resources with gender expertise**.

The absence of gender in the **institutional planning guidelines** was emphasized. (In fact the second version of the guidelines did mention gender as a crosscutting theme but, apparently, this version was not widely distributed or read). So was the fact that n*o institutional follow-up and monitoring regarding* gender integration was performed and shown to staff. It was suggested that an analysis of how PAHO is responding to the gender equality mandate should be carried-out and made public.

**SOs, OWERs, RERs and OSERs** reportedly were given, not allowing much flexibility for integrating gender into their own planning area or for connecting office objectives with the SO7 gender- specific indicators. Explicit mention was made of SOs not overtly incorporating gender (excepting SO7), thus affecting its subsequent integration in the development of OWERs, RERs, and OSERs.

Finally, managerial levels most directly concerned with the promotion of gender equality (e.g., SO, area, unit) were deemed multiple, overlapping and difficult to coordinate.

**b. In implementation**

* *Understanding and technical capacities*

Low gender sensitivity and understanding among **others,** particularly among some PAHO managers were seen as obstacles. PWRs, reportedly, lean disproportionately towards biomedical issues at the expense of social matters and often see gender as a “soft” issue. Moreover, many staff members believe that promoting gender equality is not PAHO’s responsibility, but the duty of other UN agencies such as UNFPA or UNIFEM. Mentions were also made to the lack of gender understanding and sensitivity on the part of Ministries of Health (MOH) and to sexist cultural norms prevailing in the countries. A main challenge was worded as “*Getting a mind-set change of the entire organization to support gender equality in Human Resources”.*

* *Institutional environment*

The absence of gender in the planning guidelines and indicators was seen as a determinant of gender not being a factor in the implementation. The perception that gender is not an institutional priority for the evaluation of programs or individual performance, and the consequent lack of incentives or accountability in this respect were remarked.

Constraints in terms of financial, human and time resources were noted. Emphasis was placed on limitations on human resources with gender expertise and on financial resources to hire this type of experts.

1. **In monitoring & evaluation**
* *Understanding and technical capacities*

According to responding planning officers, a significant challenge to gender integration was the generalized lack of understanding of gender equity objectives in the context of PAHO’s mission apt for translation into evaluation indicators and criteria convened at the planning stage. Other noted challenges alluded to the absence/shortage of gender-specific evaluation tools, and of technical expertise in the two areas of related interest, gender and evaluation.

* *Institutional environment*

In 12 of the 21 interviews, reference was made to gender not having been an institutionally formal criterion from the planning stage, thus not becoming part of the institutional evaluation guidelines. It was also remarked that no feedback is received from the PAHO Office of [Planning and Program Budget](https://intranet.paho.org/DPM/PPS/PB/PPS_PB_Overview.asp) (PB) when gender issues are not addressed in planning or evaluation reports. A PB officer in turn indicated that the technical units “responsible” for each of the six crosscutting themes (gender among them) had not contributed with planning and evaluation criteria.

Finally, it was repeatedly stated that insufficient time elapsed between the approval of the PAHO Gender Policy (9/30/05) and the beginning of the 2006-2007 BPB planning process (10-11/05) to allow for this policy translation into planning and related monitoring.

* 1. **Facilitating Factors**

The factors most often cited as enablers of gender integration into the programming cycle were also classified under the analytical categories indicated above in 1.3.2., and in that framework they will be described here. In order of importance, these factors were:

* leadership and policies at the internal Institutional environment
* partnerships in the external environment
* enhanced gender understanding and competencies
* collaboration received from the PAHO Gender Unit

For the most part, these factors exerted their influence at the **planning and implementation** stages. The few instances in which gender appeared to have been part of **monitoring and evaluation** processeswereattributed to the enabling effect of the following factors: the PAHO Gender Equality Policy; the MDG framework; the availability of new corporate data permitting to identify detailed levels of gender inequality in the Organization’s Human Resources; the country BPB concordance with Objectives of Health Development at the national level; and gender criteria included in the biennial work plan, also at country level.

* 1. **Leadership and policies at the internal institutional environment**

The factors most vigorously and frequently cited as driving gender integration in the programming cycle were those related to **organizational leadership and policies**. The unwavering **support and commitment from the PAHO Director,** “*her* *leading by example”,* together with the **support of some senior managers** in HQ and CO, were reported as the decisive elements of such progress. Among these managers, some Health Ministers were actively recognized at the country level.

Throughout the cycle, but particularly at the planning and implementing phases, corporate pro-gender-equality policies were perceived as important facilitators of gender integration. The importance of the 2005 **PAHO Gender** **Equality Policy** was highlighted, not only because of its internal significance but mainly due to the weight it carried for being the voice of Member States through PAHO Governing Bodies. The organizational directive making **gender equality one of six cross-cutting themes** in the Organization’s work was thought as having exerted an encouraging influence in the recently completed 2008-2012 planning process. It was expected that this influence would carry through the subsequent implementation and evaluation phases.

* 1. **Partnerships and alliances with external stakeholders**

Factors in this category were mentioned as frequently as those referring to the internal enabling environment. The most prominent were the following: Political and financial support of progressive donors, both at regional and country levels; partnerships with other agencies of the UN and the Inter American system working on gender equality both at Regional and country levels; multi-sector work for Gender Equality and Women’s Empowerment at the country level, carried out with the Ministry of Health in alliance with other Government sectors and Civil Society. The latter included, routinely, the Ministry or Bureau of Women’s Affairs, and depending on the subject matter, the Ministries of Social Security, Education, and Culture.

The UN galvanizing policy regarding **MDGs** and, to a lesser extent, the International agreements on Sexual and Reproductive Rights, were recognized as external forces that greatly contributed to channel organizational attention and efforts towards gender equality issues.

* 1. **Enhanced understanding and capacity for gender mainstreaming**

Facilitating factors in this category were mainly cited in reference to the planning and implementation stages. In order of mentioning frequency, these factors were the following five:

(1) presence of women, gender-sensitive staff, and newly hired staff with gender expertise, in the respondent’s technical teams; (2) enhanced understanding of the relevance of gender as political priority at the international level, determinant of health inequality, and contributor to effectiveness in interventions; (3) increased access to relevant evidence on good practices; (4) having the equity framework as an umbrella for the work with gender equity; and (5) participation in discussion fora on gender and its relation to their area of interest.

* 1. **Collaboration with the PAHO Gender Network**

References to the **role of the PAHO Gender Network** as a facilitating force for mainstreaming were made in ten of the 21 interviews. Having a Gender Unit in HQ, and National Gender Focal Points in the Country Offices was an organizational feature that received high marks in terms of having initiated and given momentum to gender integration in planning and implementation. Reportedly, successes achieved on gender mainstreaming had been the product of the respective projects having a primary focus on gender **and** having counted with GE collaboration and partnership throughout the entire process. Other respondents alluded to the enhanced understanding of gender and health that resulted from their engaging with GE in inter-programmatic dialogue. And others emphasized the importance of GE collaboration and participation in the planning process.

1. **Limitations of the findings**

The significance of the above findings is limited by the small size of the sample and the narrow representation of Country Offices within this sample.

A further limitation to the analysis is related to the fact that the responses regarding the planning, implementation and evaluation processes did not refer to the same chronological programming cycle: the questions on implementation and monitoring referred to the 2006-2007 period, while the questions on planning dealt with the most recent cycle beginning in 2008. This temporal feature restricted the possibility of observing how gender integration changed through a continuing process over time and, henceforth, probing causal hypothesis. But, at the same time, it permitted to obtain information directly from those who participated in the planning process, and to gain insights into the strengths and flaws of the planning process that is currently guiding the Organizational work.

1. **Reflection of gender in Country Cooperation Strategies (CCS) and equivalent country planning processes**

The contents of the Country Cooperation Strategies (CCS) and their work plans constitute the second measurement area for the SD 2, *Bringing gender into the mainstream of PAHO’s management.* The CCS[[11]](#footnote-11) defines the strategic framework for PAHO/WHO work with that country and is generally in effect for 4-6 years. The country work plan implementing the CCS, is in effect for 2 years. Both are negotiated with the respective Government.

The two CCSs selected for this analysis were: **Honduras 2006-2010,** and **Trinidad & Tobago 2006-2009.** Their Biennial Country Work Plans corresponded to the 2006-2007 period. Following are of the indicators defined for this component and a table with their corresponding scores.

 **Indicators**

* Percentage of sampled CCS (2005 and beyond) **strongly** integrating gender: Zero
* Percentage of sampled (2006/2007) BWP **strongly** integrating gender: Zero

**Table 13.** Gender Integration Scores in Country Cooperation Strategies and Biennial Work

Plans in Honduras and Trinidad and Tobago**.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Country Cooperation Strategies**
 | None(Score 0) | Low(score 1-3) | Medium(score 4-6) | Strong (score 7-9) |
| **Honduras 2006-2010**“some” collaboration with GWHN  |  |  | 6 |  |
| **Trinidad & Tobago 2006-2009**“no” collaboration with GWHN |  |  | 6 |  |
|  |
| 1. **Country Work Plans**
 | None(Score 0) | Low(score 1-2) | Medium(score 3-4) | Strong (score 5-6) |
| **Honduras 2006-2007** “some” collaboration with GWHN |  |  | 4 |  |
| **Trinidad & Tobago 2006-2007**“no” collaboration with GWHN |  |  | 4 |  |

The gender integration scores for the CCS and work plans of both countries fell in the **higher range of the medium score.** In a scale of 0 to 9 the scores were 6 for the CCS, and on a scale of 0 to 6, the scores were 4 for the work plans in both countries. No quantitative difference in the scores was associated with the presence of collaboration with the PAHO/GE network.

**Characteristics of the sample:** Honduras and Trinidad and Tobagoare located in the Central American and English Caribbean sub regions, respectively. Spanish is the official language in Honduras, and English, in Trinidad & Tobago. Honduras is one of the priority countries for the PAHO/WHO Gender and Ethnicity Unit (GE) technical cooperation. Together with several other countries in Central America, it has been a focus of GE continued actions since 1990. Trinidad & Tobago, on the other hand, has had only sporadic contact with GE through these years.

**1. Country Cooperation Strategies (CCS)**

The agreed upon content analysis criteria revealed the following gender integration traits in the CCS of the two sampled countries: (See working tables in the Appendix).

**a. Gender referencing**: Gender- related references appeared throughout the text in both CCSs documents, slightly more frequently in the case of Honduras. In **Honduras,** these mentions dealt mainly with a **gender equity** approach to policies and programs within a framework of **health determinants,** and with issues such as access barriers for health care services, gender-based violence, MDG3, and sex-differentiated health needs. In **Trinidad and Tobago**, the references alluded to differentials regarding education, work, household headship, and political participation, also within a health determinants framework. Gender issues related to violence, women’s rights, gender discrimination, the MDG 3 and sex-differentiated health needs and outcomes were also mentioned.

Neither CCS, however, defined “***gender equality”*** and ***“women’s empowerment***”, let alone made use of these concepts as diagnostic criteria or guidance elements for actions in the health arena. The references to these concepts were few and restricted to passing mentions of the MDGs or other normative frameworks--such as the WHO 11th GPW 2006-2015 in the case of Trinidad & Tobago. No mention was made of the PAHO Gender Equality Policy. In general, neither CCS document adhered to the WHO gender guidelines, nor transpired a sense of ownership regarding the PAHO Gender Equality Policy and the MDG 3 (see Tables 1.1 and 1.2 of the Appendix).

**b. Consultations and partnerships with gender advocates:** Both documents promoted this type of interaction with women’s groups, the Women’s Affairs Government Bureaus and the UN Gender Interagency Work Group for the purpose of advancing gender-specific endeavours.

**c. Promotion and use of sex-disaggregated data** (SDD): Neither CCS included explicit recommendations or comments regarding the use of SDD. The Honduras CCS referred only implicitly to SDD by designating the application of the gender approach to epidemiological analysis as one of its technical cooperation priorities. The **use of SDD** was rather sparse in the two CCS reports, particularly in Honduras. Both countries used SDD it in the demographic context and in relation to violence. Additional SDD use appeared in the Trinidad and Tobago’s epidemiological profile, and in the Honduras’ description of PAHO’s Human Resources.

**d. Gender analysis**: Neither country showed strength in analyzing or interpreting differences between women and men in terms of determinants or outcomes **in relation to health.** This type of analysis was almost absent in the Honduras CCS, despite the acknowledgement made of the existence and magnitude of gender-based violence. The Trinidad and Tobago CCS did contain short analytical comments regarding two issues: women’s lower remuneration level relative to men’s, domestic violence’s disproportionate mortality impact on women.

**e. Promotion of actions to address gender themes**: Both CCSs specify and promote related actions. In the case of **Honduras*,*** gender-specific actions are explicit components of the Strategic Cooperation Agenda within the broader objective of addressing *the social and environmental determinants of health within the framework of health promotion and intra/inter sector coordination. These specific actions deal with (i)* ensuring the gender approach in health policies and programs by “ strengthening the staff’s capacities to develop the gender equity component in policies, programs, and the National Health Plan, and by establishing coordination with other sectors and civil society”. (ii) Guaranteeing the sustained participation of skilled staff in the process of addressing gender and gender-based violence themes.

*(iii)* setting-up a Health Services Information System that incorporates intra-family violence.

In **Trinidad and Tobago,** gender-related actions are stated in a less explicit language, but they do aim at highly relevant gender issues within the Strategic Agenda. They refer to “Strengthening sexual and reproductive health (S&RH) programmes that address teenage pregnancy, domestic violence, STIs, and reproductive organ cancer in both sexes, focusing on the implementation of the S&RH Strategic Plan with Regional Health Authorities”, and with the collaboration of the Women’s Network.

**2. Country Work Plans**

In comparison with the CCSs, the treatment of gender in the country biennial work plans was less crosscutting, more restricted and branded. There were also important qualitative differences between the two countries in the ways gender was integrated.

 **a)** Gender issues were not considered in the **situation analysis** that supported the work plan in Honduras. They did surface in Trinidad & Tobago’s situation analysis but only through references to women being more affected by poverty and discrimination, but without any further elaboration on the connection between these differentials and health. Honduras did not use any sex-disaggregated **health data** in the analysis, aside from the women-exclusive data on reproductive health. However, Gender Mainstreaming became a separately funded Office Specific Expected Result (OSER) in its work plan.

 **b**) Both plans had activities and tasks involving collection, promotion and use of SDD**.**

 **c)** Both plans specified activities or tasks involving **collaboration with women’s groups**

 **d)** OSER indicators were not disaggregated **by sex** in either country. However, there were numerous gender-explicit indicators of OSERs in the Honduras plan and a few gender-related actions in the Trinidad & Tobago’s. Both plans had **at least one OSER or product or activity that specifically addressed gender,** but the differences between the two countries were significant**:** In **Honduras,** three OSERs addressed gender; two of these dealt with gender-specific issues: gender-based violence; and gender mainstreaming in policies and programs within the Health Sector, the Women’s Affairs Ministry, and PAHO Country Office. The third one also dealt with gender-based violence, but within the broader context of a project on Human Security. In budgetary terms this meant a total of 10 broad “activities” and nearly 80 “tasks” with financial resources allocated. In contrast, the **Trinidad & Tobago** plan did not have any gender-specific OSER, although it explicitly addressed the integration of SDD regarding sexual and reproductive health, gender-based violence variables and other gender-sensitive data, in national and local Information Surveillance Systems.

**3. Differences associated with PAHO/GE collaboration**

Judging by the identical scores earned by the two countries, it would appear that a sustained collaboration between GE and a country office—such as that occurred in Honduras-- did not have a significant effect on the gender integration process. However, to answer this question, it would be necessary to introduce additional elements of **quantity, quality,** and **resourcing** both in the analysis criteria and in the scoring of results. The following comments are pertinent:

Regarding quantity and resourcing, for instance, the fifth and seventh content analysis criteria for the work plans allow only a Yes/No answer to the questions *“Does the country work plan have at least one OSER or product or activity or service that specifically mentions addressing gender?”*. *“Does the document specify actions to address gender?*” The answer was YES to both questions on both countries, and the score was 1 irrespective of the number of planned actions that mentioned and addressed gender issues. However, as already noted the difference between the two plans was substantial regarding the extent and funding of the planned interventions in each country.

Beyond quantity and resourcing of actions, it is important to examine both the existence of gender-specific interventions and the extent to which gender actions aim to penetrate or have indeed penetrated the various components of the CCS and the work plan. Elements to be examined are, for instance, the situation analysis in the CCS and the BWP that informs future actions. Others have to do with the way this analysis translates in the wording and content of the objectives and indicators, the degree of sex-parity among the office’s staff, the inclusion of gender experts in the team, and the establishment of relevant internal and external alliances and partnerships. Some but not all of these elements are currently identified by the content analysis criteria for this project.

**4. Limitations of the findings**

The reader must be warned about the unlikely representativeness of the CCS findings for the PAHO Region as a composite of 46 countries and territories, or at least, for the 34 that have completed or are completing the midterm planning process. This assertion regarding representativeness finds some empirical backing in the next section regarding gender integration into the country profiles of the Region produced by the respective Country Offices. Nevertheless, the results here documented do illustrate very interesting instances of similarities and differences in gender mainstreaming within the planning processes of two countries with quite different geographical, economic, cultural, linguistic, and ethnic backgrounds.

As just noted in the previous section, the tool to measure gender integration in the CCS and country work plans resulted weak in terms of its ability to capture some important quantitative and qualitative differences between countries. The Yes/No responses attached to the analysis criteria, that otherwise covered an appropriate range of issues, were too restrictive impeding to measure significant differences of degree.

It is worth noting that the preparatory work that went into effect for the development of both these CCS and work plans began to take shape simultaneously with-- or immediately after-- the issuing of the “*WHO Guiding Framework (2005) for CCS” [[12]](#footnote-12),* and also the approval of the “*PAHO Gender Equality Policy”.* The short time (if any) elapsed between the latter and the planning and programming processes was mentioned by some planning officers during theinterviews as a hindrance for having come in contact, digested and incorporated the policy into their work plans (see planners interviews).Therefore, the reflection of either two instruments on the planning process could not be fairly appraised for the convened reference period.

**C. Sex Parity in Staffing**

 Sex parity in staffing –-i.e., equal number of women and men at each and all levels in the Organization-- is regarded as an important requisite for ensuring that the concerns of both sexes are considered in the work of WHO/PAHO. It constitutes the third measurement area for SD 2, *Bringing gender into the mainstream of PAHO’s management.* Following are the definitions for the two selected indicators in this measurement area and two tables with the corresponding values for these indicators.

 **Indicators**

* Percentage of professional and administrative long- term and temporary posts, by sex, and grade (cumulative) until Dec 31 2007
* Percentage of long-term and temporary *new appointments* in 2007 by sex and grade (P, G, NPO).

**Summary Results for Indicators of Sex Parity in Staff**

**Table 14.** AMRO/PAHO: Percentage of women among **all active staff,** by grade, contract type, and location. December 31, 2007.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total**  | **Contract Type** | **Location** |
| **# staff** |  **% women** | **Long term** | **Temp** | **HQ** | **CO** |
| **Total Staff** | **889** | **59.3** | **59.2** | **60.2** | **64.6** | **52.9** |
| **Total P** | **459** | **40.7** | **39.5** | **50.0** | **50.0** | **30.0** |
| P01 |  9 | 77.8 | 66.7 | 83.3 | 75.0 | 100.0 |
| P02 |  44 | 65.9 | 56.7 | 85.7 | 66.7 | 62.5 |
| P03 |  74 | 41.9 | 46.6 | 25.0 | 50.9 | 11.8 |
| P04 | 223 | 34.1 | 34.1 | 33.3 | 42.9 | 28.8 |
| P05 |  69 | 39.1 | 38.8 | 50.0 | 43.9 | 32.1 |
| P06/D01 |  35 | 38.9 | 38.9 |  | 43.8 | 35.0 |
| D02 |  1 |  0.0 | 0.0 |  | 0.0 |  |
| UG |  3 | 100.0 | 100.0 |  | 100.0 |  |
| **Total NPO** | **33** | **69.7** | **69.7** |  |  | **69.7** |
| NOA |  8 | 75.0 | 75.0 |  |  | 75.0 |
| NOB |  6 | 50.0 | 50.0 |  |  | 50.0 |
| NOC | 14 | 78.6 | 78.6 |  |  | 78.6 |
| NOD |  5 | 60.0 | 60.0 |  |  | 60.0 |
| **Total GS** | **397** | **79.8** | **79.7** | **81.5** | **79.6** | **80.3** |
| G00 |  1 | 100.0 | 100.0 |  |  | 100.0 |
| G01 |  1 |  0.0 | 0.0 |  |  | 0.0 |
| G02 |  5 | 20.0 | 20.0 |  | 0.0 | 25.0 |
| G03 |  6 | 16.7 | 16.7 |  | 0.0 | 20.0 |
| G04 | 90 | 80.0 | 78.6 | 85.0 | 79.0 | 82.1 |
| G05 |  129 | 82.9 | 83.6 | 71.4 | 81.8 | 85.4 |
| G06 |  128 | 84.4 | 84.4 |  | 78.8 | 90.3 |
| G07 |  37 | 73.0 | 73.0 |  | 81.8 | 60.0 |

 0= no women in that category; Blank space= no staff of either sex in that category

 Total P includes D and UG

**Table 15.** AMRO/PAHO: Percentage and number of women among **new appointments**, by grade and contract type. Dec. 31, 2007

|  |  |  |
| --- | --- | --- |
|  |  **Total** | Contract Type  |
| Long term | Temporary |
| N | % women | N | % women | N | % women |
| Total | 170 | 60 | 35 | 54 | 135 | 61 |
| P\* | 121 | 52 | 22 | 41 | 99 | 55 |
| NPO | 8 | 88 | 8 | 88 | 0 | -- |
| G | 41 | 78 | 5 | 60 | 36 | 81 |

 \*Includes D and UG

The sex-parity analysis in this Region was based on the PAHO Human Resources Data Base[[13]](#footnote-13), which contained a more complete and detailed set of information than the *WHO* *Human Resources: Annual Reports.* Comparisons between Regions were drawn only in reference to ‘long-term contracts’, the only category that lent itself to this type of analysis.

**1. Sex parity among all PAHO staff at December 31 2007**

 **1.1. Sex parity in professional positions**

* *By grade*

Women represented **41%** of all professional staff (HQ and Country Offices) and outnumbered men in the two extremes of the scale: the two lowest grades (P1 and P2) and the top managerial positions (UG) where the three Directors-- Regional, Assistant, and Deputy—all three are women. They were however under-represented at the higher professional ranks of Ps and Ds, with P4 standing out as the grade with the lowest women’s share (See Figure 1).

**Figure 1.** AMRO/PAHO: Percent and absolute sex distribution of all **Professional** staff (HQ+ Country Offices) by grade. December 31, 2007



* *By contract type: long- term and temporary*

Temporary contracts represent approximately 10% of all PAHO staff contracts.

At the total level, women’s share is roughly 60% of either long-term or temporary contract holders. At the professional level, women hold **39.5%** of the long-term and **50%** of the temporary contracts. At the G level, the corresponding percentages are 80 and 82 (Table 14).

The sex-distribution by grade level in the long-term contracts closely resembled the distribution described for all professional staff. Among temporary appointments, the sex-disparities become larger, women’s share rising to 83% and 86% at the P1 and P2 levels, and dropping to 25% and 33% among the P3 and P4 levels. Women and men were equally represented (one to one) in the temporary P5 category.

**Figure 2.** AMRO/PAHO: Percent and absolute sex distribution of professional staff (HQ+ Country Offices), by contract type and grade. December 31, 2007.

 a. Long Term



 b. Temporary



* **By location: Head Quarters and Country Offices**

Women’s share of professional staff in PAHO/HQ (Washington DC) reaches parity at **50%.** This figure is higher than the corresponding 44% reported for WHO/HQ (Geneva), as it will be seen in the following section.

Women in PAHO/HQ are over represented at the lowest two P grades, constituting ¾ of the P1, 2/3 of the P2, and slightly over ½ half of the P3 grades. At the P4 to D1 levels their share stays in the lower 40% and, as already stated, it goes up to 100% at the Directorial level.

At country offices, women’s share of all professional staff declines to **30%,** reaching its lowest levels at the P3 (12%) and P4 (29%) grades.

 **Figure 3.** AMRO/PAHO **Percent and absolute s**ex distribution of all PAHO professional staff, by location and grade. December 31, 2007

1. Headquarters b. Country Offices



* **Comparison with other WHO Regions**

As stated above, the interregional comparisons were restricted to the ‘long- term’ category, due to this category being the only common denominator for all regions and WHO/HQ.

Regarding long-term **professional** staff, women’s share was **39.5%** in PAHO, making this Region rank third to EURO (47%) and WHO/HQ (44%). PAHO’s third place derives from its comparatively lower ranking with respect to the P4 grade. In fact, PAHO ranks first among all WHO Regions and WHO HQ in terms of women’s share among the higher grades of P5, P6, D and UG; but when it came to P4, PAHO’s percentage of 34, fell below the WHO overall average of 37, placing the Region in fourth place after WHO/HQ (56), EURO (45), and EMRO (40).

Among long-term **National Professional Officers,** PAHO amply surpassed the sex- parity level with a proportion of 70% of women, the highest of all Regions in that category, well above the overall WHO figure of 38%. And within the long-term **General Service** category, women were overwhelmingly over represented with a share of 80%, also the largest of all WHO Regions, far above the overall WHO percentage of 38.

* **Changes between 2006 and 2007**

Data in Figure 4 shows that between December 31 of 2006 and December 31 of 2007 there was an increase of women’s participation at the ungraded Director level (from 2 to all 3 posts). In the remaining professional grades no other gain was registered but rather a loss in absolute and proportional terms at the total level, more pronounced at P3 and P6/D1 levels, but also noticeable at P4 and P1 positions. Given the small size of the numbers, both absolute and proportional changes are depicted in Figure 4.

**Figure 4.** AMRO/PAHO:Changes in the number and proportion of **professional** (P) women between 12/31/2006 & 12/31/2007, by grade.

1. Number of women

12

30

40

86

27

15

0

2

7

29

31

76

27

14

0

3

0

20

40

60

80

100

P01

P02

P03

P04

P05

P06/D01

D02

UG

2006

2007

b. Women as % of total

0

20

40

60

80

100

2006

2007

2006

80.0

65.2

49.4

35.8

38.6

41.7

0.0

66.7

43.2

2007

77.8

65.9

41.9

34.1

39.1

38.9

0.0

100

40.7

P01

P02

P03

P04

P05

P06/D01

D02

UG

Total

 **3.1.2. Sex parity among Professional National Officers**

* *By grade (A to D)*

Women represented 70% of all PAHO National Officers (NPO), equating or surpassing men’s share in all four NPO levels. It must be kept in mind, however, that compared to their international P counterparts stationed in the field, NPOs enjoy lower levels of salary, benefits, decision making authority and job stability. No distinction could be drawn between long-term and temporary NPOs, since all NPOs appeared under the first grouping.

**Figure 6.** AMRO/PAHO: Percent and absolute sex distribution of **National** **Professional Officers** at Country Offices, by grade. December 31, 2007



* *Changes between 2006 and 2007*

During the period elapsed between 12/31/06 and 12/31/07 the proportion of women among the NPO staff in CO increased in the two higher grade-levels (C and D) and remained virtually the same in the lower ones (A and B). Because of the small size of the numbers, both absolute and proportional changes are depicted in Figure 7.

**Figure 7**. Changes in the number and proportion of women among National Professional Officers between 12/31/2006 and 12/31/2007, by grade.

1. **Number of women**

6

4

5

0

6

3

11

3

0

5

10

15

NO A

NO B

NO C

NO D

2006

2007

**b. Women as % of total**

0.0

25.0

50.0

75.0

100.0

2006

2007

2006

75.0

50.0

62.5

0.0

60.0

2007

75.0

50.0

78.6

60.0

69.7

NO A

NO B

NO C

NO D

Total

 **3.1.3. Sex parity among General Services Staff**

* *By grade*

Women represented **80%** of all PAHO/ GS staff including, both HQ + CO and long-term + temporary employees. There were only 13 staff members in the lower grades of G0 to G3, and 10 of these13 were men. Women, on the other hand, predominated heavily in the G4 to G7 grades.

* *By contract type*

No sizeable sex-distribution differences were detected between long-term and temporary G contracts.

* *By location*

At the total level, women’s share of Gs was basically the same in HQ and CO (80%). The difference between HQ and CO laid on the relative prevalence of women, or men, within G grades: the female share in Country Offices was larger than in Head Quarters at all G grades above G1, except for G7 where men’s inroad had amounted to 40%.

**Figure 8.** AMRO/PAHO: Sex distribution of PAHO **General Service** staff, by grade and location. December 31, 2007.

 a. Head Quarters + Country Offices



 b. Head Quarters c. Country Offices



* **Changes between 2006 and 2007**

Women’s share was virtually the same in 2006 and 2007, both at total and most grade levels, although there was an absolute 5% decrease in the number of women in G positions.

**Figure 9.** AMRO/PAHO: Changes in the number and proportion of women in General Service staff between 12/31/2006 & 12/31/2007, by grade-level

 **a. Number of women**

1

0

1

2

79

116

29

1

0

1

1

72

107

27

108

107

0

20

40

60

80

100

120

140

G00

G01

G02

G03

G04

G05

G06

G07

2006

2007

**b. Women as % of total**

0

20

40

60

80

100

2006

2007

2006

100.0

0.0

16.7

28.6

79.8

84.7

83.6

72.5

80.0

2007

100.0

0.0

20.0

16.7

80.0

82.9

84.4

73.0

79.8

G00

G01

G02

G03

G04

G05

G06

G07

TOTAL

**2. Sex parity among new appointments in 2007**

This section pertains to the second overall indicator for sex parity. It is based on the analysis of the information on recruitments completed during a given calendar year (2006, 2007) and active at December 31 of the corresponding year. The PAHO Office of Human Resources provided this data disaggregated by sex, grade, type of contract and location (HQ or CO). A more detailed disaggregation by grade level was also made available in relation to the professional categories of UG, D, P, and NO. The following are the most relevant findings.

* ***By grade***

Women represented **60%** of the total number of new recruitments. The respective proportion was **52%** in the P and higher grades, **88%** in the National Officers and **78%** in the General Services categories (Table 16a).

**Table 16.** AMRO/PAHO: Number of men and women, and percentage of women newly hired in 2007 or 2006, according to grade, type of contract, location, and year.

|  |  |  |  |
| --- | --- | --- | --- |
| **a.** **2007** | **Contract type** | **Total** | **%** **Fem** |
| **Long term** | **Temporary** |
| **HQ** | **CO** | N | **%** Fem | HQ | CO | N | % Fem |
| Male | Fem | Male | Fem | Male | Fem | Male | Fem |
| **P+** | 6 | 4 | 7 | 5 | 22 | 41 | 30 | 47 | 15 | 7 | 99 | 55 | 121 | 52 |
| **GS** | 1 | 1 | 1 | 2 | 5 | 60 | 7 | 29 | 0 | 0 | 36 | 81 | 41 | 78 |
| **NPO** | 0 | 0 | 1 | 7 | 8 | 88 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 88 |
| **Total** | **7** | **5** | **9** | **14** | **35** | **54** | **37** | **76** | **15** | **7** | **135** | **61** | **170** | **60** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **b.****2006**  | **Long Term**  | **Temporary**  | **Total** | **% Fem** |
| **HQ** | **CO** | N | % Fem | **HQ** | **CO** | **N** | **% Fem** |
| Male | Fem | Male | Fem | Male | Fem | Male | Fem |
| P+ | 8 | 4 | 4 | 3 | 19 | 37 | 29 | 40 | 23 | 12 | 104 | 50 | 123 | 48 |
| GS | 1 | 2 | 0 | 2 | 5 | 80 | 8 | 24 | 0 | 0 | 32 | 75 | 37 | 76 |
| NPO | 0 | 0 | 0 | 2 | 2 | 100 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 100 |
| **Total** | **9** | **6** | **4** | **7** | **26** | **50** | **37** | **64** | **23** | **12** | **136** | **56** | **162** | **55** |

 P+ includes P, D, and UG; NPO are l National Professional Officers

* ***By contract type***

Women predominated among both long-term and temporary contract categories, but their share remained higher among the temporary (61% vs. 54%). Despite their overall majority, women were under-represented (41%) in relation to men among the **long-term P grade** (and higher) appointments (Table 16a).

* ***By location***

74% of all new recruitments were made for HQ. Women’s share of the new hires relative to men was **65%** in HQ and **47%** in CO. At **P** and higher grades, women’s share constituted **55%** in HQ and **41%** in CO. In the category of national professional officers (NPO), 7 out of 8 new hires were women. (Table 16a)

* ***Among new professionals, by grade***

Figure 10a presents the sex distribution of all new long-term professional appointments (P, D, UG, NO) active at the end of 2007.Although the numbers are too small to warrant definite conclusions by grade level, they, **first,** highlight the hiring of two women at a UG (Deputy Director) and P6 positions. **Secondly**, they corroborate that the P4 category stands out as critical sex parity concern as it did for all staff (see section 1.1). Despite the fact that, in absolute numbers, more women were hired as P4 than in any other grade, in proportional terms this P4 category remained eschewed towards men, contrasting with all lower and even some higher Ps. This sex disparity among new P4 appointments was larger in the countries than in HQ.

* ***Changes in sex distribution between 2006 and 2007***

The comparison of the 2007 data (Table 16a) on **all** new hires by grade and type of contract, with the corresponding information for 2006 (Table 16b) indicated a number of changes in the sex composition of the staff categories under analysis. In fact, during the period of Dec.31, 2006 to Dec. 31, 2007, the percentage of women,

* increased for **all** new hires, from 55 to 60;
* increased for new **P** appointments, from 48 to 52;
* increased for new **GS** recruitments, from 76 to 78;
* declined for **NPO,** from 100 to 88, but the absolute number of women increased from 2 to 7;
* remained virtually unchanged in terms of its temporary/long-term ratio: 1.12 in 2006 and 1.13 in 2007.

The available grade-level disaggregation of the professional long-term appointments indicated the following changes (see Figure 10):

 **Figure 10.** Sex distribution of all (HQ+CO) new professional long-term

appointments active at Dec. 31 of each year: 2007 and 2006.

1. New 2007 appointments by grade-level, active at 12/31/067

46.7

100

100

100

64.3

33.3

53.3

100

100

100

100

100

**35.**7

66.7

0%

20%

40%

60%

80%

100%

2007 Female

0

2

5

0

1

0

0

1

0

1

4

2

16

2007 Male

0

1

9

2

0

1

0

0

1

0

0

0

14

P02

P03

P04

P05

P06

D01

D02

UG02

NOA

NOB

NOC

NOD

Total

 b. New 2006 appointments by grade-level, active at 12/31/06



1. Overall, more women than men were hired in professional positions (P + NPO) in 2007 while the reverse was true in 2006. This change stemmed from a substantial increase in the number of women’s appointments as national officers at the B, C and D levels and to a modest gain in the proportion of females in the combined category of P3-4 & P6 recruitments. It must be noted, however, that the tendency remained for men outnumbering women among the international P appointments (thirteen to nine in 2007) and women prevailing among national officer recruitments (seven to one in 2007).
2. Numbers also need to be qualified by the power attached to the positions. In this sense, it must be noted that a woman was added to the ungraded Directorial level, thus completing an all-women trio at PAHO’s helm.
3. For managerial male-dominated positions (P5, P6 and Ds) one woman and three men were hired in 2007. This could be seen as a step backward regarding the 2006 women/men recruitment ratio at those levels, which was of two women to three men.
4. The most frequent hires for both men and women occurred at the male-dominated P4 level: 11 in 2006 and 14 in 2007. In both years, these appointments continued favouring men although in 2007 there was a slight increase in the women/men ratio.
5. For P3 positions, two women and one man were recruited in 2007, proportion that could be deemed as a small inroad into a male-dominated field, particularly when compared to the corresponding 2006 ratio of one to one.
6. There were no new recruitments in 2007 at the levels of P2 and below that affected the predominance of women at those levels.

**3. Institutional measures to promote sex-parity**

Information obtained during the planners interviews (see previous section) indicated that several measures have been put in place to promote women’s recruitment at professional posts. The first one has been to set a quota of 20% female applicants before beginning the selection process. If this quota is not met, the advertising time is extended. The second type of measures is to ensure the participation of women in the committees that conduct the initial selection and the interviewing. And the third is to assign weight to the “female factor” as a selection criterion.

|  |
| --- |
| STRATEGIC DIRECTION 3: PROMOTING AND USING SEX- DISAGGREGATED DATA AND GENDER ANALYSIS |

The objective of this assessment area was to provide insight into whether key WHO publications, were promoting or using sex disaggregated data (SDD) and gender analysis.

**1. Summary findings**

Following are the numeric values for the two indicators selected to measure this SD3, a classification of the sampled publications according to each indicator, and a table containing the scores assigned to the sampled publications

 **Indicators definition and values**

* Number of sampled PAHO documents that promote or use sex-disaggregated data……2
* Number of sampled PAHO documents that strongly promote or use gender analysis in health………………………………………………………………………………………….. 2

 **Indicator 1: Promotion or Use of Sex Disaggregated Data (SDD)**

This indicator had two dimensions: recommending or using/ presenting SDD[[14]](#footnote-14): Two (2) publications made **extended use of and promotion** of SDD:

* *Social Protection in Health* *Schemes for Mother, Newborn and Child Populati****o****ns*
* *Health in the Americas 2007. Volume I-Regional.*

Use and promotion of SDD were barely visible in the *Countries Volume II of* *Health in the Americas 2007*; *and* **not mentioned** at all,in *Renewing Primary Health Care in the Americas*, or in *Guidelines for the preparation and review of PAHO BWP 2008-2009.*

 **Indicator 2: Promotion or Use of Gender Analysis**

This indicator was a composite of four dimensions: (i) explicit and appropriate statements/ references to gender; (ii) consultations and partnerships with women’s groups/ gender advocates; (iii) analysis/ interpretation of sex-disaggregated or sex-specific data in the light of socially constructed asymmetries between women and men in terms of the roles they play, their access to resources and power, and their needs being met; (iv) specific actions/ recommendations to address gender issues; and (v) use of inclusive/non sexist language. According to these criteria, the publications were characterized as follows:

 ***Strongly*** promoting or using gender analysis

* *Health in the Americas 2007.* *Volume I-Regional ,*
* *Social Protection in Health* *Schemes for Mother, Newborn and Child Populations*

 ***Somewhat*** promoting or using gender analysis, in descending order,

* *Health in the Americas 2007. Volume II-Countries*
* *Renewing Primary Health Care in the Americas*
* Guidelines to HQ and CO for the preparation and review of PAHO Biennial Work Plans 2008-2009.

**Table 17**. Summary scores indicating the extent to which sex-disaggregated data and gender analysis are promoted or used in a sample of 2007 PAHO/WHO documents

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of document | Name of document or publication | TotalGenderIntegra-tionScore | Indicator 5.1: Promotion or Use of SDD | Indicator 5.2:Promotion or Use of Gender Analysis |
| **Yes**(score 2-3 ) | **No**(score 0-1) | **Yes**(score5-7) | **Some what**(score2-4 ) | **No**(score0-1) |
| 1. Seminal | *Health in the Americas 2007.* *Volume I (2007)* | **8** | 2 |  | 6 |  |  |
| *Health in the Americas 2007.* *Volume II (2007)* | **5** |  | 1 |   | 4  |  |
| 2. Policy | *Renewing Primary Health Care in the Americas: A Position Paper of PAHO/WHO ( 2007)* | **3** |  | 0 |  | 3 |  |
| 3. Evidence | *Social Protection in Health Schemes for Mother, Newborn and Child Populations: Lessons Learned from the Latin American Region. (2007)* | **9** | 3 |  | 6 |  |  |
| 4. Tools |  Instructions for Preparing Biennial Work Plans 2008-2009. (2007) | **2** |  | 0 |  | 2 |  |
| Internal Peer Review Guidelines 08-09 Biennial Work Plans: HQ and Centers BWPs (2007). | **2** |  | 0 |  | 2 |  |
| Internal Peer Review Guidelines 08-09 Biennial Work Plans: Country Office WPs (2007)  | **2** |  | 0 |  | 2 |  |

The following paragraphs contain a description of the sample and a detailed characterization of the included documents in terms of the criteria used for the content analysis.

**2. Composition of the sample**

The following is the composition of the PAHO sample of key documents produced and or published during 2007. It is constituted by one document (single or set of documents) for each of four categories:

***Category 1.*** Seminal institution-wide publication: *Health in the Americas 2007.* Scientific and Technical Publication No. 622. Washington DC, PAHO, 2007 (1172 pages). Prepared by the Health Analysis and Statistics Unit (HA)

* Volume I--Regional (425 pages)--This volume was produced at the regional level.
* Volume II—Countries (747 pages).-- This volume was the joint product of regional and country offices.

***Category 2.*** Policy/ Governing Bodies document:*Renewing Primary Health Care in the Americas. A Position Paper of the Pan American Health Organization/ World Health Organization (PAHO/WHO),* Washington DC, PAHO, 2007 (48 pages). Prepared by the Health Services Organization Unit (OS).

***Category 3.*** Evidence type publication:*Social Protection in Health Schemes for Mother, Newborn and Child Populations: Lessons Learned from the Latin American Region.* Washington DC, PAHO, 2007 (60 pages). Prepared by the Health Policies & Systems Unit (HP) <https://intranet.paho.org/DPM/SHD/HP/SHD_HP_Overview.asp>**.**

***Category 4.*** Tools/normative guidelines***:*** Guidelines for preparing and reviewing PAHO Biennial Work Plans 2008-2009. (Set of three documents). November 2007 (27 pages). Prepared by the Office of Planning and Program Budget (PB).

* Instructions for Preparing Biennial Work Plans 2008-2009. Washington DC, PAHO, November 2007
* Internal Peer Review Guidelines 08-09 Biennial Work Plans: HQ and Centers BWPs. Washington DC, PAHO, November 2007
* Internal Peer Review Guidelines 08-09 Biennial Work Plans: Country Office BWPs”. Washington DC, PAHO, November 2007

All these documents, with the exception of Health in the Americas, Volume II, were originated at the Regional level (HQ and regional centers). Although a sample of four (or seven, if volumes are considered separately) documents is hardly representative of the considerable PAHO publishing production in 2007, one of these publications, *Health in the Americas 2007, Volumes I and II,* constitutes in itself a reflection of the Organization’s technical production during a five year-period. This publication is part of the series *Health in the Americas* reportsthat represent the coordinated effort and product of all PAHO technical offices in HQ and the countries. As such, it received particular attention in this analysis.

**3. Characterization of documents in terms of gender integration criteria**

The following section presents the results of the various content analysis criteria applied to the sampled publications. The discussion is organized by document, and within each document, by criteria regarding the presence of gender considerations in its contents. (See Word Search and Content Analysis Tables in Appendix 5).

3.**1.** Seminal Institution-Wide (Flagship) Publication

***Health in the Americas 2007****.* Scientific and Technical Publication No. 622*.* Volumes I and II. Washington DC, PAHO, 2007 (1172 pages). Prepared by the Unit of Health Analysis and Statistics (HA)

This PAHO’s most important official publication is the latest in the series of five-year reports that offer an updated, comprehensive presentation of the health situation throughout the Americas, generally and specifically in their 46 countries and territories. It describes and analyzes the progress, constraints, and challenges of PAHO Member States in their efforts to improve the health of the peoples of the Region. This publication was directed and coordinated by *the Health Analysis and Statistics Unit* but involved the participation of each and all technical offices in HQ and the countries. Because of the wide organizational range of its contributions, it constitutes in itself a mini sample of PAHO’s technical production during the period. It is important to note that the Gender Unit had a steady role in the preparation and development of this publication, through participation in its steering and review committees.

 ***Volume I:*** ***Regional***. ***Health in the Americas 2007****.*  (425 pages)

*Health in the Americas, Volume 1* (HA I) contains a **Preface** by the Director, a Regional Health **Overview,** and six chapters that are fairly representative of PAHO’s major technical areas of work: *Chapter* ***1***: Health in the context of development; *Chapter 2:* Health conditions and trends;-- *Chapter* ***3****:* Sustainable development and environmental health;-- *Chapter* ***4****:* Public policies and health systems and services;-- *Chapter* ***5:*** Health and international cooperation--. *Chapter* ***6:*** Prospects for Regional health***.***

The content analysis criteria (in bold italics) yielded the following characterization of this volume:

**a.**  It includes ***“one or more explicit statements/references to gender equality or gender equity” :*** about 30 explicit references to gender equality and gender equity, and 92 specific and appropriate mentions of the term *gender.* It is important to note that these references are not restricted to a particular section of the volume but that they are in 7 of the 8 main sections of the book, including the *Preface* by the Director. *The only section not including gender referencing was Chapter 5: Health and international cooperation.* This ample thematic spread of gender citations is certainly an indicator of a wide range of gender awareness existing across HQ technical units. In the same vein, it is important to note that the MDG 3, “Promoting Gender Equality and Women’s Empowerment”, was cited throughout the volume, except in two chapters*: ‘Public Policies & Health Systems***’, and** *’Health and International Cooperation’***.** Interestingly, the MDG 3 component of *Women’s Empowerment* received much fewer mentions than the one on *Gender Equality*.

**b.**  It fully complies with the criterion of including “***one or more "implicit" or indirect references to gender”.*** In fact there were more than 200 references (in text and tables) related to inequalities between women and men in access to resources and power, and to health opportunities and outcomes. Gender-based violence was alluded to throughout the whole volume (25 times), with the exception of Chapters 4 on *‘Public Policies & Systems’*, and Chapter 5 on *‘International Cooperation’***.** There were not references in this volume to ***“consultation/ partnerships with women's groups”*.** However,the final version of the book received the inputs of other agencies, UNIFEM among them.

**c.** It widely ***“uses/presents sex-disaggregated data*** (SDD)***,*** although not consistently in all areas where it was relevant. There were about 163 references to SDD throughout the book, which appeared in all but one chapter (*Health & International Cooperation*). On the other hand,HA Idoes not “***recommend the use of SDD”***, exceptin one isolated instance: the *Adolescent and Youths Health* section. No mention of SDD was made in the most pertinent sections referring to requirements and challenges for strengthening health systems information.

**d.** It “***uses gender analysis*”** and not only in the gender-specific section. Aside from *Chapter 1,* *Health in the context of development*, two subsections in Chapter 2 were particularly rich in this respect: *‘Health of Adolescents and Youths’* and *‘HIV/AIDS’.* There were however, numerous missed opportunities to quote and discuss relevant data throughout the volume.

**e.** It “***specifies at least one action/ recommendation to address gender”,*** and in a direct way. It underscores the need to address gender- based violence, involve men in reproductive health programs, and create conditions that empower women, particularly adolescents in the context of HIV and other health problems. In an indirect way, it does so by bringing attention to unjust gender inequities that demand intervention: e.g., unfair differences in terms of access to health services, avoidable health outcomes, power to control one’s life, access to decision making positions within the health sector, etc. Finally, it ***uses inclusive, non-sexist language***.

***Health in the Americas 2007****.*  ***Volume II—Countries*** (747 pages)

A random sample of the country profiles included in this second volume, 14 out of 46, was analyzed. These countries were: Antigua & Barbuda, Argentina, Aruba, Barbados, Bolivia, Canada, Costa Rica, Ecuador, Honduras, Nicaragua, Suriname, Uruguay, El Salvador, and Trinidad & Tobago (222 out of the 747 pages in this volume). The following are the results of the analysis of this second volume of *Health in the Americas 2007* (HA 2):

**a.** In terms on the inclusion of ***“ one or more ‘explicit’ statements/references to gender equality or gender equity”,*** HA 2 barely qualified***. :*** *Gender equality* was explicitly mentioned only once and in one country profile: Argentina. Gender equity was not explicitly alluded to in any country. Furthermore, the utilization of the *gender* term was not either widely widespread: only 9 out of 14 country profiles contained this concept. Most references came from Trinidad & Tobago (14), and El Salvador (7). With the exception of Trinidad & Tobago that referred to sex-parity in education, no other mentions were made to MDG 3 although the MDG framework was frequently alluded to in most countries.

**b.**  When it came to including ***“one or more "implicit" or indirect references to gender”,*** HA2 contained more than 150. They dealt with gaps and inequalities between women and men in terms of access to resources and power, and with special issues affecting women: **‘*Gender-based violence’*** or ‘violence against women’ was probably the single most mentioned gendered health issue (32 references). It was highlighted in all but two of the sampled countries: Uruguay and Argentina**.** *It must be noted, however, that 5 of the 14 countries did not contain any gender-related references.*

**c.** HA 2 does not specifically ***“recommend the use of SDD”,*** however it does ***“use/present SDD”.*** There are approximately 465 references in text, tables and graphs to SDD covering social, demographic and health issues. These references were fairly widespread throughout the sample of countries, being more frequent in some countries. In the preface to the book, the Director expresses clear concern about this issue: *“It bears noting, that the quality of information from the countries varies considerably and that it was impossible to obtain from some of them within-country disaggregation of data that would enable measurement of disparities in the health status of specific population groups”.* The use of ***“Gender analysis”*** is mostly restricted to the social context and seldom applied to health themes except in reference to HIV, GBV, and other SRH issues.

**d.** Regarding “***specification of at least one action/ recommendation to address gender”,*** HA2 most often limits itself to pinpoint gender inequities but without reference to actions to address them. There were some exceptions, such as the ‘Program of Healthy Sexuality and Responsible Procreation’ in Argentina.

**e.**  There was no mention in the volume of “***consultation/ partnerships with women's groups” .***

**3.2. Policy/ Governing Bodies publication**

***Renewing Primary Health Care in the Americas.*** *A Position Paper of the Pan American Health Organization/ World Health Organization.* Washington DC, PAHO, 2007 (48 pages). Prepared by the Unit of Health Services Organization (OS).

Primary Health Care is one of PAHO’s six crosscutting themes. This document, approved by PAHO Governing Bodies, “ *is intended to be a reference for all countries moving forward to strengthen their health care systems, bringing health care to people living in urban and rural areas, regardless of their gender, age, ethnicity, social status, or religion “* (From the preface by the PAHO Director). The results of the content analysis were the following:

**a.** Regarding the inclusion of ***“one or more "explicit" statements/references to gender equality or gender equity”:***  The only time at which *gender equality* was explicitly mentioned in the entire document was within a footnote listing all the MDGs. The concept of *Gender equity* was **not** directly mentioned either despite the fact that equity was repeatedly acknowledged as a core value. Gender equity was indirectly alluded to in the following contexts: (a) gender being one of several distinctions to be recognized--or addressed— when considering equity of access to health care, for instance, *“...bringing health care to people ... regardless of their gender, age, ethnicity, social status, or religion, political belief, or economic or social condition” (Preface by the PAHO Director);* and (b) health care models being gender and culturally sensitive: “*addressing the specific needs of particular populations such as* ***women****, the elderly, the disabled, indigenous, or afro–descendent populations who may not receive appropriate care” (p.14).*

**b.** No “***consultation or partnerships with women’s groups*** “ were indicated. Regional and national consultations did take place in 2005. At a country level, the position paper was reviewed by representatives of ministries, academia, NGOs, professional associations, health service providers, decision makers, consumers and other social sectors. These consultations may or may have not included women’s groups.

**c.** The document does not ***“recommend the use of SDD” despite the fact than a***mong the recommended actions to prioritize during the first two years is the development of situation analyses and diagnostics. No explicit mention was made to any type of data disaggregation in this context; neither was made in a subsequent recommendation to *“develop a methodology and indicators to monitor and evaluate the progress made by the countries and the Region as a whole in the implementation of PHC–based health systems” (p.22).* No quantitative data was presented in the document, thus there was not “***use/presentation of SDD”***

**d.**  The publication does not ***“make use of gender analysis”,*** except for the above mentioned broad statements alluding to the importance of recognizing and addressing differences in needs and preferences of various populations groups as defined by place of residence, gender, age, ethnicity, social status, religion, political belief, or economic or social condition. None of such references to gender was followed by any elaboration regarding the nature, consequences and policy implications of gender differences; consequently, no indication was made with respect to “***actions/recommendations to address gender”.***

**3.3. Evidence ( Research) Type publication**

***Social Protection in Health Schemes for Mother, Newborn and Child Populations: Lessons Learned from the Latin American Region.*** Washington DC, PAHO, 2007 (60 pages). Prepared by the Unit of Health Systems and Policies (HP).

Social Protection in Health is another one of PAHO’s six crosscutting themes. This publication presents the experiences and lessons learned from seven Latin American country case- studies on systems of social protection in health (SPHS) aimed at mothers, newborns, and children.

The results of the content analysis were as follows:

**a.** Inclusion of ***“one or more "explicit" statements/references to gender equality or gender equity”:*** the documentincludes **one** explicit reference to *gender equality* in the context of the MDG framework, and nine statements related to *gender equity.* In also contains 25 explicit and appropriate mentions of *gender* in relation to inequality, discrimination, partnerships and health determinants. From the very presentation of the document, *gender* is highlighted as a health determinant.Most relevant for this assessment are the references to *women’s empowerment* in the context of the MDG 3. These references go beyond naming the MDG 3, to analyze the health repercussions of the power imbalance between women and men and to emphasize women’s empowerment as a condition to achieve gender equality and other MDG objectives, such as maternal health.

**b.** Inclusion of ***“one or more "implicit" or indirect references to gender”:*** the text contains more than 30 references alluding to gender as a health determinant, a source of inequity, a focus for interventions, and an approach to analysis and policy development. It throws light on key issues of gender inequality in the distribution of labour, access to health care, and access to resources & power both in society at large and **within the family: “***the improvement of women’s social status within the family...appears to be crucial in the ability of the SPHS to tackle negative social determinants” (Pags. 3-4).*

**c.** The document does not ***“refer to consultation/ partnerships with women's groups,*** but alludes to contributions by women’s groups to relevant policy making in a country (Ecuador), and quotes data provided by that country’s Government Gender Bureau.

**d.** The publication does not explicitly ***“recommend”*** **SDD’**s use. However, the analysis and conclusions --especially those dealing with women’s status relative to man, as predictor of maternal health-- point to the need to work with this type of data. *“Women’s status, as measured by indicators such as level of education relative to men, age at first marriage, and reproductive autonomy, is a strong predictor of maternal mortality” (p.33).* Since the document focuses on maternal health, most health data refers to women only. However, **SDD is presented** in the socio-demographic contest and it is used to make a case for gender as a health determinant.

**e.** The use of ***gender analysis*** is the document’s strongest asset in terms of gender integration. Beyond the simple presentation of SDD, the document makes a case for gender as a health determinant, examines the health repercussions of women’s lower status, and analyzes the policy development implications of gender differences in roles, norms and power.

**f.** On the subject of ***“specifying at least one action/ recommendation to address gender***”, adocument’s central input is the emphasis placed on the importance of addressing intra-household inequalities: *“As learned from these experiences, conditioned programs achieve better outcomes when they are directed to families instead of individuals and when the mother is the recipient of the monetary or in-kind benefit.... giving control of monetary benefits to the mother improves the status of women within the family” (p.145).* Another significant contribution is that of calling into question the wisdom and justice of common practices: *“... targeting the maternal* and child population, using age or pregnancy as a main criteria, brings *up the question of equity of access to health for the rest of women of reproductive age and for older children”(p.145).*

##  3.4. Tools/normative guidelines

Guidelines for preparing and reviewing PAHO Biennial Work Plans 2008-2009. November 2007 (27 pages). Prepared by the Office of Planning and Program Budget (PB)

* Instructions for Preparing Biennial Work Plans 2008-2009. Washington DC, PAHO, November 2007
* Internal Peer Review Guidelines 08-09 Biennial Work Plans: HQ and Centers BWPs. Washington DC, PAHO, November 2007
* Internal Peer Review Guidelines 08-09 Biennial Work Plans: Country Office BWPs”. Washington DC, PAHO, November 2007

As their names indicate, this set of documents distributed in November 2007, aimed to assist HQ and CO staff in the preparation and peer reviewing of the 2008-2009 Work Plan. The analysis of this set of documents indicated the following:

**a.** The only explicit reference to *gender* in each of the three documents was a statement indicating that,  *“When an entity prepares its Biennial Work Plan, they should take into account the six cross-cutting technical cooperation topics:* ***1.*** *Health Promotion; 2. Primary Health Care;* ***3.*** *Human Rights;* ***4.*** *Social Protection;* ***5.*** *Gender Equity; 6****.*** *Health of Indigenous Populations. The Assistant Director‘s Office is developing technical guides for implementing the cross-cutting topics within the BWPs….. “*

**b.** There was not any other explicit or implicit reference to gender in these guidelines. In other words, they did not promote--or mention-- any of the other themes pertaining the analysis criteria, i.e., consultations with gender advocates, use of sex- disaggregated data, practice of gender analysis, or consideration of actions to address gender.

**c.** Three additional issues merit acknowledgment in this context: *First,* a previous version of the guidelines for preparing the work plan, distributed in October, did not include the instruction about considering the cross-cutting technical cooperation issues, and both versions were still posted. *Second,* the peer review guidelines explicitly declared that **the six cross-cutting issues did not apply to administrative entities.** And, third,the technical guides from the AD Office to integrate the cross-cutting themes had not been issued.

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| STRATEGIC DIRECTION 4: ESTABLISHING ACCOUNTABILITY |

As it is the Organization's policy to ensure that all research, policies, programmes, projects, and initiatives with WHO involvement, address gender issues, it would be expected that such issues were incorporated in the senior managers’ speeches. In this context, the reflection of gender equality concerns in major speeches given by the PAHO Director was selected as the sixth area of measurement.

**1. Summary results for the selected indicators**

As already indicated, all online-available four (4) speeches and five (5) power-point presentations given in 2007 by the PAHO Director, Dr. Mirta Roses Periago, were included in the sample. The only criteria for exclusion referred to speeches made specifically on gender or women's issues, e.g. the speech on International Women's Day. The summary results for the selected indicators are in the following chart and the list of the sampled speeches/ presentations appears in Table 18.

|  |  |
| --- | --- |
|  **Indicators**  |  **Values** |
| 1. Number of 2007 major sampled speeches by the PAHO Director in which at least one gender-related reference was made
2. Number of times gender was referred to in the speeches (to assess the strength/depth of reference to gender in each speech)
 | **8** out of 9 speeches**39** Refs.in 9 speeches |

## 2. Gender integration characteristics

## The information in Table 18 highlights the following:

**a.** Gender references tended to appear most frequently in **broad-scope** presentations of three types:

* Empirical progress report, like *“Improving Health in the Americas: How far we come and how far do we have to go?”*  (15 references in 33 slides),
* Guiding principles and conceptual frameworks, such as “*New Life for Primary Health Care: the Social Determinants of Health”.*  (6 references in 15 slides). Note that the speech was more on social determinants than on primary health care.
* Strategic orientations, like her *Acceptance speech* *as re-elected Director of the Pan American Health Organization* (5 references within 1668 words).

## b. The frequency of gender-related references tended to be lower in specific-issue focused presentations such as Sustainable Democracy, and Primary Health Care. Some clarifications are warranted in this respect: first, the theme of primary health care had numerous gender-related references when the main focus was not care, but health determinants. Second, in qualitative terms, the presentation, *“Improving People’s Health through Healthy Environments*”, was the one most explicitly registering and developing theme-specific gender concerns and translating the MDG #3 into health terms.

**Table 18.** Gender references in selected 2007 PAHO Director’s speeches

|  |  |
| --- | --- |
|   Sampled PAHO Director’s Speeches & Presentations (2007)  | No. ofReferences |
| “Improving People’s Health through Healthy Environments”. Power Point Presentation at the 7th National Conference on Science, Policy and the Environment. Washington D.C., 2 February, 2007 (29 slides).“Latin America and the Caribbean: United in Diversity toward Universal Access”. C**losing Address at the IV Latin American and Caribbean Forum on HIV/AIDS/STI.** Buenos Aires, Argentina, 20 April 2007 (1662 words)*“New Life for Primary Health Care: the Social Determinants of Health”.*  Power-point presentation at the 8th Commissioners' meeting of the Commission on Social Determinants of Health. Vancouver, Canada. 7-9 June 2007 (15 slides)*“Health is essential for sustainable democracy in Americas”.* Power-point presentation to the Organization of American States Ambassadors Permanent Council. Washington D.C., June 20, 2007 (18 slides)*“*[***Achievements, Challenges and Leadership***](http://www.paho.org/english/D/Presentation_MR_Forum%28Eng%29.ppt)*”.* Power-point Presentation at the Candidate Forum for New PAHO Director. Washington, D.C. PAHO HQ, June 25-29, 2007 (40 slides).*“Improving Health in the Americas. How Far We Come and How Far Do We Have to Go?”.* Power-point presentation at the UFBA (Federal University of Bahia) given before national authorities and foreign delegations. Bahia, Brazil. July 17, 2007 (33 slides).Closing Statement at the *Buenos Aires 30/15 International Conference on Primary Health Care.* Buenos Aires, Argentina, 17 August 2007 (2735 words).*Acceptance Speech* on her re-election as Director of the Pan American Health Organization, before the 27th Pan American Sanitary Conference and 59th Session of the Regional Committee. Washington D.C., October 3, 2007 (1668 words). *“Partnership for Health Development”.* Power-point presentation at the 4th Global Meeting of Heads of WHO Country Offices with DG and RDs. Geneva, 12 November 2007 (11 slides) *All nine presentations* | 536121525039 |

## c. The only one presentation without any explicit or implicit gender-related reference was *“Partnership for Health Development”.* This theme also happened to be the only one within PAHO’s official publication *Health in the Americas 2007,* (Chapter 5: *Health and international cooperation*) which showed a total absence of gender-related statements.

## d. Explicit gender references often dealt with the MDG #3, covering notions of gender equality, gender equity, and women’s empowerment. The linking of gender equity to the MDG #3 was also observed in the Director’s preface to *Health in the Americas 2007.* The equity emphasis—reaching disadvantaged groups— in the approach to gender on her presentations was explicit in her references to applying a gender perspective to policies and in the strategic priority she assigned to women, particularly the poor and the young. In this same context of equity, there were references underscoring the importance of producing sex-disaggregated data and indicators, and addressing women and men’s differential roles, needs, power and health outcomes.

## 3. Limitations of the analysis

## A first limitation to this type of inquiry was the pool from which the sample was selected that referred only to those presentations available in the internet. A second limitation was imposed by the fact that the verbal discourse that normally accompanies the skeletal presentations in power-point slides could not be part of this analysis.

## But a more significant limitation refers to the weakness of the indicator itself for measuring accountability from the Senior Management. As already stated, this indicator only holds the very top level of senior management (DG and RDs) accountable through speeches, but there is no measure to hold the next few layers of senior management accountable. But the absence of gender in some manager’s agendas was indeed identified during the planner’s interview as a main challenge to gender mainstreaming.

## Furthermore, the integration of gender in the discourse, while necessary, appears insufficient for the purpose of measuring commitment or establishing accountability because it does not deal with the ways in which words are translated into actions. In the context of the information collected by this study, PAHO’s advancement in terms of sex parity policies in recruiting could constitute one complementary indicator of the Director’s commitment to gender equality. Other indirect measures could have been the planning focal points responses qualifying the Director’s support as the key facilitating factor to gender integration.

## A final note in this respect alludes to the fact that if documents are taken as indicators of commitment to Gender Equality, the most relevant and significant for this Region is the PAHO Gender Equality Policy (2005), first approved by the Director, Dr. Mirta Roses, who subsequently led the process that resulted in the official approval of this policy by the PAHO Governing Bodies.

**IV. SUMMARY AND DISCUSSION**

The purpose of this baseline assessment was to determine the current status for implementing the four strategic directions (SD) of the WHO Gender Strategy (2008-2013) and, in the PAHO’s case, the Gender Equality Policy and Action Plan (2009-2012); and by so doing, to contribute to identify actions needed to strengthen the implementation of the WHO Gender Strategy and the PAHO Gender Equality Policy. Its specific objectives were: *First,* to assess the institution wide capacity for gender analysis and actions (SD1). *Second,* to gauge the extent to which PAHO/WHO’s management has integrated gender (SD2) in: strategic and operational planning and programme cycle processes; Country Cooperation Strategy (CCS) documents and country work plans; and achievement of sex parity in staffing in 2007. *Third,* to map the extent to which key PAHO/WHO publications promote and use sex disaggregated data (SDD) and gender analysis (SD3). *Fourth*, to assess Senior Management (Director General/Regional Directors) commitment to promoting gender equality (SD4).

The methodology shared by all WHO Regions employed a mix of qualitative and quantitative methods including an all staff survey, interviews with planning focal points from selected departments, and content analysis of various types of documents: Country Cooperation Strategies, Country Work Plans, key PAHO/WHO publications, and Director’s speeches. The following is a summary of the main results yielded by this assessment in PAHO:

**1. Building the capacity for gender analysis and planning (SD1)**

The corresponding assessment tool was an email survey on staff capacity for gender analysis and planning sent to all WHO staff. The ***response rate*** for PAHO was **44%** (390 of 889),figure well above both the 20% expected for this kind of surveys, and the 25% reached by WHO staff as a whole.

1. The survey data indicated that in PAHO, approximately **nine out of ten** staff members, were aware of WHO and PAHO gender policies**, six** had good knowledge of basic gender concepts**, six** felt that gender was relevant to their work, **four** applied this knowledge to their work, and **four** acknowledged having received institutional support for doing so. These figures clearly revealed a sizeable institutional gap between awareness and knowledge, on one side and action, on the other, regarding the promotion of gender equality.
2. Large and statistically significant differentials were identified between **professional (P) and general service (G)** staffalong the dimensions of perceived relevance, knowledge application and institutional support received with respect to gender mainstreaming. This breach was also evident from the low G response rate to the survey **(26%)** which was less than half that the P response (59%). These findings acquire particular relevance in the face of the PAHO Official Peer Review Guidelines for the 2008-2009 Work Plans, explicitly declaring that*“the six cross-cutting issues* (gender equality among them) *did not apply to administrative entities*”.
3. No significant sex-differences were registered in PAHO with respect to gender related awareness and knowledge. Sex-differences were statistically significant, favoring men, when referred to perceived relevance of gender to the respondent’s work, application of gender concepts to that work, and institutional support received for that purpose. These differentials, however, might very well have been the spurious result of the predominance of women (80%) among G staff, the large share of Gs in the sample (45%), and the fact that this staff category has not yet been targeted by gender mainstreaming efforts. To arrive at any conclusion in this respect, sex differentials would have to be calculated within grades.
4. Statistically significant **differences among the four WHO Region**s **and WHO/HQ** were identified. PAHO ranked first among all regions along the dimensions of gender policy awareness, application of gender knowledge to work, and reported institutional support for gender mainstreaming. It ranked second to EURO in terms of level of knowledge of basic gender concepts, and to SEARO and AFRO respectively, regarding reported relevance of gender to office’s and individual’s work.
5. The WHO global data illustrated the existence of significant differences between WHO/HQ and Country Offices and there were strong indications coming from the qualitative analysis of PAHO materials to surmise that important differences of this type could also be at play within each Region. However, the disaggregation of the survey data by location (HQ and Country Offices) wasnot yet available at the regional level.
6. The nature of the factors most often noted by PAHO surveyed and interviewed staff as ***challenges or barriers*** for gender mainstreaming suggested that the knowledge--application gap was connected to the **lack of specificity** of the gender knowledge held by staff in relation to their current work areas. Associated with this knowledge generality the following factors were emphasized: *insufficient understanding of the role played by gender in their particular work fields;* the consequent *lack of “know how” to apply gender knowledge*; and the *absence or short supply of area-specific gender evidence and tools.*
7. Regarding ***facilitating factors*** for gender mainstreaming, the PAHO staff responses highlighted availability of information and **hands-on technical collaboration** **tailored to** **specific areas of work.** PAHO’s responses coincided with those from the rest of WHO in underscoring the importance of: *collaborating* ***with*** *colleagues* with gender expertise; sustaining *discussions on gender in one’s area of work* in office-staff meetings; accessing *gender information relevant to one’s area of work; and having designated gender focal points*. The latter draws attention to the importance assigned to *sustained* technical support. The relatively low rating assigned to training opportunities merits further exploration in view of the priority generally assigned to this component within gender mainstreaming strategies. It must be noted that the present survey contained several questions on training yet to be processed and analyzed. This analysis will help to ascertain whether the low priority assigned to training stems from a small number of staff in the sample who had gender training, to a training received that was not considered helpful for action purposes, or from other factors.
8. Consequently, the types of ***institutional support deemed necessary*** to advance gender mainstreaming focused on *developing knowledge* *and skills;* *facilitating access to area-specific gender data/evidence; and enabling a sustained technical collaboration from either Gender Focal Points or the Gender Unit.*

**2. Bringing gender into the mainstream of PAHO’s programme management (SD2)**

This strategy was drawn along three dimensions: (1) operational planning and programme cycle processes; (2) Country Cooperation Strategies (CCS) and corresponding two-year work plans; and (3) level of sex parity among staff.

 **2.1. Operational planning and programme cycle processes**

Twenty one (21) planning focal points (PFP) in PAHO/HQ and CO were interviewed regarding the extent of gender integration into the different phases of the operational programming cycle: planning, implementation and monitoring/evaluation.

 *2.1.1. Extent of gender integration*

1. 39% of the interviewed PAHO PFPs indicated that a **“*strong”***gender integration was achieved at the **planning** phase (2008-2012 Strategic Plan). In this respect PAHO fared slightly better than the WHO’s average for all Regions (37%). On the other hand, no strong gender integration was reported by PAHO PFPs for the implementation and evaluation phases of the past 2006-2007 work plan, whereas the respective WHO averages were 6% and 2%.
2. Only a moderate level of gender integration was acknowledged for the **implementation** and **monitoring/ evaluation** phases by less than two thirds and one fifth of the PFPs, respectivel**y.** In general, the proportion declaring “none or weak” gender integration in planning and implementation was lesser in PAHO than in WHO as a whole, but the reverse was true for monitoring/evaluation. In any case, both in PAHO as in all WHO, gender integration was judged to be weakest in the monitoring/evaluation phase.
3. Due to the small sample size, definite conclusions regarding grade **differentials** in gender integration were not feasible, but some consistent associations were observed: gender integration was more frequent (at both strong and moderate levels) among women relative to men, among directors relative to professionals, and among planners with *some,* relative to planners with *no* previous collaboration with the PAHO Gender Unit network.

 *2.1.2. Perceptions on inhibiting and facilitating elements for gender mainstreaming*

* *Inhibiting factors*
1. Gender integration weaknesses in the **planning stage** (2006-2007 work plan)**,** particularly in regards to the **situation analysis,** were charged with holding back gender visibility and integration in the subsequent stages of implementation and monitoring.
2. The most important reported obstacles for gender mainstreaming were related to staff **limited understanding and technical capacity** regarding gender and health. These limitations rested less on lack of awareness regarding organizational gender policies--or on knowledge of basic gender concepts-- than on limited understanding of the relevance of gender to their **specific work areas** and on the ways to address gender equality issues in those areas. Emphasis was placed on the lack of *shared conceptual frameworks*, access to *supporting empirical evidence*, availability of practical **tools** to translate knowledge into action, and opportunities to discuss and *exchange pertinent ideas.*
3. Other key factors perceived as hindering the advancement of gender integration in the programming cycle were: the **lack of organizational guidelines** for gender integration into planning and evaluation; the seeming **absence of accountability** mechanisms and procedures in this respect; and the **invisibility of gender in some manager’s agendas.** Severe limitations in enabling resources, particularly, in terms of **gender-skilled human resources**, were also emphasized.

 *Facilitating factors*

1. The facilitating factors most frequently mentioned referred to the institutional internal environment. They were: ***first,*** the decisive *support from the PAHO Director* and some senior managers in HQ and Co; ***second*** the institutional pro-gender equality policies, with special emphasis on the *PAHO Gender Equality Policy;* ***third****,* the *enhanced gender competencies* on the part of the corresponding technical teams, expanded with the hiring of professionals with gender expertise, and paired with increased access to relevant information; and ***fourth*,** the collaboration received from the *PAHO gender network* in HQ (GE Unit) and in some countries (GE focal points).
2. Other facilitating factors characterized as critically influential for gender mainstreaming had to do with the external environment. They referred to financial and political *support received from progressive donors*; alliances and partnerships with other *agencies from the UN and Inter American Systems* both at the regional and national levels, and *multi-sector work* in the countries involving Women’s Affairs Ministries or Bureaus.

 **2.2. Country cooperation strategies and corresponding work plans**

Two countries were selected for this analysis: Honduras and Trinidad Tobago. The first had a long history of collaboration with the GE Unit, the second had not. Both countries’ CCS and work plans indicated only medium values of gender integration. Although it was evident that gender equity concerns were making significant headway into the planning processes of these two countries, the resulting documents did not adequately reflect WHO and PAHO mandates on making gender equality a cross-cutting issue in the Organization’s work.

1. Advances were visible in both countries towards inscribing gender within the framework of health determinants and identifying it as a marker of socio-economic inequalities. Two gender issues were salient: **gender-based violence,** in both countries,and sexual and reproductive health in Trinidad & Tobago. An active engagement with external actors --the Government Gender Bureau, the women’s network, and the UN national gender officers was clear in both countries.
2. Awareness of gender equality mandates was **explicitly** manifested in the Honduras’ CCS and BWP through proposals *to ensure a gender approach in policies and programs*. These proposals were formulated from the perspective of laying the groundwork for subsequent interventions and included: strengthening staff’s capacities in gender planning; establishing coordination with other gender-aware government sectors and civil society; strengthening information on gender based violence; and guaranteeing the sustained participation of skilled staff in the process.
3. Despite reiterated endorsements of the MDG framework and, specifically, of the MDG 3, no planning document of either country attempted to translate the concepts of **gender equality** and **women’s empowerment** into concrete actions in the health field. Most significantly, neither country used these or other gender notions as criteria for developing their health situation analysis and identifying problems in need of response.
4. The use of **sex-disaggregated data** was thin in both types of documents, particularly in Honduras. SDD was mostly confined to demographics and violence, with the exception of some epidemiological data in Trinidad & Tobago. None of the documents **explicitly** acknowledged the importance of SDD for analysis and planning, or devised specific strategies towards producing and using this type of information, except in the case of violence. Beyond single-sex-data (such as maternal health), when health SDD was presented, it was not followed by any **analysis** of causes, consequences, or actions to address those differences.
5. An important distinction drawn between the two countries was associated with the occurrence of a long-term GE technical cooperation relationship and the presence of a gender focal point in the Country Office. This distinction referred to the much stronger visibility of gender themes in the Honduras work plan, feature that did not translate into scoring differences given the low-stringency in the criterion of merely having “**at least one** OSER, activity or product addressing gender”. It must be noted however, that this strong gender visibility tended to stay within the boundaries of gender-specific objectives, without explicitly permeating the situation analysis or other expected results. One important exception in this respect within this Honduras work plan was the insertion of gender within the broader OSER on human security.
6. Summing up, the examined CCSs and corresponding work plans, although evidencing gender policy awareness, do not yet reflect an understanding or sense of ownership regarding the PAHO Gender Equality Policy (or its precursor mandates), the WHO directives, or the third MDG, that make gender a cross-cutting issue in the cooperation with countries. Relevant but relatively isolated actions addressing gender themes were included in the strategies and work plans. Gender-based violence constituted the issue most effectively mainstreamed. These findings must be pondered, however, by the understanding that both the strategic agendas and the work plans were not the work of PAHO officers alone. These planning instruments reflect a joint agreement between PAHO and the country’s government regarding specific areas of cooperation in and with the country.

 **2.3. Achieving sex parity in staffing**

Sex parity in staffing –-i.e., equal number of women and men at each and all levels of the Organization-- is regarded as an important requisite for ensuring that the concerns of both sexes are considered in the work of WHO/PAHO. The indicators selected to measure sex parity referred to two broad categories: all existing staff at December 2007, and all new appointments taken place during the same year.

 ***2.3.1.*** *Sex parity among all active staff at December 31 2007*

1. Women comprised **60%** of all PAHO staff, **41%** of International Professionals, **70%** of National Professional Officers, **80%** of General Service staff, **59%** of long-term appointments, **60%** of temporary recruitments, **53%** of Country Offices staff, and **65%** of HQ staff. In other words, women outnumbered men in the total and in all subcategories under analysis, except one*: international professionals (P).*
2. Among **Ps,** women outweighed men in the two extremes of the scale: the two lowest grades (P1 and P2) and the top managerial positions (UG). In fact, all three of the highest Directorial positions-- Regional, Assistant, and Deputy—were occupied by women. On the other hand, women were underrepresented at professional ranks higher than P2 (particularly, P4), among Ds, and among long-term professionals. Attention should be drawn to the fact that **sex parity among professionals was reached at PAHO/HQ** (Washington DC). At country offices, however, women’s share of the total professional staff was 30%, share that is markedly higher at the lowest P levels (100% at P1, 63% at P2).
3. In the **National Professional Officers** (NPO) category, women’s percentage was **70**, surpassing or equalling men’s in all four NPO levels. This advantage is tempered by the fact that compared to their mostly male international P counterparts stationed in the field, NPOs enjoy lower levels of salary, benefits, decision making authority and job stability.
4. Among the **General Service staff,** women amounted to **80%** of the total andpredominated in the G0 and G4-G7 grades. Men, on the other hand, outnumbered women in the G1-G3 levels.

 ***2.3.2.*** *Sex parity in new appointments during 2007*

 Women represented **60%** of all new recruitments, **52%** at P and higher grades-- including the appointment of a Deputy Director-- **88%** of National Officers and **78%** of GS. However, women continued to be under-represented in relation to men in the recruitment of **long-term Ps and Ds** (**41%**), particularly for Country Offices.

Special attention is called to the composition and changes of the P staff. **P4 stands out as the most unequal P category,** showing the lowest female representation, whether all staff or new appointments is considered.

**3. Promote or use sex-disaggregated data and gender analysis (SD3)**

An analysis to assess the extent to which key PAHO documents promote or use sex-disaggregated data (SDD) and gender analysis in health was carried out for four categories of documents: Seminal institution- wide publications; Policy/ Governing Bodies documents; evidence type (research) publications; and tools/normative guidelines. The following 2007 PAHO publications and papers were analyzed: “*Health in the Americas* 2007”, “*Renewing Primary Health Care in the Americas”, “Social Protection in Health* *Schemes for Mother, Newborn and Child Populations”,* and “Guidelines to HQ and CO for the preparation and review of PAHO Biennial Work Plans 2008-2009. *Health in the Americas 2007 (Volumes I and II),* bore particular weight in terms of allocated time resources (1172 pages), given its importance as reflection of PAHO’s work in all regional and national offices. The analysis main findings were the following:

* 1. A **wide range of variation** was observed in terms of the degree to which gender was integrated into these four works (seven, if Volume I and II of Health in the Americas and the three BWP guidelines are considered separately). In a scale of **0 to 11**, the gender integration scores achieved by these documents fluctuated between a **9** for “*Social Protection in Health Schemes****...”;* 8,** for “*Health in the Americas 2007, Volume 1”;* **5,** for ”*Health in the Americas* 2007, *Volume II”*; **3,** for “*Renewing Primary Health Care in the Americas...”;* and **2** for “Guidelines for the preparation and review of PAHO Biennial Work Plans”.
	2. All four types of documents transpired a general **awareness** *or acknowledgement of* gender-related mandates (PAHO’s and MDGs). However, some sections of these documents did not fare as well. These were: in *Health in the Americas, Regional Volume,* one of eight main sections, ‘Health and international cooperation’; and in the *Countries Volume* of the same publication, most sampled country profiles.
	3. In contrast with this broad awareness, explicit **knowledge** (defined in this instanceas appropriate use, or specific statements regarding the nature of gender concepts) was restricted to two publications: *“Social Protection...”* and “*Health in the Americas Vol. I”*. This type of clear, understanding **was not explicit** in 5 of the 14 sampled countries in Health in the Americas Volume II, and it was barely present in “*Primary Health Care...”.* Regarding the latter, it is noteworthy that in the text of a central policy document like this, the terms Gender equality and/or Gender equity are **not** mentioned at all. Finally, in the *“Guidelines...for the preparation of work plans”*, the reference to *gender equality* was reduced to two words, “Gender equality”, inscribed in the list of PAHO’s six cross-cutting issues.

d**.** It is important to underscore that the extensive use of appropriate gender citations throughout the different chapters of the Volume1 of *“Health in the Americas ...”,* constitutes a significant reflection of the wide range of gender awareness existing in PAHO/HQ. At the same time, the scarcity or absence of such citations in the sampled countries, points to an important awareness and knowledge gap between HQ and the field.

e. Special mention must be made in this context, of the manifest weakness in the use –or rather exceptional use—of two central notions of the PAHO Gender Equality Policy (and the MDG 3): *women’s empowerment* and *women’s rights as human rights.* The outstanding exceptions refer to the *“Social Protection....”* book and the subsectionson Adolescent health and HIV/AIDS in the *Volume I of “Health in the Americas...”*

f. On the subject of expressed **gender relevance to a given subject**, there is internal variation within work teams. An instance in this respect is the different treatment conferred to the MDG 3, ‘Gender equality and women’s empowerment’ by two works produced by the same technical team, The endorsement of this MDG 3 as a UN mandate pertinent to PAHO and this area of work was unambiguous and **strong** in the publication “*Social Protection in Health Schemes****...”.*** In contrast, the chapter on ‘Public policies and health systems and services’within “*Health in the Americas, Volume 1”,* wasone of the only two chapters in this PAHO flagship publication in which such endorsement (or even mention), however pertinent, was absent. Both documents were produced by the PAHO ‘Health Systems and Policies Unit’.

g. Two gender issues received particular attention throughout the two volumes of Health in the Americas: **‘*Gender-based violence’*** and ‘***Sexual and reproductive health’*.**  ***Gender-based violence*** **was probably the single most mentioned gendered health issue.** It was alluded to throughout all of Vol. I except for Chapters 4 ‘Policies & Systems’ and 5, ‘International Cooperation’, and it was also highlighted in 12 of the 14 sampled countries from Vol. II.

h. Regarding the use and promotion of ***sex- disaggregated data,*** the results varied widely. The **use of SDD was extensive** in two of the publications: “*Health in the Americas...Volume I-Region”,* and *“Social Protection in Health* *Schemes.........”* It was **moderate to low** in *Health in the Americas...Volume II-Countries.* The other two publications, *“Renewing Primary Health Care in the Americas,* and “Guidelines for......Biennial Work Plans”, did not present statistical data. None of these four types of publications explicitly recommended the use of SDD, despite having dealt in the text with the subject of improving health information systems.

i. The variation in the use of ***Gender analysis*** resembled the variation regarding use of SDD. Gender analysis was **strong** in ***“****Health in the Americas 2007.* *Volume I-Regional”,* and in *“Social Protection in Health* *Schemes.......*” It was **limited** in *Health in the Americas 2007 Volume 1-Countries,* and **moderate to** **low** in “*Renewing Primary Health Care in the Americas....”* The Guidelinesto.....Biennial Work Plans”, as already mentioned, simply stated that gender equality was one of the six cross-cutting issues in planning and reviewing.

1. **Establishing Accountability from the Senior Management (SD4)**

The selected indicator for this SD was ‘reflection of gender in the speeches given by the PAHO Director in 2007’. Nine speeches and presentations available in the PAHO Director’s internet site were analyzed. Eight of this nine speeches/ presentations included at least one reference to gender issues or concerns, thus expressing a consistent Director’s interest an mirroring an organization-wide reach of concern with respect to gender issues. The thirty nine unevenly distributed gender and gender-related references in those presentations were suggestive of a varying depth of attention and perception of gender relevance to the issues being addressed. Gender references were most frequent in wide-scope presentations and in those related to health determinants and healthy environments. The MDG 3 was a recurrent theme in those speeches.

 **V. CONCLUSIONS AND RECOMMENDATIONS**

**Conclusions**

1. PAHO’s reported levels of staff capacity for gender mainstreaming were among the highest of all Regions. But these high levels coexisted, as in other regions, with a large gap between knowledge and application seemingly connected to the non-specific nature of the gender knowledge held by staff with respect to issues and evidence particular to their work areas.

2. Two other divides revealed by the findings demand particular attention. The first one is the **gap between HQ and CO** with respect to gender integration in planning and other types of documents, and to sex parity among professional staff. The second one is the **divide between professional and general service staff** regarding application of gender concepts to their work. Although the e-survey did not specifically address G functions and responsibilities, the divide between Ps and Gs was perceptible from the Gs’ low survey response and low scores on perception of gender relevance to their work, but very importantly, from the explicit exclusion of gender considerations from administrative functions, unambiguously stated in the latest official PAHO planning guidelines.

3. Gender integration into the planning and monitoring/evaluation phases of the **programming cycle process** warrant urgent consideration. The **planning** phase emerged as the most fundamental since *genderless* implementation and evaluation, particularly the latter, were explicitly linked by PAHO staff to *genderless* planning. But the lack of feedback and **accountability** regarding gender integration was also seen as lessening the motivation to comply and the sustainability of the gender mainstreaming process.

4. Although gender equity concerns seemed to be making headway in the **CCS and biennial work plans** of the two sampled countries, these planning documents did not reflect WHO and PAHO directives on gender as a **cross-cutting issue** in country programming. Aside from lacking a gendered situation analysis that provided basis for gender-related actions, these documents revealed a disconnect between comprehensive gender-related policy statements, and concrete activities that were part of the mainstream of technical cooperation in the country. An important boost for gender integration in the work plans proved to be the presence of a PAHO gender focal point in the CO and the collaborative engagement of gender experts working in other UN agencies, government offices, and civil society.

5. While PAHO has achieved sex parity in P staffing at HQ, challenges remain in attaining parity at country level and in some P categories. **P4 stands out as the P grade with the lowest female representation.** It is noteworthy that while PAHO ranks first among all WHO Regions and WHO/HQ in sex parity among P and D grades other than P4, it ranks fourth in this particular grade. P4 is of vital importance for sex parity, since it comprises half of all professional staff and represents the main pool for future promotion at managerial levels.

6. The wide variation in the use and promotion of sex- disaggregated dataand gender analysis between the sampled documents and Director’s presentations, is just a reflection of the varying levels of actual gender integration in the work of the different organizational technical units and country offices.

7. The role of the PAHO Gender network was deemed central to the mainstreaming process by surveyed and interviewed respondents. Its influence was also made evident through the CCS, work plans and some key documents in whose preparation this network had collaborated.

8. Overall, the results of this assessment suggest that awareness and even “knowledge” of general gender mandates and concepts (of the type transmitted through one-time workshops or a set of tools and guidelines) seemed to act as entry points, at best, but not as drivers of gender mainstreaming. A need was identified for **sustained** and **tailored** technical collaboration to build and apply knowledge that emphasized participatory **bottom-up,** instead of **top-down** approaches.

9. Most importantly, the assessment pointed out that while technical capacity is necessary, the political commitment and pro-active support of managers is essential and imperative to drive the gender mainstreaming process, and ensure its sustainability and accountability.

**Recommendations**

Several of following recommended approaches were directly voiced by the planners during the interviews. These recommendations are not necessarily new ideas since some of them may have been already considered and tested by the Organization during the last several months. Needless to say, such undertakings would extend beyond the responsibilities of the existing gender network.

*On capacity building*

1. Build gender capacity that goes beyond sensitization or general training towards competency tailored to key substantive areas of knowledge and action. This will require focusing on few strategic subjects and staff groups at a time and strengthening the availability of specialized technical support. Working on the intersections of gender with the other five cross-cutting issues could have a multiplier effect. Specific training for managers in HQ and CO is strongly emphasized.
2. Bolster a participatory **bottom-up,** rather than a top-down approach to mainstreaming. This would entail the active participation of staff in the development of conceptual frameworks, evidence, tools, and experience on the ground, thus promoting ownership of knowledge
3. Engage the Staff Association in placing gender integration in the context of administrative concerns and internal human resources policies.

*On engendering the planning cycle*

1. Revise the integration of gender in RERs if gender is to effectively become a cross-cutting issue.
2. Bring the PAHO Gender network and the Office of Programming and Budget to collaborate in the preparation/revision of gender integration guidelines for the already ongoing processes of biennial programming and evaluation.
3. Ensure the active participation of the GE network (regional, sub regional and national) in the planning phase of the programming cycle, and aim-- through different avenues-- to broaden the available gender expertise pool throughout the Organization.
4. Support the development and institutionalization of monitoring indicators and mechanisms that guarantee accountability and provide incentives for gender-friendly performance to managers, teams and individuals. Disseminate the results of the corresponding evaluations.

*On engendering CCS and Country Work Plans*

1. WHO gender integration guidelines are too general. A companion tool could be prepared to support country teams in identifying questions to be asked, types of information to be collected, and issues to be considered, that would engender the CCS and work plan, with special emphasis on the situation analysis.
2. Establish coordination between WHO/GWH, PAHO/GE, and the respective Offices in WHO and PAHO in charge of supporting and overseeing CCS development, so the latter will explicitly carry a message consistent with the WHO gender guidelines.
3. Strengthen the planning capacity of the GE network in the field (country and sub regional focal points) and facilitate in coordination with the PWRs, its proactive participation in the process of CCS development and evaluation.

*On achieving sex parity in staffing*

1. Give special consideration to the recruitment and promotion of women into the P4 grade, within the context of the Plan of Career Development in Human Resources. Draw attention to the restricted opportunities in the P2 and P3 levels to move up. In this context, also focus efforts on closing the gap on sex parity between HQ and CO.

*On promoting SDD and gender analysis in PAHO production*

1. Maintain GE presence in the Regional Group on Basic Indicators and in the steering committee of Health in the Americas. Prioritizing strategic types of data (rather than all data) to be sex- disaggregated and analyzed could be an option.
2. Strengthen training efforts in HQ but, particularly in the field, on integrating gender in the production and analysis of statistical data. Involve multi-sector users and producers of information to ensure data relevance and accountability of its use.
3. Investigate barriers to the production of SDD and to the use of existing SDD. Provide incentives and demand the collection, compiling and publication of key SDD in PAHO key publications and situational analyses. Make this a monitoring/evaluation item of work plans.
4. Strengthen the presence of the GE network and local gender experts in similar information committees at country level.
5. Integrate gender elements in the guidelines for the preparation of documents to be presented to PAHO Governing Bodies, and engage the collaboration of the Governing Bodies Office in overseeing the respective compliance.
1. [↑](#endnote-ref-2)
2. Planning focal points are defined as those individuals involved in the strategic and operational planning process in 2006 and 2007 (typically directors of Departments or Divisions and/or coordinators of units, teams) [↑](#footnote-ref-2)
3. Planning focal points are defined as those individuals who were involved in the strategic and operational planning process in 2006 and 2007 (typically directors of Departments or Divisions and/or coordinators of units, teams) [↑](#footnote-ref-3)
4. A list of the additional areas to be measured at the mid-term review and evaluation stages are detailed in Annex 7. [↑](#footnote-ref-4)
5. Refers to Office-Specific Expected Results, which are overall expected result statements for each budget centre (e.g. Department or Unit) in the organization at various levels. [↑](#footnote-ref-5)
6. Products refer to deliverables that contribute to the Office-Specific Expected Results such as publications and activities. [↑](#footnote-ref-6)
7. This sex-difference, however, could be the spurious result of women predominating among the G staff category which has not been a priority target of gender mainstreaming and is indicating (Tables 4-5, and Figure 3) significant lower percentages in reporting both gender relevance and gender knowledge application to PAHO’s work [↑](#footnote-ref-7)
8. To arrive at this indicator value, the percentage figures for the cells "some support" and "strong support" were added up. [↑](#footnote-ref-8)
9. These included: (a) implementation of related products, activities or services; (b) promotion and use of sex-disaggregated data; (c) financial expenditure on related products or activities; and (d) allocation of human resources for related products or activities. [↑](#footnote-ref-9)
10. Specific references were made to whether or not this process included: (a) being asked to assess if gender inequalities were addressed by products, activities or services; (b) having office discussions on this subject as part of the monitoring process; (c) having sex-disaggregated indicators to monitor outcomes; (d) analysing relevant indicators to assess effect on gender inequalities; (e) taking corrective actions to rectify gender inequalities. [↑](#footnote-ref-10)
11. The WHO Country Cooperation Strategy (CCS) reflects a medium-term vision of the World Health Organization for its cooperation with a given country. It defines a strategic agenda for working with that country. The strategic agenda states the priorities jointly agreed upon for WHO cooperation in and with the country and clarifies the role WHO will play in which areas. The CCS is flexible. It is generally developed with a vision of four to six years but this time frame can be shorter, in particular for countries in crisis situations. The CCS is the key WHO instrument for alignment with national plans and strategies, and harmonization with partners at the country level. The CCS is thus used as a basis for dialogue, advocacy, resource mobilization and planning. [↑](#footnote-ref-11)
12. It must also be noted that during the promotion by WHO of the CCS framework in the regional and country offices, the issue of gender as a cross-cutting concern **was not part** of the presentations given by WHO in the Regions. [↑](#footnote-ref-12)
13. The author wishes to express her gratitude to Peg Boyne of the PAHO’s Human Resources Administration Office who kindly and timely provided all the PAHO data used in this analysis. The author also wants to thank Lily Jara, from the PAHO Gender, Ethnicity and Health Unit, for her invaluable help in translating this data into the tables and graphs included in this section and its corresponding appendixes. [↑](#footnote-ref-13)
14. SDD involves *both*, sex-differentiating situations *common* to both sexes, anddistinctly documenting those *exclusive* of one sex. [↑](#footnote-ref-14)