

# Advancing health through attention to gender, equity and human rights

STORIES FROM THE WESTERN PACIFIC REGION





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## ABBREVIATIONS

<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination against Women
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>cVDPV</b>	circulating vaccine-derived poliovirus
<b>DFAT</b>	Australian Department of Foreign Affairs and Trade
<b>ERAR</b>	Emergency Response to Artemisin Resistance
<b>MDG</b>	Millennium Development Goal
<b>MDR-TB</b>	multidrug-resistant tuberculosis
<b>NCD</b>	noncommunicable disease
<b>RPRH</b>	Responsible Parenthood and Reproductive Health
<b>SDG</b>	Sustainable Development Goals
<b>SHSS</b>	Subnational health system strengthening
<b>STI</b>	sexually transmitted infections
<b>TB</b>	tuberculosis
<b>UHC</b>	universal health coverage
<b>WHO</b>	World Health Organization

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- Co-chairs: Vivian Lin, Susan Mercado
- Divisional representatives:
  - Shalala Ahmadova
  - May Chiew (until May 2017), Joy Rivaca Caminade (from June 2017)
  - Luke Elich
  - Howard Sobel
- Secretariat: Britta Baer, Anjana Bhushan, Howard Sobel

Report development was coordinated by Britta Baer under the supervision of Anjana Bhushan and Vivian Lin. Takeshi Kasai and Vivian Lin championed overall report development and provided valuable guidance and comments.

The following current or former staff members in country offices and in the Regional Office co-authored stories and provided technical inputs (listed in alphabetical order by story):

- Making polio vaccines in the Lao People's Democratic Republic more acceptable to all: Shalala Ahmadova, Joy Caminade, May Chiew, Siddhartha Datta, Li Ailan, Luo Dapeng, Jennie Musto, Babatunde Olowokure, William Schluter
- Integrating an equity focus into analysis for tuberculosis control in Papua New Guinea: Shalala Ahmadova, Tauhidul Islam, Nobuyuki Nishikiori, Lungten Wangchuk
- Using gender and equity analysis to improve access to water, sanitation and hygiene in the Philippines: Nasir Hassan, Rifat Hussain, Bonifacio Magtibay
- Analysing gender-based violence in Cambodia: Britta Baer, Anjana Bhushan, Kannitha Cheang, Vivath Chou, Alejandra De Benito, Serongkea Deng, Momoe Takeuchi
- Tackling discrimination against people with psychosocial disability in the Pacific islands: Darryl Barrett, Yuta Setoya, Bai-Feng Sobel
- Equity-focused health policy-making in Viet Nam: Britta Baer, Anjana Bhushan, Annie Chu, Luke Elich, Benedicte Galichet, Socorro Escalante, Thi Kim Phuong Nguyen
- Advocating reproductive health and rights in the Philippines: Jacqueline Kitong, Howard Sobel
- Promoting the health and rights of sex workers in Viet Nam : Masaya Kato, Linh-Vi Le, Ying-Ru Lo, Van Thi Thuy Nguyen, Quang Hieu Vu
- Gender and health policy-making in Papua New Guinea: Britta Baer, Anjana Bhushan, Rufina Latu, Jessica Yaipupu
- Overcoming geographical barriers in access to services in Mongolia: Britta Baer, Anjana Bhushan, Erdenechimeg Enkhee, Soe Nyunt-U, Delgermaa Vanya

- Addressing the needs of a displaced group in the Philippines: May Chiew, Li Ailan, Roy Cosico, Gerardo Medina, Nevio Zagaria
- Empowering women to fight tobacco in China: Katia De Pinhos Campos, Kelvin Khow Chuan Heng
- Strengthening the health sector response to gender-based violence against women and girls: Britta Baer, Anjana Bhushan, Madeline S. Salva, Kate Silburn, Jessica Yaipupu
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- Ensuring an equity focus in the tuberculosis programme in the Philippines: Shalala Ahmadova, Nobuyuki Nishikiori, Rajendra Yadav
- Incorporating gender into HIV/AIDS monitoring and evaluation in Viet Nam: Masaya Kato, Linh-vi Le, Ying-Ru Lo, Van Thi Thuy Nguyen, Quang Hieu Vu
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# INTRODUCTION

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## Background

The Sustainable Development Goals (SDGs), adopted by the United Nations General Assembly in 2015, aim “to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment” (1). A central tenet of the SDGs and universal health coverage (UHC) is the principle of leaving no one behind. Leaving no one behind is based on the recognition that poor health and well-being are a result of the unequal distribution of power and resources. Health programmes are increasingly recognizing that a one-size-fits-all approach does not deliver benefits equitably to all population groups and that in some cases inequity may even be exacerbated. Programmes are also acknowledging that attention to gender, equity and human rights is crucial for advancing health and sustaining achievements in health and development. But the question is: how can this be done? How can health programmes consider the concerns and experiences of women, men, girls and boys from diverse groups as an integral dimension of the design, implementation, and monitoring and evaluation of policies and programmes?

Poverty, gender inequality, low education, lack of information, and other socio-economic disadvantages together entrench and amplify poor health. These social determinants of health operate independently, but also interact with each other, compounding disadvantage. For example, gender inequalities result in typically lower school enrolment rates for girls than boys, which consequently lead to poorer health outcomes. Age, on the other hand, interacts with other determinants, such as education and gender inequality, resulting in older age groups having higher levels of illiteracy. Across the World Health Organization (WHO) Western Pacific Region, older men have higher literacy rates than older women, with low- and middle-income countries showing the widest gender gaps. In addition, as women live longer than men, they are more likely to face poverty and deprivation in old age as a result of lower rates of education, employment and well-being over the course of their lives. Interlinkages and interdependencies between determinants of health require new approaches, including collaboration across sectors, among stakeholders and with communities themselves in order to achieve sustainable development.

The SDGs purposely highlight health equity and the socioeconomic basis of health. SDG 10, for example, aims to reduce inequality within and among countries. The SDGs include a specific goal on gender equality and women’s empowerment (SDG 5) and also integrate gender across all other goals. The SDG agenda recognizes the need for policies and actions to be guided by the purposes and principles of the Charter of the United Nations, with full respect for international law and human rights principles, including non-discrimination, participation and accountability.

Emphasis on gender, equity and human rights in health is not new (see Box 1). The Constitution of the World Health Organization was the first international instrument to enshrine the enjoyment of the highest attainable standard of health as a fundamental right of every human being (“the right to health”). Every country in the world is now party to at least one human rights treaty that addresses health-related rights – that is, the right to health as well as rights that relate to conditions necessary for good health. The commitment to gender equality dates to 1946 when the United Nations Economic and Social Council (ECOSOC) created the Commission on the Status of Women, dedicated to promoting gender equality and women’s rights. In 1979, United Nations Member States adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). A series of world conferences on women, including the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995), were milestones on the path to the Millennium Development Goals (MDGs) in 2000. These initiatives addressed women as equal to men and as active, productive contributors to society with entitlements and rights to health, social protection and civic participation. In 2007, the Sixtieth World Health Assembly adopted the *Strategy for Integrating Gender Analysis and Actions into the Work of WHO* in World Health Assembly resolution WHA60.25, which committed the Organization to integrate gender by:

- **ensuring capacities** for gender analysis and planning;
- **mainstreaming gender** in corporate functions, for example, gender-responsive, results-based management planning, budgeting, monitoring and evaluation;
- **disaggregating data** and conducting gender analysis; and
- **establishing accountability** for mainstreaming gender.

In 2012, in the context of the WHO reforms, the Director-General initiated an integrated approach that brought together technical work on gender, equity and human rights so as to strengthen the effectiveness of technical programmes (2). This coincided with global developments to which WHO is committed, including the *United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women* and the United Nations human rights-based approach to development.

At the same time, the work of the WHO Commission on Social Determinants of Health as well as the global momentum around the SDGs has resulted in renewed interest in the social determinants of health and health equity. Recognizing the synergies between gender, equity, human rights and the social determinants of health, WHO in 2015 developed and adopted *Integrating Equity, Gender, Human Rights and Social Determinants into the Work of WHO: Roadmap for Action, 2014–2019*, which aims to ensure an integrated approach for gender-responsive, equity-enhancing and rights-based WHO programmes (3).

## Box 1. Key concepts and definitions

### What is gender?

Gender refers to the socially constructed roles, behaviour, activities and attributes that a society considers appropriate for men and women. Gender is an important determinant of health. Because of gender norms, roles and relations, significant differences exist between men and women in exposure to disease and injury; household-level investment in nutrition, care and education; access to and use of health services; and the social impact of ill health. Such differences can lead to gender-based inequities – that is, those differences that systematically and unfairly disadvantage one group. Given the influence of gender on health, efforts to improve health need to include due attention to gender.

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### What are human rights?

Human rights are legal norms and principles inherent to all human beings, regardless of sex, income, nationality, place of residence, ethnic origin, colour, religion, language or any other status. A human rights-based approach to health is guided by human rights standards and norms, ensuring that health interventions support the capacity of duty bearers (primarily States) to meet their obligations and empowering affected communities (rights holders) to claim their rights. In international human rights law, the right to health is a claim to a set of social arrangements – norms, institutions, laws and an enabling environment – so that everyone can be as healthy as possible. The right to health is an inclusive right, extending not only to access to timely and acceptable quality health care but also to the underlying determinants of health, for example gender equality, access to health information, access to water and food, housing, etc.

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### What is equity?

Equity is the absence of avoidable or remediable differences among groups of people, whether defined socially, economically, demographically or geographically. Evidence suggests that the impressive health gains achieved over recent decades are unequally distributed and have largely failed to reach the poor and other marginalized or socially excluded groups. Persistent and growing inequities in health are increasingly evident, both between and within countries.

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### What are social determinants?

Social determinants of health are the conditions in which people are born, grow, live, work and age – and they include gender. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. In its report to the World Health Assembly in 2009, the WHO Commission on Social Determinants of Health observed that although health inequities are increasing both within and between countries, they are not inevitable, but rather the result of policy failures. Social determinants of health are mostly responsible for health inequities: the unfair and avoidable differences in health seen within and between countries.

## Attention to gender, equity and human rights

Commitments to gender, equity and human rights are both goals in themselves and conditions for achieving sustainable development. Mainstreaming refers to a process of assessing the gender, equity and human rights implications of any planned action, including legislation, policies or programmes, in all areas and at all levels (see Box 2). It is a strategy for making concerns and experiences of women, men, boys and girls from diverse groups an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that everyone benefits equitably and inequity is not perpetuated.

There has been increasing attention on integrating equity-focused approaches in health for a number of decades, although the term “equity mainstreaming” is still relatively unknown (4, 5, 6). Human rights mainstreaming has been emphasized by the United Nations Development Group (7, 8), including with regard to guidance and efforts on applying a human rights-based approach to development (9). Gender mainstreaming was reaffirmed by the *Beijing Platform for Action* (1995) and

### Box 2. Mainstreaming

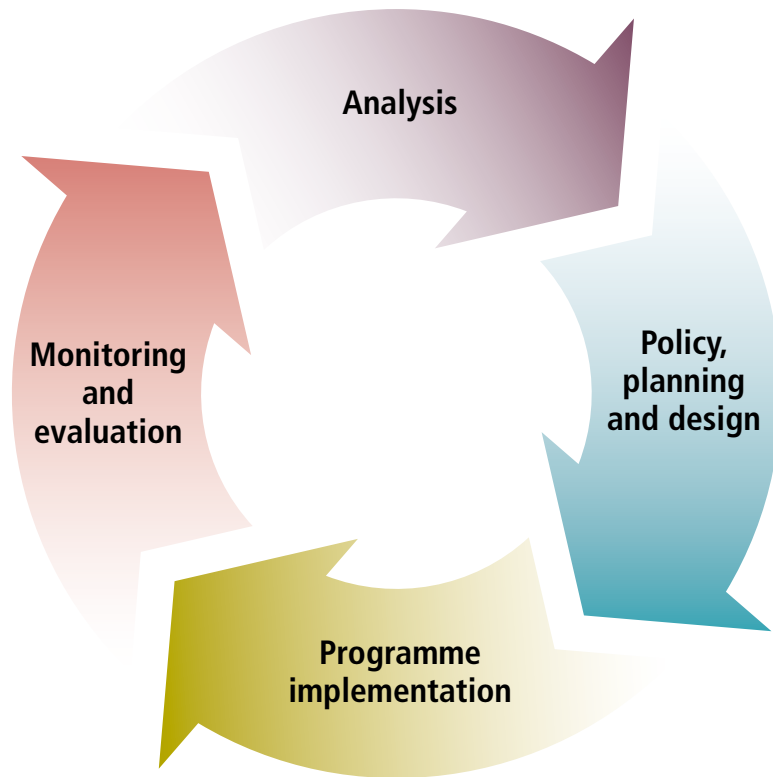
The strategy of mainstreaming is defined in the ECOSOC agreed conclusions, 1997/2, as:

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

can draw on a substantial body of literature, including lessons learnt and challenges of applying a gender lens in the health sector. There are important differences in the conceptual underpinnings of work on gender, equity and human rights as well as the strength of the evidence and tools available. At the same time, gender, equity and/or human rights link to health (and each other) in multiple ways, thus offering many different, intersecting windows for achieving equitable and inclusive societies.

For WHO, applying a gender, equity and human rights lens implies that health programmes, policies, procedures and mechanisms should enable and facilitate the development, implementation and monitoring of health programmes and plans that are gender responsive, enhance equity and promote human rights, both in WHO and in its technical collaboration with countries. This means that gender, equity and/or human rights can be considered across any stage of the programme cycle, from analysis to monitoring and evaluation (Fig. 1). Health programmes can start to consider gender, equity and human rights wherever they see an entry point to reflect on linkages and ways forward.

Fig. 1. Entry points for gender, equity and human rights



Source: WHO

In the Western Pacific Region, gender, equity and human rights, as well as the social determinants of health, are increasingly recognized as core dimensions of efforts to advance UHC and the SDGs (10, 11). Much progress has been made, but a significant unfinished agenda remains. To foster collaboration and coordination across technical units, the WHO Regional Office for the Western Pacific set up the cross-cutting Technical Working Group on Gender and Social Determinants in late 2015 with the following objectives to:

- **enhance collaboration** across units as well as future strategic activities to address gender and the social determinants of health in the Western Pacific Region;
- **identify new and practical ways to integrate gender-responsive**, equity-enhancing, human rights-based and social determinants-focused approaches in health; and
- **facilitate resource mobilization** and liaise with stakeholders within and outside WHO, including focal points in WHO country offices and in Member States.

To successfully advance health through attention to gender, equity and human rights, an organization must also transform its culture from within. One critical step towards doing this is to identify strategic entry points, based on lessons learnt from examples of success or promising practices. Accordingly, the Technical Working Group identified as one of its major activities in 2016 the development of a report illustrating such examples, through a reflective and interactive cross-divisional process. WHO staff at the Regional Office and in country offices were engaged in an internal reflection process to identify and develop examples. This report does not provide an exhaustive list of these examples and discussions, but rather represents snapshots across various health topics and programmes and across different functions of WHO in the Western Pacific Region.

The report aims to:

- **review the progress** by WHO technical programmes in advancing health through attention to gender, equity and/or human rights, including in WHO-supported activities in Member States of the Western Pacific Region;
- **identify and document examples** of advancing health through attention to gender, equity and human rights, as well as related lessons learnt; and
- **discuss triggers and strategic entry points** for gender, equity and human rights.

The report is intended to inform future WHO efforts on advancing health through attention to gender, equity and/or human rights in the context of the SDGs – for improved country impact in the Western Pacific Region.

# **STRENGTHENING ANALYSIS**





## Making polio vaccines in the Lao People's Democratic Republic more acceptable to all

During the last quarter of 2015, an acute flaccid paralysis patient tested positive for circulating vaccine-driven poliovirus (cVDPV) type 1 in the Lao People's Democratic Republic (12). Since then, 11 people have been diagnosed with cVDPV type 1. All of them belonged to the Hmong, an ethnic community group living mainly in the northern regions of the country, many of whom had not been vaccinated. In recent years, outbreaks of vaccine-preventable diseases have occurred predominantly in this group. These recurrent outbreaks indicate that many Hmong communities face significant barriers in access to, as well as utilization of, immunization services.

### How did the Ministry of Health reach out to Hmong communities?

Following the latest outbreak, the Ministry of Health recognized that targeted efforts were needed to ensure Hmong communities had access to acceptable health and immunization services, including polio vaccination. In response, the Ministry of Health, in collaboration with its development partners including WHO, started

by engaging stakeholders, including people from various Hmong communities, to develop a suitable strategy. Consultations were conducted with these stakeholders, along with key informant interviews, a field assessment and a desk review, to better understand the reasons behind low utilization of immunization services among the Hmong people.

The consultations highlighted a number of barriers to access to immunization services that people from Hmong communities face. Some live far from health facilities. The Hmong are traditionally rice farmers and often leave their villages for several days to work in remote fields. Covering the long distances to the health facilities requires money, transport and time. Many Hmong people lack adequate financial resources for transport, and they cannot afford to spend long hours away from their daily income-generating activity. Even though vaccination is provided free-of-charge at health facilities, some Hmong households struggle with obtaining the necessary resources to deal with possible vaccine side-effects, including

medication, in the event of fever or pain, if not provided by the health centre. In addition, the analysis found that the Hmong people had low knowledge of poliomyelitis (polio) and were not aware of the threat it represents for their communities. Sociocultural barriers, including gender, carried substantial weight. In Hmong families, men have the predominant decision-making role for family members' health, which in turn could limit women's control over their own health, the health of their children, or the resources needed for access to immunization.

The analysis also highlighted challenges with regard to the acceptability of immunization services among Hmong communities. The Hmong people may attach spiritual interpretations to various illnesses, rather than seeing them as being caused by pathogens. Thus, they may not perceive the use of health services as an appropriate or complete response. A common practice is to consult a traditional healer and take natural remedies. Side-effects of vaccines have resulted in mistrust among the Hmong people, some of whom fear that the vaccine causes illness. The absence of any direct costs associated with immunization further raises suspicions on the quality of and need for immunization. The acceptability of services is further limited by the fact that the Hmong language is different from the language usually spoken by the government officials and front-line staff in the health facilities. This poses a further challenge in accessing and using immunization services.

On the basis of the findings from the situation analysis, the Ministry of Health, in collaboration with partners, reviewed existing information materials on immunization and developed culturally appropriate messages in the local Hmong language to promote immunization, including messages on polio symptoms, transmission, prevention, the target age group and completion of the vaccination schedule.

A culturally appropriate communication strategy identified appropriate channels for dissemination of this information. For example, with prior notification and participation of village leaders, information sessions were organized in target villages.

Dates of the sessions were carefully selected to avoid clashing with important events or festivals such as the Hmong New Year in November or December or important economic activities such as rice farming. The information sessions were conducted in the Hmong language by Hmong influencers – for example, village leaders (*xingxao*) or elders, local health workers or field epidemiologists, representatives of civil society organizations, or others who had the respect and trust of the community. The sessions used videos and games to attract community members and incentivize healthy behaviours.

Based on the information gained during the situation analysis, and the feedback received from communities themselves, efforts were made to ensure the design and content of information sessions directly addressed the concerns of Hmong communities. For example, the sessions included information on the quality and effectiveness of the vaccine and clarified that health services would also be able to manage any side effects. Since the Hmong people commonly rely on oral traditions, efforts were made to identify complementary audio channels for dissemination of messages, including radio. The messages were also disseminated through loudspeakers in the village during daytime, a well-accepted channel of communication in Hmong villages. Pictorial illustrations, rather than leaflets with texts, were developed as visual aids. Lastly, to recognize the valuable participation of communities, village leaders were given certificates, and vaccinated children received small notebooks that included a vaccination calendar.

All staff members involved in the immunization campaign (local government officers, provincial and districts health workers, village leaders, local field epidemiologists and teachers) were trained in practical skills for engaging communities and delivering key messages in an acceptable manner.

Efforts were made to involve representatives of affected communities themselves. For example, the support of village leaders as champions was crucial, as they played a critical role in informing community members, persuading families to return from the rice fields on vaccination days and

urging parents to take their children for vaccination.

In addition, staff who were not Hmong were introduced to Hmong knowledge, attitudes and practices to increase their skills to effectively engage communities. For example, staff members were taught how to pronounce Hmong names correctly and how to greet clients in the Hmong language. They learnt to initiate conversations with a neutral topic (for example family or the weather) to make Hmong clients more comfortable, before approaching the topic of polio vaccination.

Together, these interventions aimed to gain the Hmong people's trust and encourage them to see vaccines as a desirable measure to protect their children against polio. The participation of Hmong local government officials, traditional leaders, village leaders or elders, local health workers and others across different stages of the process, from analysis to implementation, ensured the acceptability of the messages and interventions among Hmong communities in advance of the designated vaccination days.

### **What was the result of the shift to participatory and culturally appropriate responses?**

The efforts to strengthen participation in and acceptability of polio immunization services in Hmong communities had a direct result on the uptake of immunization and on health in these communities. Anecdotal evidence from members of the risk communication task force showed an increase in demand for and use of immunization services. The country was able to halt cVDPV transmission, and there have been no new infections identified since January 2016. In some villages, the total number of children vaccinated exceeded the initial target. Improved acceptability of the health services, including immunization services, will also contribute to the prevention of other diseases in future. The targeted response made immunization more acceptable to communities, and built trust in the system. A key feature was the participation of the Hmong people across different stages, from programme design to implementation, operationalizing a human rights-based approach. By increasing the voice and participation of the affected community, the national immunization programme was able to meet its targets while addressing the health needs of Hmong communities.

## **LESSONS LEARNT**

- **Participation of affected communities is essential to inform analysis and action.**
- **Community representatives and village leaders are important stakeholders.**



## Integrating an equity focus into analysis for tuberculosis control in Papua New Guinea

### Who is affected by tuberculosis?

Papua New Guinea has struggled to control tuberculosis (TB) since the early 1990s. While gaps in data hinder informed policy-making, these have gradually been addressed in recent years. For the first time, starting 2012, all provinces were reporting to the central level, allowing the national TB programme a better overview of existing progress as well as areas needing accelerated action. In particular, the evidence pointed to people living in urban settings as the main high-risk group for TB, with 70% of all new TB patients registered coming from urban health facilities (13). Low-income urban areas within informal settlements are characterized by low-standard housing, poor ventilation and overcrowding. In Port Moresby, over half of the population lives in informal settlements, and dwellings as small as 60 square metres can often house up to 15 household members. Culture and traditions related to the *wantok* system require richer households to provide shelter for

tribal members who are more vulnerable. Vulnerabilities are often compounded by generally low health education and limited access to services, particularly in informal urban settlements.

### Integrating equity to strengthen the TB response

In 2014, Papua New Guinea drafted a new national strategic plan for TB control. The strategy was data-driven and benefited from the availability of improved data, including data disaggregated by province. Moreover, gender and equity analysis as part of the development of the strategy drew attention to marginalized groups in society. The analysis confirmed the importance of meeting the needs of marginalized urban population groups, including those living in informal settlements by designing and implementing equity-focused action to prioritize the 30 TB health facilities catering to the highest volumes of patients in urban areas. These health facilities (11% of all TB facilities)



cater to 53% of the national TB burden and 75% of patients who fail to complete treatment (patients lost to follow-up) (13). Failure to complete treatment increases the risk of drug resistance to TB.

In response, up to 80% of the budget – including external funding provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria – and additional health staff were allocated to the 30 priority health centres (13). Most of these resources aimed to strengthen the capacity of the health facilities. However, some were used to address the demand-side barriers and vulnerability factors. For example, following diagnosis, health-care providers now provide TB patients with detailed information on TB and explain the importance of adhering to and completing treatment. To strengthen connections between patients and health facilities, each TB patient selects a treatment supporter – either a health-care worker, a trained community supporter or a family member – who will supervise their treatment and act as a contact person. Patients and treatment supporters have access to a transport allowance to facilitate monthly visits to the health facility. During this visit, patients participate in discussion groups with other patients where they can share experiences, ask questions and address any concerns. Patients, especially those with multidrug-resistant TB (MDR-TB), have access to food vouchers in order to improve their nutritional status – and thereby adherence – as well as help ease the financial bur-

den on families affected by MDR-TB, particularly women TB patients who are usually responsible for food purchasing and preparation. Culturally sensitive and gender-sensitive messages are delivered during awareness-raising events and through local media to increase general TB knowledge. The programme involves community-based organizations in implementation to serve as a link between the health facility and the community and foster the acceptability of activities.

### **The TB programme shows promising results**

An equity analysis based on disaggregated data allowed the TB programme to optimize the allocation of financial and human resources, thereby expanding the programme's reach and effectiveness. The participation of affected communities themselves in identifying barriers as well as in designing and implementing interventions was a critical component of success. Though implementation of the national strategic plan is still in its initial stages, the early signs of improvement are evident. The treatment success rate has risen from 55% in 2013 to 64% in 2015. The number of patients lost to follow-up has fallen from 29% in 2013 to 22% in 2015 (14). Nevertheless, Papua New Guinea still faces a long journey for achieving overall TB control. Maintaining an equity focus will help increase the efficiency of the programme along this journey.

## **LESSONS LEARNT**

- **Equity analysis based on disaggregated data is key to programme effectiveness.**
- **Participation of affected communities enables understanding of which groups are left behind and why.**



## Using gender and equity analysis to improve access to water, sanitation and hygiene in the Philippines

Safe and readily available water is important for health, whether used for drinking, domestic use, food production or recreational purposes. For several decades, WHO has been developing guidelines for drinking-water quality (15). The third edition of the *Guidelines for Drinking-water Quality* introduced a framework for drinking-water safety that includes the development of water safety plans (16). However, the implementation of the framework in countries proved quite challenging. More comprehensive guidance on water safety plans systems was published in 2011, but did not address fully gender and equity concerns (17).

Women and girls are the major users and managers of water in their households (17). Due to the gender-based division of labour, they are usually responsible for collecting household water, often over long distances, and maintaining household hygiene. Poorly targeted services can threaten the health and security of women and girls, for example, through a lack of privacy and

safety while carrying water from long distances or accessing sanitation facilities. Gender norms related to menstruation and pregnancy can also limit the access of women and girls to facilities. Due to unequal power relations, women and girls may not have due influence on water- and sanitation-related decision-making or access to needed information to protect their health. On the other hand, gender-responsive water and sanitation approaches offer an opportunity to strengthen the participation of women, men, boys and girls from diverse population groups in the design, implementation, and evaluation programmes and services. Such programmes have the potential to reduce gender-based inequities, for example by helping to address women's time poverty due to multiple household tasks, including water-related tasks, thus freeing their time for more social and income-generating activities. Gender intersects with other determinants of health, including income, place of residence and age, compound-

ing the vulnerabilities of and barriers faced by marginalized subgroups, for example women slum-dwellers. Evidence further suggests that poorer households are often disadvantaged with regard to access to improved drinking water and improved sanitation, compared to those that are better off. Similarly, access to improved water and sanitation is almost always significantly better in urban areas than in rural areas. Poor urban communities, including informal settlers, are a rapidly growing population group with especially severely limited access to adequate water and sanitation. Given the relevance of gender and equity, integrating these lenses into water and sanitation programmes can help them better reach marginalized groups, accelerate implementation and ensure the sustainability of achievements.

### **What was done to strengthen the gender and equity analysis**

Recognizing the links between gender, equity, and water and sanitation, and to strengthen water safety planning, WHO commissioned an equity study in 2013–2014 to explore the gender and equity aspects of water safety planning, based on case studies and experiences in selected countries and to inform the development of global guidance by WHO for the systematic integration of gender and equity into water safety planning (18). In the Philippines, the Dasmariñas Water District participated in a study commissioned by WHO, in consultation with national agencies such as the Department of Health and Local Water Utilities Administration and in collaboration with the Institute for Sustainable Futures, University of Technology Sydney.<sup>1</sup> The Dasmariñas Water District water safety planning team conducted a user survey of 78 people in an informal settlement area. The aim of the survey was to collect information on the experiences of diverse population groups, especially those in informal and poorer areas. It assessed whether households had safe water in line with their water safety plan, and why or why not, taking into account gender and equity concerns. For example, the survey found that households in informal settlements faced an unfair higher burden of installing and maintaining a greater length of piping, and thus an increased

risk of water contamination, compared to those in more affluent urban areas. Findings from the user survey informed discussions between the Dasmariñas Water District and partners to address these challenges. Ideas were brainstormed to strengthen gender and equity concerns into water safety planning, for example by placing water metres closer to collection points to reduce the burden of pipeline installation and maintenance for individual households.

The experiences of the Dasmariñas Water District demonstrated the benefits of considering the diversity of communities in water safety planning and strengthened the evidence base for improving access to safe water for all population groups in the community. While it represents only one example, attention to gender and equity is not a new concern in the Philippines. Substantial progress has been made over the last decades – for example, the Philippines ratified CEDAW in 1981 (19). In 2009, the Magna Carta of Women (Republic Act No. 9710) was endorsed, promoting the rights of women, including those from marginalized groups, and guaranteeing non-discrimination against women (20). The Magna Carta provided a solid legal base for mainstreaming gender. Subsequent guidance for implementation further underlined the responsibility of all government departments with regard to gender mainstreaming, including establishing or strengthening an existing gender focal point system (21). This includes, for example, relevant focal persons, mechanisms and efforts on gender and development by the Local Water Utilities Administration (22). These legal and policy achievements have facilitated greater awareness of gender and development issues among sector agencies, although more efforts are needed on the ground to translate these achievements into reality. The pilot in Dasmariñas resulted in useful lessons learnt and commitments to improve the water system in this district.

These experiences also informed the development of global guidance by WHO for the systematic integration of gender and equity into water safety planning.<sup>2</sup> The draft guidance suggests actions to integrate gender and equity into each stage of the water safety planning process – from

<sup>1</sup> User surveys strengthen water safety planning and equity outcomes in the Philippines. Draft (unpublished) prepared by the Institute for Sustainable Futures, University of Technology Sydney in collaboration with the World Health Organization. Geneva: World Health Organization.

preparation, system assessment and planning, to management, communication, feedback and improvement – thereby strengthening the effectiveness of interventions overall.

In the Philippines, the Pro WATER joint programme 2015–2017 recognized the added value of gender-responsive and equity-focused approaches in water and sanitation (23, 24). The joint programme brings together Government departments, the National Water Resources Board, United Nations partners including WHO, civil society organizations and other stakeholders to empower citizens and communities with improved access to sustainable and safe water and sanitation services. Since implementation is ongoing, gender mainstreaming has primarily focused on institutional aspects, that is, the integration of gender into programme design, team composition, monitoring and other processes. For example, the programme includes specific goals and objectives on gender equality, aiming to: (i) increase the participation of women and girls in planning, decision-making, monitoring and implementation of safe water, sanitation and hygiene projects and programmes; and (ii) reduce the incidence of waterborne diseases and practice of “open defecation” in target municipalities. Plans also pay attention to meeting the needs of specific vulnerable subgroups, including indigenous and rural women. In addition, targeted efforts were made during the preparatory phase to ensure equal participation of women and men in data collection and analysis, including in the household survey, focus group discussions and key informant interviews to assess water, sanita-

tion and hygiene at the project sites. Both women and men participated in the technical working groups at the regional and national level to steer implementation, and a gender expert was hired as part of the programme team to facilitate applying a gender lens. The programme collected and analysed sex-disaggregated data, and identified a number of gender-focused indicators for monitoring and evaluation. By December 2016, the project reported an increase in the participation of women and girls in planning, decision-making, monitoring and implementation of safe water, sanitation and hygiene programmes (25).

### **Moving from analysis to action**

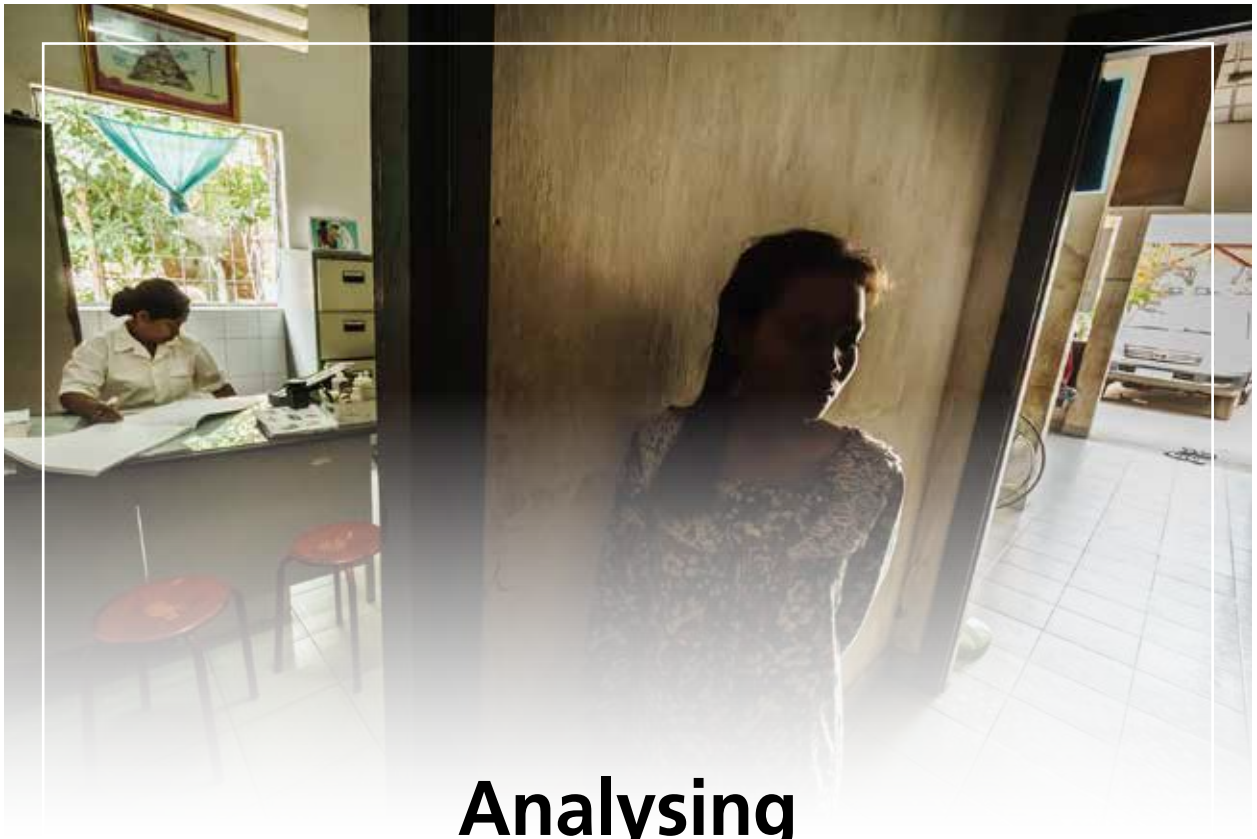
This example from the Philippines highlights the added value of considering gender and equity concerns in analysis and programming on water, sanitation and hygiene. Investments in improved water and sanitation have not always equally benefited all population groups, resulting in significant differentials between men and women and boys and girls (26), and this gap is mentioned in the MDG publication of the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (27). Clean water and adequate sanitation are integral to efforts to reduce the global burden of ill health, reduce poverty, improve education, and achieve gender equality, as most recently highlighted under the SDGs and relevant targets for water (SDG6.1) and sanitation (SDG6.2). Applying gender-responsive and equity-focused approaches in water and sanitation programmes will be essential to make these commitments a reality for all population groups.

## **LESSONS LEARNT**

- **Attention to gender and equity goes hand-in-hand with institutional changes, for example changes in team composition and expertise.**
- **Collaboration with the United Nations and other partners provides opportunities for advancing health through attention to gender, equity and/or rights.**

2 Guidance for integrating equity into the Water Safety Plan process. Draft (unpublished) prepared by the Institute for Sustainable Futures, University of Technology Sydney in collaboration with the World Health Organization. Geneva: World Health Organization.





# Analysing gender-based violence in Cambodia

## Violence against women as a gender and health priority

Violence against women is a human rights violation and represents a significant public health concern in the Western Pacific Region (28). In Cambodia, one in five women has experienced either sexual or physical intimate partner violence, with wide-ranging health and social costs. Almost all women who reported being injured by their husband/partner had been hurt severely enough to need health care (90%). Unequal gender norms and attitudes held by both women and men make violence acceptable. For example, 49% of women agreed that a husband/partner is justified in hitting his wife/partner under certain circumstances. Unfaithfulness and failure to take proper care of children were justifications that women most commonly agreed with. About one in five women think no excuse can lead to denial of sex to their husband. Violence against women is rooted in gender inequality and cannot be understood in isolation from the gender

norms, roles and relations within the community, which greatly influence women's and girls' vulnerability to violence. Applying a gender lens is thus essential in order to better understand and address such violence.

## Integrating gender into research on violence

Recent milestones to promote gender equality and eliminate violence against women in Cambodia include the Law on the Prevention of Domestic Violence and the Protection of Victims (2005) (29) and the second *National Action Plan to Prevent Violence against Women (2014–2018)* (30). While Cambodia benefited from a variety of different research initiatives, these had mainly focused on specific aspects or questions. Government leaders increasingly recognized that nationally representative and comprehensive quality data were needed to accelerate action. In response, the Government launched the National Survey on Women's Health and Life Expe-

riences in 2014 (31) as a collaborative exercise of the Ministry of Women's Affairs and the Ministry of Planning's National Institute of Statistics, with support from WHO and UN Women, formally known as the United Nations Entity for Gender Equality and the Empowerment of Women.

The survey used the WHO methodology to measure violence against women (32), first developed in 2005 and later implemented in numerous countries and settings in the Region. The methodology is seen as the gold standard for obtaining valid and reliable data because it is based on feminist theory and integrates a gender lens. For example, in Cambodia, all interviewers went through comprehensive training, building an understanding of intimate partner violence and related gender norms, roles and relations. This gave interviewers the needed skills to ask the questions and record information in a non-judgemental and gender-sensitive manner. Ethical and safety standards were closely followed, integrating human rights-based and gender-sensitive perspectives. For example, the name of the survey did not explicitly refer to intimate partner violence and all data were collected in a fully private and confidential setting to preserve the safety of respondents. Collected data were then analysed using a gender lens, allowing the final report to unpack related gender norms, roles and relations, and inform the development of gender-responsive recommendations.

### **Informing policy and action in Cambodia**

The report of the *National Survey on Women's Health and Life Experiences* was successfully launched in November 2015 (33), bringing together and attracting the attention of various

government sectors and international and national partners. The survey findings are critical to inform sector-specific and cross-sectoral policy and action to combat gender-based violence against women and girls in Cambodia. The buy-in and ownership of the survey's findings by multiple national and international stakeholders set an important platform for change. The validity and reliability of the survey's findings are directly related to the rigorous and gender-sensitive methodology for the collection and analysis of the data. Key recommendations (34) of the survey relate to the importance of fostering women's empowerment and challenging the acceptability of violence, further drawing attention to the gender-related factors associated with violence. The findings have also been translated into policy development and action in the health sector. For example, the updated *National HIV Clinical Management Guidelines for Adults and Adolescents* in 2015 included HIV post-exposure prophylaxis and presumptive treatment of sexually transmitted infections and emergency contraception and follow-up pregnancy test free-of-charge for survivors of sexual violence. Following the endorsement of the *National Guidelines for the Management of Violence against Women and Children in the Health Sector*, the Ministry of Health officially launched the *Clinical Handbooks on Health Care for Women and Children Subjected to Violence or Sexual Abuse* in 2017, adapting relevant guidance from WHO and partners. Strong commitment and decisive actions from a broad range of sectors, from health to education and law enforcement, are critical to progress on this agenda. The survey provides an important foundation to policy and action to eliminate gender-based violence and achieve gender equality.

## **LESSONS LEARNT**

- **Well-established WHO methodology and related tools provided an important foundation for action.**
- **Gender awareness and the skills of the research team were critical in ensuring the quality of the research.**

**POLICY DIALOGUE  
AND DESIGN  
AS AN ENTRY POINT**



## Tackling discrimination against people with psychosocial disability in the Pacific islands

Disability in the Western Pacific Region, as elsewhere, is quite diverse. While some people with disability have poor health and extensive health-care needs, others do not. At the same time, people with disabilities have the same general health-care needs as everyone else and therefore need access to regular health-care services. Despite this, people with disabilities, especially psychosocial disabilities, often report greater unmet needs (35). The term psychosocial disability is used to describe the impairments, activity limitations and participation restrictions experienced by people with mental health conditions.

Mental health services are gradually improving in the Pacific. Stress management wards were established in three hospitals in Fiji, a new community and outpatient unit was opened in Kiribati, and some psychiatric wards are being upgraded in Samoa and Solomon Islands and will be upgraded in Tonga. The availability of community-based mental

health services such as halfway homes and outreach services is also increasing. However, access to these and other services by people with disabilities is often constrained by stigma, perceived low quality and mistrust. A lack of understanding of psychosocial disabilities, coupled with discriminatory attitudes and practices among staff and communities, has been identified as a key challenge limiting the effectiveness of services as well as their reach to the most vulnerable groups among people with disabilities (35).

To address these concerns, the Government of Australia, in collaboration with WHO and the Pacific Disability Forum, is supporting the training of key stakeholders on the health and human rights of people experiencing psychosocial disabilities. National training is taking place across six Pacific island countries (among them Fiji, Samoa, Tonga, Vanuatu and others, to be confirmed) between 2016 and 2018. The interactive training includes different

cadres of mental health practitioners (nurses, physicians and psychiatrists), government officials, civil society organizations, particularly disabled people's organizations, and people experiencing psychosocial disabilities themselves. The workshops have provided these diverse stakeholders the opportunity to discuss developments and challenges of meeting the health needs of people with disabilities.

Participants received detailed information on the United Nations Convention on the Rights of Persons with Disabilities (CRPD)<sup>3</sup>, an international legal framework for human rights, shaping policy reform that supports the empowerment of people with disabilities to demand their highest attainable standard of health without discrimination, including ways in which services can be reshaped accordingly.

The training also included a gender component to ensure that gender issues are understood and addressed in the health system response, including improving the cultural and gender sensitivity of the health workforce. In addition, participants were introduced to the mental health consequences of gender-based violence and shared experiences of responding to gender-based violence against people with disabilities. In addition to building the skills of participants to better respond to the health needs of people with disabilities, the training helped to consolidate existing networks or establish new networks of stakeholders advocating a human rights-based approach to improving the health of people with psychosocial disabilities.

These awareness-raising and capacity-building training sessions are preparing the ground for accelerated action to foster the health and well-being of people with disabilities. The first training was conducted in Fiji in 2016 with generally positive feedback from participants. The Ministry of Health and Medical Services of Fiji plans a second training for their staff, and a local nongovernmental organization and partner will conduct a workshop for people with psychosocial disabilities and their families. In 2017, a similar training is expected to take place also in Samoa and Tonga.

In addition, Solomon Islands and Vanuatu have started reviewing laws related to people with psychosocial disabilities to align with and incorporate principles from the CRPD.

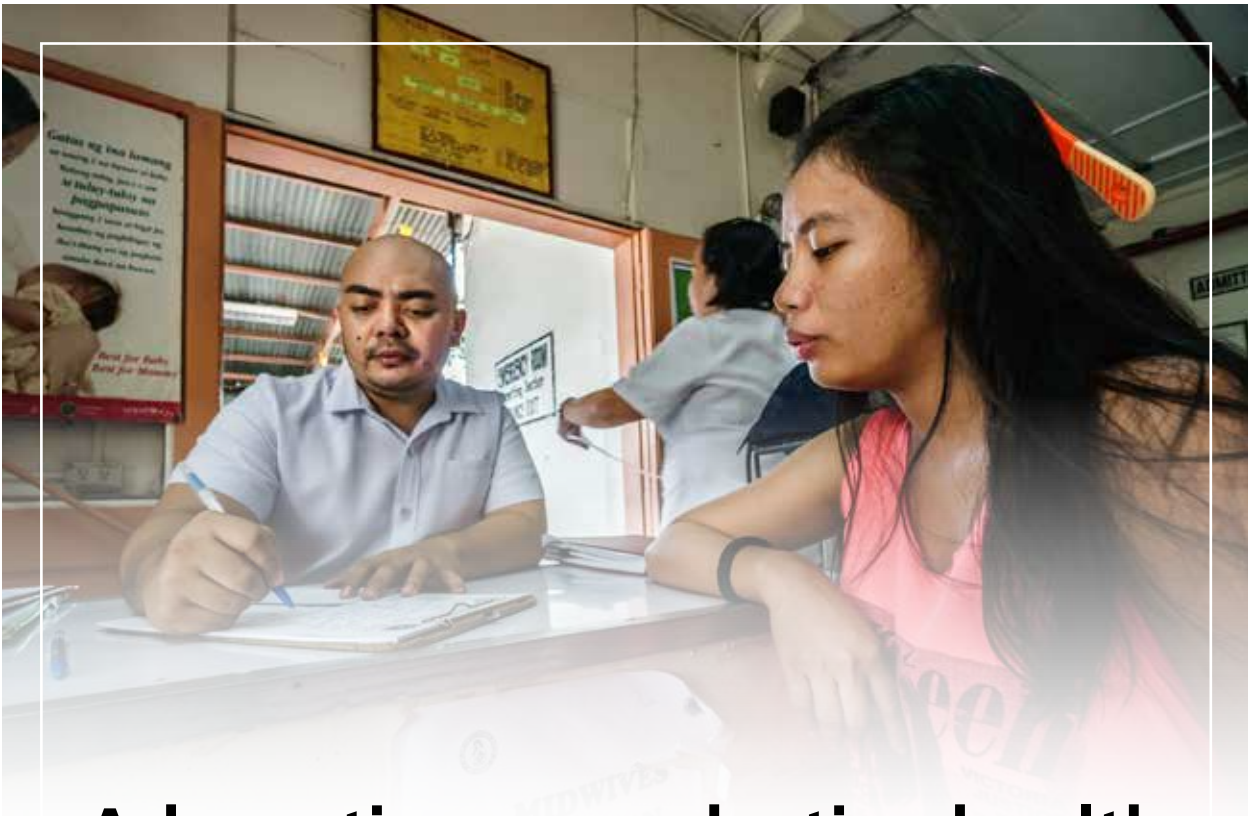
Explicitly including human rights in mental health advocacy and response is broadening policy discussions from a biomedical to a sociocultural approach that places individuals and their priorities at the centre. This is expected to facilitate whole-of-government and whole-of-society action to meet the priorities of people with psychosocial disabilities and their families. It has also expanded the network of partners advocating change beyond medical specialists to public health and community workers, educational institutions, civil society, people with disabilities themselves and their families.

## LESSONS LEARNT

- **Before integrating equity, gender and human rights into policy-making, it is vital to strengthen understanding and awareness of basic concepts.**
- **The application of human rights instruments can help to identify opportunities for advancing health, especially to people who experience discrimination as a result of policies, laws or practices.**

<sup>3</sup> The CRPD was ratified by Kiribati in 2013, the Federated States of Micronesia in 2016, Samoa in 2016 and Vanuatu in 2008. It was signed by Fiji in 2010 and Tonga in 2007.





# Advocating reproductive health and rights in the Philippines

## Universal access to reproductive health services

The Philippines has made generally good progress in women's empowerment, with nearly universal female education rates, high literacy, active economic and political participation, and good progress in key health indicators. Despite these achievements, the Philippines has continued to struggle with ensuring universal access to reproductive health services (MDG 5b).

Surveys have found that the prevalence of modern contraceptive methods has increased only marginally from 33.4% in 2003 to 37.6% in 2013 (36). Unsurprisingly, in 2013, unintended pregnancies stood high, at around 2 million and accounted for over half of all pregnancies (37).

Abortion is criminalized by Philippine law. Articles 256, 258 and 259 of the Revised Penal Code of the Philippines mandate imprisonment for women who undergo an abortion, as well as for any person who assists in the procedure. Despite this, around

a third of unintended pregnancies end in abortion (38). It is estimated that abortions increased from 560 000 in 2008 to 610 000 in 2012 (39). The process of obtaining an abortion in the Philippines is often not straightforward, and may involve many methods and attempts, some of which may have serious health consequences. The skill and training of providers as well as the safety and effectiveness of methods vary widely as abortions are often conducted clandestinely by untrained people. This resulted in 4700 deaths of women in 2010, mostly those from low-income households, with many others experiencing long-term disabilities as a result of unsafe abortions (39).

In addition, lack of control over pregnancy results in small birth spacing, which increases the risks of detrimental effects on maternal, perinatal and infant health (40).

The number of adolescent pregnancies is on the rise, posing especially adverse health risks to adolescent girls and their children. In 2013, 13.6% of girls aged 15–19 years were pregnant or had

had children, up from 6.3% in 2002. Besides direct health considerations, early childbearing is also a social issue, as it is associated with lower educational attainment and fewer employment opportunities for the young mother, which often translates into meagre income, hence fuelling the poverty cycle.

### **The Government responds: the Responsible Parenthood and Reproductive Health Act**

In response to this growing area of concern, the Government of the Philippines passed the Responsible Parenthood and Reproductive Health (RPRH) Act in December 2012 (41).

The law called for universal and free access to family planning methods and other reproductive health services in public facilities and the inclusion of sexual and reproductive health education in school curricula. While this Act recognizes that abortion is illegal and punishable by law, it further specifies that the Government shall ensure that all women needing care for post-abortive complications and that all other complications arising from pregnancy, labour and delivery and related issues shall be treated and counselled in a humane, non-judgemental and compassionate manner in accordance with law and medical ethic.

However, shortly after the passing of the law, staunch opposition, primarily from Catholic groups, led the Supreme Court to put a temporary restraining order on its implementation in March 2013 (42).

### **Using gender-sensitive and rights-based language to advocate women's health**

The RPRH Act, Section 3(m) states “Gender equality and women empowerment are central elements of reproductive health and population and development”. Based on this, and following issuance of the restraining order, the Department of Health in collaboration with its partners continued to advocate gender equality and women's access to reproductive health services.

To support the Government, WHO held and attended forums to proactively disseminate scientific evidence on the benefits of modern family planning. This helped debunk the false claims by opposition groups during senatorial, congressional and Supreme Court hearings, press conferences, and reproductive health forums that family planning methods resulted in defects and abnormalities for children.

WHO became a resource, answering real-time queries of politicians, nongovernmental organizations and others needing correct information. Fact sheets (43) were developed, and a peer-reviewed study (44) was published on the ineffectiveness of natural family planning; these were used and quoted by advocacy groups. Advice on the most effective ways to improve family planning in the Philippines was also provided and served as input for the development of the law. Policy advocacy and awareness-raising specifically integrated gender-responsive and rights-based language, drawing a connection between the RPRH Act and the Philippines' commitments under international human rights instruments such as CEDAW.

Framing the issues in terms of gender equality also allowed for a broadening of arguments, aligning health with other stakeholder groups, including advocacy groups of women and feminist networks, youth networks, educational institutions, nongovernmental and community-based organizations, thus strengthening the voices and the weight of the argument.

A year later, in April 2014, the Court upheld the constitutionality of the RPRH Act, but removed some provisions in full or partially: This means that (i) health-care providers may deny services based on their personal or religious beliefs in non-emergency situations; (ii) women require spousal consent to access reproductive health services in non-life-threatening situations; and (iii) minors including those who have been pregnant or had a miscarriage need parental consent to receive such services.

Despite these limitations, the adoption of the law remains a milestone on the path towards gender equality. While the law is only a starting point, and

more work needs to be done, it provides a legal framework for ensuring women's access to reproductive health in the Philippines. Opposition to family planning remains political as demonstrated by the diversion of 1 billion Philippine pesos in 2016 intended for the procurement of family planning commodities to other programmes (45).

Integrating gender and rights-based rationales and aligning with new partners, as this example shows, can help strengthen policy advocacy by the health sector and advance the health agenda.

## **LESSONS LEARNT**

- **Gender and human rights language can strengthen policy advocacy on health.**
- **Paying attention to gender, equity and human rights provides opportunities to engage with new partners and stakeholders across government and beyond for improved health.**





# Equity-focused health policy-making in Viet Nam

## Who benefits from health gains in Viet Nam, and who is left behind?

The health sector of Viet Nam is at crossroads. While it has achieved substantial progress towards UHC as well as gains in health, it also faces the challenges of a rapidly developing middle-income country. The gains from recent years remain unequally distributed across the population (Fig. 2). Households commonly face out-of-pocket expenditures for health care that are sometimes catastrophic, dragging them into poverty. The poorer households continue to face important access barriers to health services as well as adverse social determinants of health (46, 47, 48). According to data from the 2009 Vietnam Population and Housing Census and the 2010 Viet Nam Household Living Standard Survey, 95% of the poor live in rural areas (47). Poverty rates are markedly higher among ethnic minority households than Kinh and Hoa households. Even within the same mountain or delta region, there remains a large gap in poverty between ethnic minority households and Kinh (Hoa) households. Evidence also points to gaps

between urban slum areas and non-slum areas in terms of health service utilization (49). These inequities put the sustainability of existing achievements in the health sector in Viet Nam at risk and hindered further progress.

The Joint Annual Health Review (50) for 2015 focused on assessing these challenges and served as the analytical basis for developing the *National Health Sector Development Plan 2016–2020* and other health reforms. These policy processes were considered critical entry points for strengthening the focus on equity and social determinants into national health sector policies and plans in order to maintain and accelerate health system development.

## How is Viet Nam addressing inequities?

To inform policy-making, the Government, with assistance from WHO, reviewed the current health system situation and trends in Viet Nam from an equity perspective.<sup>4</sup> The review analysed

<sup>4</sup> Hanoi Medical University with WHO. Understanding health inequities in Viet Nam: evidence for policy and action. Draft manuscript (unpublished). Manila: WHO Regional Office for the Western Pacific.

data on health service use, out-of-pocket health expenditures, catastrophic health expenditures, impoverishment due to health payments, and their determinants over time by subgroups and stratifiers such as household expenditure quintile, geographic location and province. For example, findings showed a considerable decline in average catastrophic health expenditures from 5.1% in 2006 to 2.3% in 2014, although households in the lowest and second-lowest expenditure quintiles consistently incurred catastrophic health expenditures higher than the national average (Fig. 3). To complement the quantitative analysis, qualitative research including a desk review, key informant interviews and focus group discussions systematically examined barriers for five layers of service coverage using the Tanahashi framework: availability, accessibility, acceptability, contact and effective coverage. The study identified gaps in meeting the health needs of all population groups, including marginalized subgroups, from both demand- and supply-side perspectives, and made recommendations for addressing these barriers. This included, for example, recommendations to improve staff attitudes and responsiveness towards patients (patient-centred carers), while increasing health education efforts to improve people’s awareness about health issues, risks and services. The equity-focused analyses and recommended lines of action were compiled in a policy report, validated during an equity-focused

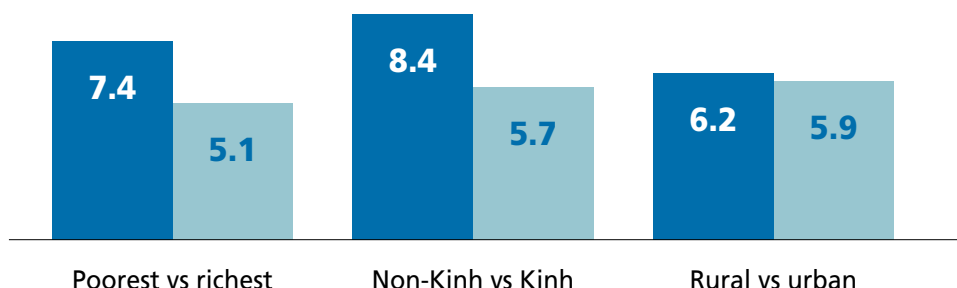
workshop with key stakeholders. The policy dialogue discussed implications of the findings and recommendations for the revised national health plan and health sector reform, and advocated increased and equity-focused resources, including more domestic financing for health. Findings were also presented to the National Assembly.

### Viet Nam integrates equity and social determinants into national health sector policy-making

At the current beginning of the SDG era, Viet Nam is better equipped to integrate equity and social determinants into ongoing health sector policy development. The study was conducted in direct response to the Government’s request to strengthen the equity focus in health policy-making in order to tackle relevant access barriers for marginalized groups. The study provided valuable quantitative and qualitative evidence as a foundation for informed policy-making. The implementation process of the study also raised awareness among a wide range of stakeholders about the importance of integrating equity-focused actions into health policies and programmes. It built skills among national counterparts to review and advocate equity-focused health policy-making and suggested ways forward.

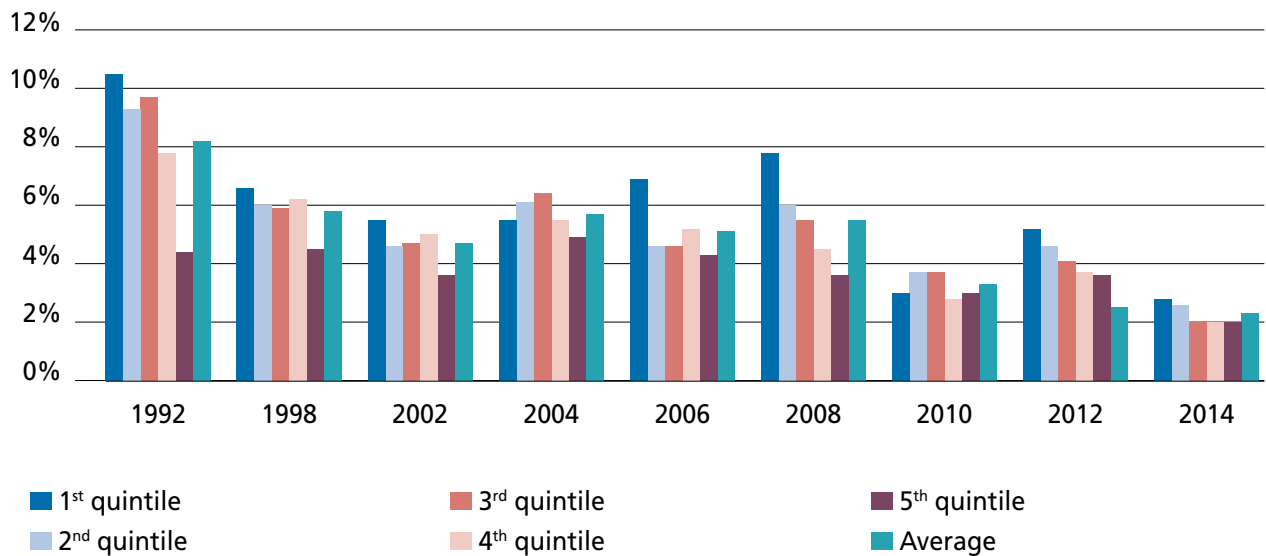
Following the study, WHO has participated and supported multiple assessments to better under-

**Fig. 2. An example of inequity by different types of stratifiers: the percentage of women with unmet need for family planning in Viet Nam in 2014**



Source: General Statistics Office and UNICEF (51).

**Fig. 3. Catastrophic health expenditures by household expenditure quintiles in Viet Nam**



Source: Hanoi Medical University with WHO (unpublished).

stand how policies designed and adopted at the national level are practically implemented in local, hard-to-reach areas and population groups and to what extent they meet the needs of communities. The hard-to-reach areas correspond to priority districts identified by the Prime Minister as well as other districts that are geographically remote and/or have a high proportion of people belonging to an ethnic minority group. In addition, the Politburo has commissioned a rapid assessment of health systems in hard-to-reach areas. While the overall findings are positive, the assessment points to low health literacy as a major barrier for service use, highlights the need to better understand people's health-seeking behaviour, and suggests

using village health workers and local influencers to improve links between communities and the health system. In line with this recommendation, the WHO country office is supporting a qualitative analysis of the experiences of individuals, families and health-care workers in hard-to-reach areas, and their perceptions of health and health services. Immersion visits and geographic information system (GIS) inequity mapping are helping to clarify how geographical and other barriers affect health service use. It is expected that the findings from these activities will inform the development of a province-wide health vulnerability index and the redesign of the health system, placing people at the centre.

## LESSONS LEARNT

- **An enabling policy environment facilitates attention to gender, equity and human rights.**
- **Finding entry points requires judgement and an understanding of context.**



## Promoting the health and rights of sex workers in Viet Nam

Recent decades have seen many achievements in HIV/AIDS control and prevention in Viet Nam (52). Data suggest that the HIV epidemic has remained concentrated in key populations, including people who inject drugs, men who have sex with men and female sex workers. Nevertheless, effective responses to HIV/AIDS have been hampered by their uneasy and sometimes conflicting relationship with policies on so-called social evils, in particular drug use and sex work. Sex work and drug use have historically been criminalized in Viet Nam, and people who engaged in these activities have usually been detained in compulsory detention rehabilitation centres.

In the past, criminalization and detention challenged progress in HIV/AIDS prevention and control in Viet Nam. Criminalization contributed to an environment where these populations remained hidden and did not access services, fearing they would be detained. Illicit drug use among sex workers in Viet Nam increased their likelihood of being infected with HIV (53, 54, 55). Although the availability of specific data was limited, there was

growing realization that the health and HIV-related needs of sex workers were not being adequately addressed (56, 57, 58).

### What policy changes were introduced?

In response – and to strengthen HIV/AIDS prevention and control in Viet Nam – the Government gradually introduced changes in policy. These changes were informed by Viet Nam’s commitments under international human rights law, including the right to available, accessible, acceptable and quality health services.<sup>5</sup> Advocacy and policy dialogue by international partners, including WHO, the United Nations Special Rapporteur on the Right to Health and civil society partners such as Human Rights Watch, helped draw the attention of the Government to the health and rights of sex workers and other detainees, and related consequences for HIV/AIDS control (59, 60, 61).

Applying a rights-based approach, the Law on HIV/AIDS Prevention and Control, promulgated in 2006, and Decree No.108/2007/ND-CP (62),

<sup>5</sup> Viet Nam has ratified the following international human rights treaties: International Covenant on Economic, Social and Cultural Rights; International Covenant on Civil and Political Rights; Convention on the Elimination of All Forms of Discrimination against Women; and Convention on the Rights of the Child.



which came into effect on 1 January 2007, mandated the Ministry of Health to target the most at-risk groups and work with the Ministry of Public Security and the Ministry of Labour, Invalids and Social Affairs to ensure the implementation of needle-and-syringe and condom distribution programmes for these groups in communities. In addition, the Government prioritized the dissemination of health information, guidance on correct condom use, and HIV testing and counselling in community-based settings and increased access to early HIV treatment (63, 64). Staff members in the detention centres were trained to provide better-quality services. Their understanding of and competencies in providing non-discriminatory, gender-sensitive and culturally appropriate services were strengthened.

As part of a rights-based approach, the participation of the affected communities was prioritized: Identity cards were provided to peer educators, often sex workers themselves, to protect them from arrest and detention and facilitate their work with communities. In 2011, sex workers also participated in a community consultation to inform the development of a new Law on Handling of Administrative Violations, enacted on 20 June 2012, whereby sex workers were removed from the list of individuals liable for compulsory detention. More broadly, the move away from a focus on “social evils” to more public health-oriented and rights-based approaches facilitated the establishment of a national network of sex workers in 2012–2013 as well as the expansion of the existing network of people living with HIV. Both continue to work in partnership with the central and local governments.

These developments in Viet Nam are an example of how health and human rights, and specifically advocacy on the right to health, are interlinked.

Human rights violations, for example discriminatory practices in health care, result in ill health. Applying a rights-based approach, for example through participation of affected groups themselves, can strengthen policy dialogue and implementation of interventions (65).

The Law on Handling of Administrative Violations can also be seen as a step forward for meeting the health needs of people who use drugs, as they are now entitled to court hearings and legal representation in court. However, more work needs to be done, including reviewing and revising punitive laws, policies, practices, stigma and discrimination against key populations that hinder effective responses to HIV prevention and response, and harm reduction initiatives (66). In 2015, the CEDAW Committee published their concluding observations on Viet Nam’s state report, raising concerns about the high prevalence of violence against women and girls, including against sex workers and the low rate of reporting and conviction of perpetrators of violence against women (67). The CEDAW Committee also drew attention to the stigmatization of and administrative penalties imposed on women and girls in sex work, and recommended that Viet Nam review the Law on Handling of Administrative Violations (2012) and on Administrative Penalties (2012) with a view to decriminalizing women in prostitution (67). Efforts are ongoing to strengthen progress in meeting the health needs of vulnerable groups, including tackling discrimination, promoting access to drug rehabilitation in community-based facilities, and voluntary HIV prevention, treatment and care services. Applying a rights-based approach offers additional entry points for accelerating progress under the national HIV/AIDS programme in future.

## LESSONS LEARNT

- **Ongoing capacity-building (not a one-off workshop) is important at each step of the process.**
- **A policy can provide legitimacy and a mandate for further action.**



## Gender and health policy-making in Papua New Guinea

At independence in 1975, Papua New Guinea adopted its Constitution, which enshrined gender equality goals. It has also committed to several international legal instruments on gender equality and women's human rights, notably CEDAW and the Beijing Platform for Action. Despite these achievements, women lag behind men with respect to health and socioeconomic status. The situation is illustrated by high maternal mortality, low access to sexual and reproductive health services and other essential health services, and high prevalence of poor nutrition, especially for rural women (10, 68). Women's literacy rates are significantly lower than those of men, and safety concerns hinder girls' school attendance. Papua New Guinea has one of the highest rates of gender-based violence, with enormous social and health consequences for women and girls, including increased vulnerability to HIV and other sexually transmitted infections (STIs) (10, 68).

Through increased political commitment over recent decades – as well as policy advocacy and capacity-building by United Nations agencies

including WHO and with other partners – gender has progressively become part of the Government's agenda (69) and is reflected in major strategic plans such as the *Papua New Guinea Vision 2050* (70) and the *Papua New Guinea Development Strategic Plan 2012–2030* (71). Several departments have developed specific guidance on gender, for example, the Department of Community Development's *National Policy for Women and Gender Equality 2011–2015* (72) and the Department of Personnel Management's *Gender Equity and Social Inclusion Policy* (73). Recognizing the important links between gender and health, the health sector has taken a leadership role in championing the development of the first *Health Gender Policy 2014* (74), a milestone on the path to gender equality.

### **Papua New Guinea's first gender and health strategy**

The Policy seeks to systematically incorporate a gender perspective into the health sector, from law and policy development to the implementation and monitoring of programmes (74). To im-

prove the health status of the whole population, the Policy commits to increasing gender equity in access to health information and use of services. It integrates gender into administrative policies and procedures of the National Department of Health and in service delivery. Notably, it puts emphasis on strengthening the health sector response to gender-based violence, recognizing that gender inequality is a root cause of such violence.

The National Department of Health has led the development of this Policy and is also responsible and accountable for its implementation. It was finalized through broad-based consultation, drawing on expertise from various sectors and support from WHO and other partners. Women and representatives of women's civil society organizations also contributed to the policy development. Gathering national stakeholders to contribute to the development of the draft and for the policy launch was crucial to generate ownership and support for implementation.

### **Next steps**

The development of the *Health Gender Policy 2014* has been a milestone in applying a gender lens to health in Papua New Guinea. The Policy

has strengthened the mandate for gender mainstreaming in the health sector. Implementation of the Policy has been under way through existing government administrative arrangements. In collaboration with WHO, the National Department of Health has been building the capacity of health managers at national and provincial levels to promote and implement gender-responsive approaches in health, in line with the Policy (75). It has also provided new impetus for strengthening the health sector response to gender-based violence. Most recently, the National Department of Health developed and endorsed national clinical practice guidelines on medical and psychosocial care of survivors of such violence. The guidelines aim to support health workers in providing quality, gender-sensitive care to survivors. While implementation is ongoing, these policy commitments signal the Government's commitment to address gender as core component of improving the health of women and girls, their families and communities. Papua New Guinea is adamant to have gender integrated in all government policies. With the relevant policies, tools and frameworks in place, a gender lens can be successfully applied and implemented.

## **LESSONS LEARNT**

- **Attention to gender, equity and human rights is facilitated by the international legal commitments of the country.**
- **Attention to gender, equity and human rights expands the group of partners, including affected communities themselves.**

**GENDER, EQUITY AND  
RIGHTS-BASED PROGRAMME  
IMPLEMENTATION**





# Overcoming geographical barriers in access to services in Mongolia

## Overcoming geographical barriers in access to services in Mongolia

Mongolia is sparsely inhabited. Of its 3 million people, half live in the capital of Mongolia and the other half is spread across vast distances, without easy access to roads. The overall population density is estimated at 1.9 people per square kilometre. Distances between the most remote *soums* and the *aimag* centres range between 35 and 400 kilometres. The delivery of health services is challenged by the country's extremely low population density over a large territory.

Geographical barriers and the particularities of a nomadic lifestyle prevent rural populations from accessing quality health-care services. For example, remote and migrant population groups, including herders, traditional ethnic groups, border populations and informal small-scale miners, must travel long distances to reach the closest health facility. This can delay timely access to services and increase the overall costs, including transport costs and opportunity costs from time missed at work.

Having health workers with appropriate skills at all levels of the health system is critical for ensuring access to quality services.

To address existing challenges, since 2013, the WHO country office in Mongolia has initiated a subnational health system strengthening (SHSS) programme involving national and international partners. Under the SHSS programme, the country office put UHC and health security at the core of local health system strengthening. Following the introduction of the SDGs and the *Mongolia Sustainable Development Vision 2030*, the Ministry of Health and WHO conducted three consecutive national workshops in the context of the SHSS programme between September and November 2016 with technical and financial support from the three levels of WHO. Under the leadership of the Ministry of Health, this initiative involved all 21 *aimags*/provinces and 9 districts of the capital city, highlighting the concept of “leaving no one behind”, a planning approach to reach UHC and the *Mongolia Sustainable Development Vision 2030*. This served as a foundation underpinning how to

address gender, equity and human rights for marginalized populations across the whole country by building a platform for health system strengthening at the subnational level. In addition, the initiative also demonstrates evidence of continuing ownership of the Ministry of Health to support SHSS, which is reflected in the State Policy on Health for 2017–2026 approved by Government Resolution No. 24 in 2017. “Leaving no one behind”, the core principle of the SDGs, is also reflected in this State Policy and the Ministry’s subprogramme on implementation at the aimag and district levels.

### **Institutionalizing the provision of mobile health services**

In response to the relatively high levels of morbidity and mortality in rural areas, the Ministry of Health introduced a new model of mobile health services in 2000. The model is comprised of two main components: 1) sending a team of specialized doctors from *aimag* centres to *soums* to provide examination, diagnosis, treatment and rehabilitation care of first- and secondary-level medical services, as well as health education training and advocacy on disease prevention; and 2) sending *bagh* “feldshers” to remote households for medical check-ups and disease prevention, referring patients to *soum* doctors as needed. By 2009, all 21 *aimags* of Mongolia had initiated mobile health services, typically provided once a year. While there remained substantial variation in arrangements across *aimags*, all mobile services provided primary care services, with some also offering secondary care services. Fifty per cent of *aimag* mobile health services included public health activities such as training and educational handouts on sexually transmitted infections (STIs), maternal and child health, nutrition, and so on. An assessment of mobile health services in 2015 found that these activities were critical in providing outreach to marginalized communities and generally had a positive health impact on the communities who normally would not have had any access to care (76). The assessment also highlighted a number of challenges in implementing mobile health services, including a lack of standards across *aimags*, limited coordination and questions of (financial) sustainability. In

2016, the Ministry of Health of Mongolia issued a decree that aimed to address some of these concerns. The decree defined the specific package of services, including public health, outpatient and pharmaceutical services. It listed minimum medical equipment requirements for mobile services, and outlined responsibilities of outreach teams and aimag health departments, including with regard to coordination. This decree is a major step forward in institutionalizing mobile health services and tackling geographical barriers faced by remote and marginalized population groups in Mongolia (76).

WHO has been providing support to the national and local governments in Mongolia to strengthen the delivery of mobile health services. Modern mobile health technology has provided cost-effective tools to reach out to rural and remote population groups. The aim has been to maximize the added value of mobile health technology innovations through integrated annual screening for noncommunicable diseases (NCDs) and communicable diseases such as hypertension, diabetes, TB, HIV/STIs and viral hepatitis B and C, in addition to medical check-ups as well as treatment and care of people with illnesses. To support these efforts, annual screening data recording software is being developed and connected to the national health information system. The continued promotion of using cost-effective mobile health technology and genetics/biotechnology for point-of-care testing is expected to improve both access and quality of primary health care in line with the SDG concept of “leaving no one behind” (76–80).

### **Developing distance e-learning platforms to build the capacity of health workers**

To tackle access barriers to education and professional development opportunities for health workers in remote areas, the Ministry of Health, with technical and financial assistance from WHO, has invested in the development of e-learning platforms housed at the Mongolian National University of Medical Sciences. These are provided nationally by taking advantage of fibre optic connectivity and the high penetration of smartphones

in the country. In Mongolia, the number of registered smartphone users outweighs the number of inhabitants and 90.3% of the former use their devices to connect to the Internet. The e-learning programme allows health workers to update their professional knowledge and skills on a wide range of health topics, such as communicable diseases, NCDs, child health, primary health care packages and emergency care, health surveillance and response, and environmental health. The programme recently added a module on mental health, including identifying substance abuse and counselling for alcohol and tobacco cessation. This virtual platform allows learners to connect with existing institutions and networks, attend lectures and participate in virtual discussions.

### **Next steps**

Successfully overcoming geographical barriers in the provision of health services, particularly for remote and migrant population groups, is an important dimension of moving towards UHC in Mongolia. Mobile health services that target remote communities, including through modern mobile health technology, and capacity-building for health workers in remote duty stations are important steps in tackling geographical access barriers and fostering equity in health services.

### **LESSONS LEARNT**

- **Community-based approaches provide an opportunity to consider multiple pathways for action.**
- **It is important to build the skills of health managers and workers to work with communities and meet their needs.**
- **Modern mobile health technology can be a cost-effective way to reach out to rural and remote population groups.**



## Addressing the needs of a displaced group in the Philippines

### Vulnerable subgroups among the internally displaced population

In September 2013, an armed conflict between insurgents and the armed forces of the Philippines in Zamboanga City on Mindanao island caused the displacement of over 109 000 civilians to evacuation centres. About 70 000 were initially relocated to a sports complex known as the Grandstand (81).

From the second quarter of 2014, internally displaced people were gradually transferred to transitional camps, still in use in 2016. The displacement created a social and economic disequilibrium, as most people were unable to conduct their regular daily activities. At the same time, an increase in the health needs of the affected population was observed.

During the emergency phase of the crisis, to make the range of health-care services available to all people in need at no cost, temporary health facil-

ities with health workers, medicines and supplies were set up strategically in some evacuation centres, especially those located far from the usual health facilities. These temporary health facilities included social hygiene clinics, providing specialized sexual and reproductive health services such as diagnosis and treatment of STIs, HIV counselling and testing, and condom distribution on specific days of the week.

Nonetheless, it soon became apparent that only limited numbers of patients made use of these services and that these services failed to reach the most vulnerable. Considering that HIV/AIDS and STIs were already prevalent public health concerns in the city prior to the conflict, the City Health Office of Zamboanga, together with partners and advocates for reproductive health, requested an intervention to cater for the specific needs of male and female sex workers who were identified as especially vulnerable.



Female and male sex workers faced several barriers that hampered their access to services. Lack of information was a particular challenge. Because of displacement, patients of social hygiene clinics, mostly sex workers, did not know about the new locations of the services. At the same time, the number of people engaging in sex work had increased as a result of displacement. These newer sex workers were often not familiar with available services or HIV/STI risk and protective measures. Younger sex workers faced particular information barriers in access to sexual and reproductive health services, in addition to generally lower awareness of health more broadly.

Stigma and discrimination also presented significant access barriers for sex workers. For example, the name of the package of services (“social hygiene clinic”) was reported to be a barrier in itself, as it was found stigmatizing. Sex workers and their clients feared that they would be pointed out as disease carriers if they attended the clinics. Younger sex workers avoided services altogether because they were legally required to obtain parental consent to access services. Sociocultural and gender norms compounded these barriers. Given sensitivities related to sex, both sex workers and clients were reluctant to access services oriented to detect and treat STIs, for fear of being singled out for risky sexual behaviour.

A targeted response that would tackle these specific barriers and ensure sex workers’ access to needed services without discrimination was seen as critical in moving forward.

### **Tackling stigma and discrimination in access to sexual health services**

To start with, the City Health Office, in collaboration with partners, engaged sex workers themselves to identify and assess access barriers as well as explore possible responses. In response to concerns that the name “social hygiene clinic” was stigmatizing and hindered access, the services were reframed within temporary health facilities as “wellness centers”.

Peer educators, often sex workers themselves, were identified as a key resource to support im-

plementation of activities. The City Health Office was able to draw on peer educators who had been active since before the conflict and train new ones. The peer educators had knowledge on HIV/AIDS and STIs, including symptoms, transmission, risky behaviour and protective measures, as well as strong interpersonal skills to understand, support and follow up with their peers. To tackle access barriers, peer educators reached out to sex workers and their clients at night in settings where sex trade was visible and known to take place, such as entertainment bars, parks or more distant areas of the evacuation centres. They built trust with sex workers, informing them of the range of available services and how to best access them.

Empowerment and counselling sessions provided sex workers with the skills to negotiate condom use and claim their entitlements to health services. Contact details (mobile phone and address) were maintained to allow follow-up by the peer educator with individual sex workers. Peer educators were also able to conduct home visits when deemed appropriate. With informed consent from the person at risk, counselling was also offered to family members to promote disease prevention and foster social support.

These activities led by peer educators and others were aligned with broader prevention activities by medical missions organized in the evacuation centres. The missions were used as platforms for collective awareness-raising talks, building general knowledge about sexual and reproductive health. Some information sessions were tailored to the needs of adolescents and young people.

### **Reaching and serving a hard-to-reach population group during displacement**

Although precise data are not available, anecdotal evidence from peer educators suggests a decrease in stigma and discrimination and an increase in access to sexual and reproductive health services by sex workers. The specific interventions targeted at sex workers were critical in helping them overcome access barriers to needed services and reach the highest attainable standard of health. Male and female sex workers were described as

more empowered and knowledgeable about how to protect themselves and how to access needed health services.

From a health programme perspective, risk of transmission of HIV/AIDS and STIs was reduced. Given the success of these interventions, they were continued after the displaced populations were transferred to transitional camps and are still in effect today.

## **LESSONS LEARNT**

- **Gender, equity and human rights are crucial considerations for work in emergencies.**
- **Empowering communities to be involved in decisions and programmes that affect them is an important dimension of advancing health.**



## Empowering women to fight tobacco in China

With 315 million smokers, China is the world's largest producer and consumer of tobacco. Around 28% of people aged 15 years and older are current smokers. China has made significant progress in tobacco control in recent years including adoption of comprehensive 100% smoke-free laws in three of its largest cities (Beijing, Shenzhen and Shanghai), an increase in tobacco taxation announced by the Ministry of Finance in 2015 and stronger restrictions on tobacco advertising. A national smoke-free law is currently being considered (82). There are significant differences in smoking prevalence between men and women in China. Whereas half of men use tobacco, only 2.4% of women do so (83). Despite not smoking, women (and children) are vulnerable to second-hand smoke, especially in private settings such as their homes. More than 700 million people are routinely exposed to second-hand smoke and more than half of young people aged 13–15 years are exposed to second-hand smoke inside enclosed public places each week – and 100 000 people die every year as a result (82). To address this issue, the Tianjin Center for Disease Control and Prevention, with support from WHO, initiated a small

pilot in Tianjin, China, where smoking rates mirror national trends. This pilot was implemented from February to June 2014 in one street in He Xi District and one street in Tang Gu District.

### **How did the project empower women and turn them into actors of tobacco control?**

The project integrated a gender lens by placing women at the centre of action to reduce exposure to second-hand smoke and promote smoke-free homes. The project applied three approaches to empower women: first, the capacity of women was strengthened by raising awareness, disseminating information and building skills to advocate smoke-free homes. For example, staff from the Tianjin Center for Disease Control and Prevention gave lectures on tobacco harm and trained approximately 200 women in the skills to negotiate smoke-free homes. To empower women with the knowledge and confidence to meaningfully participate in decisions that affect them, the project set up an information booth on tobacco control in a visible location near health facilities. Staff hand-

ed out 50 000 leaflets and 35 000 brochures and reached out to women in the community. An official competition was organized to encourage women to lead action in their communities, awarding innovative interventions with prizes. More than 50 participants took part in the contest.

Second, various community activities were organized to foster an enabling environment that emphasized women's role in tobacco control. For example, the project organized a calligraphy exhibition with more than 40 pieces on creating smoke-free homes. The exhibition was launched with a public event that included cultural performances illustrating the harms of tobacco and providing tips on how to quit or avoid taking up smoking. The project used social media to disseminate key messages, including through participatory online competitions involving Tianjin residents.

Third, the project engaged children – and through them their parents – to reinforce women's role in achieving smoke-free homes. For example, the project sensitized more than 1400 students on the harmful effect of smoking and second-hand smoke through lectures at schools and a visit to the calligraphy exhibition combined with an informative talk. The project also encouraged children to advocate smoke-free environments together with women. For example, letters and brochures from the school conveyed formal requests for smoke-

free homes by children. Some schools chose tobacco control as the topic for their Children's Day event.

### **Were these interventions successful?**

Nearly 1000 people, including male and female respondents, were surveyed at the beginning and end of the pilot. Results suggest that the pilot was successful in increasing people's awareness of second-hand smoking and its harmful consequences, especially for women and children. For example, the level of awareness among the general population that second-hand smoke causes stroke increased from 62% to 85% , for heart disease from 65% to 91%, for oral cancer from 34% to 83%, for sudden infant death for syndrome from 28% to 78% and asthma from 47% to 87%. Integrating a gender lens allowed the programme to tackle the underlying reasons for tobacco-related harm in the home. Women felt more empowered to stand up for their health and the health of their families, and developed the necessary skills to negotiate smoke-free spaces at home. After the intervention, 50.7% of women residents started requesting smokers to smoke outside their homes. In terms of behaviour change of smokers following efforts made by the women, the percentage of families where smoking still occurred in homes dropped by 20% within three months.

## **LESSONS LEARNT**

- **Ensuring the participation of both women and men as beneficiaries and project implementers facilitates progress.**
- **Targeted funding in a given health programme can trigger attention to gender, equity or human rights.**
- **Strong leadership by national and local counterparts is essential – women's organizations are important partners for the health sector.**





## Engaging women in the Zika virus outbreak response in Tonga

On 1 February 2016, WHO declared Zika virus and the observed increase in neurological disorders and neonatal malformations a public health emergency of international concern, under the International Health Regulations (2005) (84). Zika virus disease is a mosquito-borne disease that can also be transmitted through sexual contact. Zika virus infection during pregnancy is associated with microcephaly and other congenital malformation. Zika virus is also a trigger for Guillain-Barré syndrome. In response, WHO called for “aggressive measures to reduce infection with Zika virus, particularly among pregnant women and women of childbearing age” (84). Active engagement of pregnant women and women of childbearing age to meet their specific needs was seen as critical, given they are at greatest risk. Effective Zika virus disease prevention would both safeguard women’s health and prevent Zika virus infection-related medical conditions and disabilities in newborns.

Coincidentally, on 1 February 2016, the Ministry of Health of Tonga declared a Zika virus outbreak. By 6 March 2016, some 2220 people had been infected with Zika (2173 suspected, of which 1257 female and 916 male; 47 confirmed). Of these, 19 were pregnant women, although none had any reported complications (85). The Government of Tonga, led by the Ministry of Health, and other partners, including WHO, the Australian Department of Foreign Affairs and Trade and the Tonga Red Cross Society, initiated efforts that provided women, especially pregnant women, with needed information to protect their own health and the health of their families and communities. Several communication approaches were used in a range of settings. For example, education leaflets were developed and made available in spaces that were easily accessible to women accessing prenatal care services, such as waiting rooms in health facilities. The leaflets provided pregnant women with basic

information about the virus, modes of transmission and symptoms in the local language. Health workers organized information sessions during waiting times for antenatal care and individual consultation with pregnant women to reinforce messages, address specific concerns, answer any questions, and provide tailored information and advice. Regular feedback was sought to tailor messages to women's information needs.

Prevention measures were presented simply and through visual aids such as an “ABC aid” to easily visualize key messages: with A standing for “Avoid mosquito bites, especially during the daytime”, B for “Be aware of Zika and services available and act accordingly”, and C for “Clean your surroundings”. In addition, community-based information sessions were delivered at the same time. Local health units reached out to pregnant women and women of childbearing age in their communities, shared experiences of Zika virus disease prevention measures and provided psychosocial support. Health information on Zika virus was also disseminated through TV and radio. Since the evidence base on Zika virus had expanded by this stage and sexual transmission was suspected, mass media and leaflets to the general population included recommendations to women and men about the use of contraception to avoid transmission and/or delay pregnancy during the outbreak. These broader communication activities created an enabling environment for women to exercise their right to health.

As part of community participation, civil society organizations led clean-up campaigns to remove *Aedes* mosquito breeding sites. The clean-up activities targeted all communities throughout the country. Vector control measures such as spraying were also carried out in and around the houses of suspected patients and residences of pregnant women. Insecticide-treated mosquito nets were also distributed to pregnant women at risk of Zika infection.

### **Targeted communication activities for vulnerable populations**

Risk communication and behaviour change campaigns were key elements of the Zika response in Tonga. The focus of risk and behaviour change communications targeted those most at need, namely pregnant women and women of reproductive age. The programme can be seen as an example of gender-specific, in this case women-centred, action informed by the best available evidence of the population at highest risk. As the Ministry of Health developed communication materials and strategies, specific attention was paid to pregnant women and women of childbearing age because of their specific vulnerability to Zika virus disease.

## **LESSONS LEARNT**

- **Risk communication and behaviour change play an important role in outbreak response and they should consider gender, equity and human rights.**
- **Targeting vulnerable groups is core to mainstreaming efforts.**



## Strengthening the health sector response to gender-based violence against women and girls

One in three women globally experiences physical and/or sexual violence, mostly by an intimate partner. Violence damages women's health in many ways, both immediate and long term and both obvious and hidden. Women who have been abused or assaulted need care and support. For example, a study conducted in Victoria, Australia, by VicHealth in partnership with the Department of Human Services found that intimate partner violence accounts for 8% of the total disease burden in women aged 15–44 years (86). Among women who had experienced violence in Cambodia, 90% reported being hurt badly enough to need health care (87). In New Zealand, approximately 40% of women with a lifetime experience of violence had visited a health-care provider during the previous month (88). Health providers and health systems have a critical role in supporting women, minimizing the impact and preventing violence from happening.

Gender equality is essential to eliminate violence against women and girls because unequal gender norms and attitudes held by both women and men make such violence more acceptable. These norms exist in every society and are context specific. For example, the United Nations Multi-country Study on Men and Violence in Asia and the Pacific (2013) reported that around 56% of men in Papua New Guinea (Bougainville) agreed that there are times when a woman deserves to be beaten (89). National surveys found that 64% of women in Tonga (90) agree that a man should show he is the boss, and 49% of women in Cambodia (87) believe that a husband is justified in hitting his wife under certain circumstances. In Solomon Islands, the most common (36%) reason for never leaving a relationship was that the violence was considered “normal” or “not serious” (91). These norms and attitudes are root causes of violence and must be addressed in order to effectively respond to gender-based violence.

Responding to this challenge is not easy and requires multiple sectors and stakeholders – and communities themselves – to work together (92). The health system provides key entry points for working with other sectors and stakeholders, mobilizing communities and reaching out to survivors (93). Ministries of health in the Western Pacific Region, in collaboration with WHO and partners, have been strengthening the role of health systems to respond to, prevent and lead efforts to address violence against women and girls (94). For example, Cambodia, Fiji, Papua New Guinea, Solomon Islands, Viet Nam and others have reviewed and/or developed policy guidelines, clinical protocols or other resources that integrate gender-responsive approaches. The Fiji Responding to Intimate Partner Violence and Sexual Violence against Women and Girls Health Guidelines for Comprehensive Case Management underline the importance of understanding how differences in power between women and men determine the way that they treat each other, their access to resources to protect their health and often how the health system treats them. Informed by new survey findings, Cambodia piloted and adapted a clinical handbook on health care for women subjected to intimate partner violence or sexual violence, providing practical guidance on first-line support (95). This includes listening to the survivor, inquiring about her needs and concerns, validating her experience, enhancing safety and supporting her in her choices. Promoting women’s autonomy and dignity has also been central to efforts in Solomon Islands, with new legislation adopted in 2014 informing efforts to strengthen

the health sector response. In Papua New Guinea, the adoption and implementation of the country’s *Health Gender Policy 2014* has provided new impetus for strengthened dialogue on gender-based violence and capacity-building on gender and health, including building skills among health managers to respect women’s contributions and value, avoid reinforcing gender inequalities, and challenge norms that perpetuate violence. All these examples highlight how gender sensitivity is core to effective responses to violence against women in the health sector and beyond.

### Way forward

In recent years, many WHO Member States in the Western Pacific Region have taken impressive steps to promote gender equality and respond to gender-based violence in collaboration with WHO and its partners. Responding to gender-based violence is critical in the context of the SDGs includes a specific target on the elimination of violence against women and girls in public and private settings. The target builds on lessons learnt from the Millennium Development Goals (MDGs), specifically MDG 3 on gender equality and women’s empowerment. The health system has an important role to play as part of a multisectoral response to gender-based violence. Applying a gender lens to health system responses is critical to empower women and girls and support them in their choices. Ensuring access for women and girls to quality services is important, not only for their healthy futures but also for the future of their families and communities. Healthy girls and women make healthy families, communities and nations.

### LESSONS LEARNT

- **Strong WHO guidance on gender and gender-based violence facilitates action.**
- **Gender-based violence requires multiple sectors and stakeholders and communities themselves to work together; WHO can help to convene partners.**

**INCORPORATING GENDER,  
EQUITY AND HUMAN RIGHTS  
IN MONITORING  
AND EVALUATION**





## Ensuring an equity focus in the tuberculosis programme in the Philippines

The Philippines has made remarkable progress in the past decades (1990–2015) in TB control (96). Despite these achievements, it remains one of 30 countries with the highest TB burden globally (1). Successes in TB control among the country's 18 regions vary due to uneven progress across population groups, especially among poor urban dwellers, poorer rural households, prisoners, children, indigenous people, older people and those with TB co-morbidities such as diabetes and HIV/AIDS. These population groups are at particular risk of being infected by TB and face significant barriers in access to services.

In 2016, the National TB Control Program commissioned a joint programme review to assess progress and inform the development of the next strategic plan of action from 2017 onwards. The joint programme review included 11 teams, consisting of international and local experts who focused on key thematic areas in line with the 2010–2016 *Philippine Plan of Action to Control Tuberculosis*.

Given the uneven progress across population groups, the joint programme review included a specific objective to integrate an equity perspective. As a result, one review team was asked specifically to assess various dimensions of equity in policies, case finding strategies, monitoring and evaluation, and treatment, care and support for vulnerable groups.

The review documented many achievements. For example, the current plan specifically refers to responding to the special needs of vulnerable groups (97). Policies and guidelines have been issued to improve the TB management among prisoners, people displaced by disasters and migrant workers. Health and non-health programmes for the poor, including conditional cash transfers through the Department of Social Welfare and Development and health insurance coverage through the Philippine Health Insurance Corporation (PhilHealth), have improved health-seeking behaviour. Similarly, innovative strategies have been deployed for active case finding. The TB programme has con-



ducted mass screening in some jails, among the urban poor in Manila, congregate settings for older people and people with disabilities, and indigenous settings. Community-based health workers have been identified among vulnerable groups in an attempt to better reach marginalized groups. The TB programme also developed specific outreach programmes for the rural poor.

However, significant challenges remain. Economic barriers related to transport and diagnostic costs continue to hinder access to services by vulnerable groups. The conditional cash transfer programme has been geared mainly towards maternal and child health, with limited attention to TB control. The review also highlighted the need to fine-tune screening efforts, including more systematic implementation across relevant high-risk settings and use of more sensitive diagnostic tools that can detect drug-resistant TB. Most of the DOTS (directly observed treatment, short course) TB facilities and rural health units practise passive case finding, both for specific vulnerable groups and the general population, and do not screen contacts routinely. Better integration of TB with other health conditions and programmes offer untapped opportunities to capture more TB patients and address co-morbidities. Insufficient support and care for patients during treatment, including fostering treatment literacy and counselling, risk losing patients to follow-up. Lastly, the review found that the acceptability of services requires strengthening. Providers do not generally understand the needs and demand-side barriers

of specific vulnerable groups, nor are they trained in and systematically practise culturally sensitive approaches.

### **What are the benefits of the joint programme review on equity?**

The joint programme review was a useful entry point to assess the achievements in terms of equity and develop practical recommendations. Applying an equity lens helped shed light on the specific needs of vulnerable groups. Paying systematic attention to these needs can increase the effectiveness and sustainability of achievements by the TB programme. For example, given the high vulnerability to and prevalence of TB among the urban poor, high-impact interventions targeted at this group could result in major breakthroughs for the TB programme.

Review recommendations also identified opportunities for strengthening the accountability of the TB programme by including equity-focused targets in its monitoring and evaluation system, informed by the collection and analysis of disaggregated data by key social stratifiers (sex, age, geographical location, household income, etc.). Although only a first step, the evidence collected during the review can inform changes that leave no one behind in TB control in future, enhancing the programme's ability to reach and improve the health of all individuals, their families and communities.

## **LESSONS LEARNT**

- **National disease programme reviews are strategic entry points for identifying priority groups and interventions to address gender, equity and human rights issues.**
- **The success of applying a gender, equity and human rights lens depends on the expertise and skills of the review team, including experts on equity that can translate the concepts and actions into the language of the programme.**



## Incorporating gender into HIV/AIDS monitoring and evaluation in Viet Nam

Recent years have seen substantial progress in HIV/AIDS control in Viet Nam.

In 2014, there were an estimated 256 000 people living with HIV, 25.8% (66 000) of whom were women (98). The number of newly infected people decreased rapidly between 2007 and 2009, having stabilized at around 14 000 per year since 2010 (99).

However, a substantial proportion of all new infections occur among women in long-term sexual relationships with men living with HIV, particularly men who inject drugs, as well as men who have sex with men and men who buy sex. In 2016, male-to-female intimate partner transmission accounted for an estimated 30.2% of new HIV infections. Studies show that nearly 54% of infections among women in Viet Nam can be attributed to the risk behaviour(s) of their male sexual partners, and that condom use by men who inject drugs is particularly inconsistent when a female partner does not know the man's HIV status (100).

Female sex workers, women who use drugs, and transgender women and men are additional priority population groups, further underlining the importance of taking into account sex and gender in the HIV response.

For example, gender norms, roles and relations influence the ability of women and girls to exercise control and autonomy when it comes to matters of their own sexuality, for example choosing sexual partners, deciding when to have sex, refusing sex or unsafe sex, and using condoms (101). Gender norms about sexuality, masculinity and peer pressure may promote risk-taking among men, including engaging in unsafe sex with multiple partners.

Gender-related barriers in access to and use of HIV services result in differentials between men, women and other genders. For example, men – regardless of sexual orientation – may be reluctant to be tested or treated for HIV due to the fear of

being stigmatized for having sex with other men. Some women may need permission from their partners and/or family to seek health care, or be constrained from or delayed in accessing services due to other household responsibilities.

The social impact of HIV also differs for men and women and other genders. For example, women are more likely to take on caregiving roles if a family member falls ill. Given the influence of gender on HIV exposure, access to and use of HIV services, the social impact of HIV and other factors, efforts to respond to HIV need to include due attention to gender.

Despite these trends, the *National Strategy on HIV/AIDS Prevention and Control 2016–2020* does not adequately address gender, nor does it deal with the impact of HIV on different groups of women and girls. The Government of Viet Nam, particularly the Viet Nam Administration of HIV/AIDS Control, has increasingly recognized that limited knowledge and understanding of gender pose major challenges to accelerating an effective national response to HIV. In 2015, a gender assessment confirmed this lack of capacity among national stakeholders, including key policy and programme staff, as an important barrier to progress in HIV/AIDS control (102). The assessment also identified the lack of sex-disaggregated data in HIV/AIDS progress reporting, monitoring and evaluation, including reporting to donors, as a constraint.

### **Strengthening a gender focus in HIV/AIDS control**

In response, the Viet Nam Administration of HIV/AIDS Control initiated a number of steps to strengthen the gender focus of the national HIV response and its monitoring and evaluation framework.

First, the capacity of stakeholders on gender and health was strengthened. A national workshop was organized, bringing together a broad range of stakeholders, including staff from the Viet Nam Administration of HIV/AIDS Control, from other departments of the Ministry of Health, other ministries, as well as representatives from the provincial AIDS committees and members of civil society organizations (103).

Adapting WHO resource materials on gender (75), the workshop enabled participants to build their understanding of basic concepts, such as sex and gender. Participants strengthened their knowledge and skills to conduct gender and human rights-based analysis and gender-responsive planning, programme development, implementation, and monitoring and evaluation.

The workshop also enabled participants to review and identify gender-related gaps in their 2016 planning guidelines, a key guidance document used by the central and provincial HIV/AIDS programmes to plan activities. Participants then worked on developing priority sectoral actions and advocacy messages to be included in the 2017 planning guidelines in order to better integrate gender into the development of their annual work plans and costed operational plans.

To address identified gaps in monitoring and evaluation, a second workshop was held to build capacity among relevant staff on gender-sensitive monitoring and evaluation tools. Participants analysed the shortcomings of the current monitoring and evaluation framework and identified alternative gender-sensitive frameworks and indicators that could be used at the central and provincial level to guide gender-responsive programming on HIV/AIDS.

### **Next steps**

Integrating a stronger focus on gender in programme design, implementation, and monitoring and evaluation provides opportunities to accelerate and sustain progress in HIV/AIDS control in Viet Nam.

Both capacity-building initiatives have built needed skills among stakeholders, which is informing the revisions of the 2017 planning guidelines. In 2017, the revised guidelines will be piloted in two selected provinces, Nghe An and Dien Bien, to develop gender-responsive annual workplans and related monitoring and evaluation frameworks at the provincial level. If successful, the model will be expanded to other provinces and inform policy dialogue to revise the national HIV monitoring and evaluation policy.

Other gender-responsive actions to which the programme has committed include integrating a gender perspective into the upcoming development of a concept note for the Global Fund to Fight AIDS, Tuberculosis and Malaria, cooper-

ating with relevant departments of the Ministry of Health to implement the Government's action plan on CEDAW, and undertaking operations research to increase understanding of gender in the HIV programme.

## **LESSONS LEARNT**

- **Strong ownership by national counterparts is essential for action on gender, equity and human rights.**
- **WHO expertise on gender and health as well as related tools complement the work of other United Nations partners.**





# Integrating gender into the fight against malaria and artemisinin resistance in the Greater Mekong Subregion

## Malaria programmes in the Greater Mekong Subregion

Malaria is a major challenge in the Greater Mekong Subregion.<sup>6</sup> Despite considerable advances, malaria remains a prominent public health issue for all six Greater Mekong Subregion countries, with high prevalence and the emergence of resistance to artemisinin and its partner drugs.

The WHO framework *Emergency Response to Artemisinin Resistance in the Greater Mekong Subregion* was established in 2013 to support containment of drug resistance in the subregion (104). After two years of implementation, an independent midterm review commissioned by DFAT observed that the programme had failed to incorporate gender is-

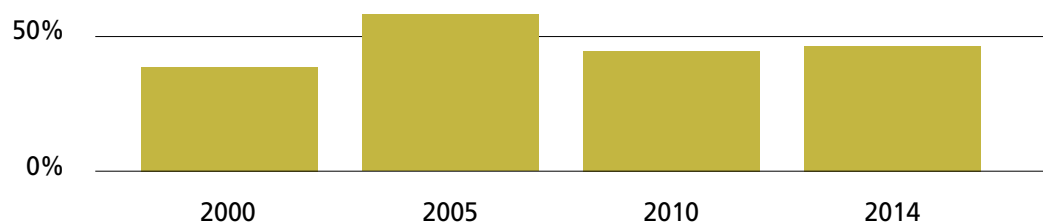
sues. The report recommended the development of an action plan that would define and promote gender equality and social inclusiveness (105).

## Efforts required to integrate gender in the regional and national malaria programmes

Based on these recommendations, and to inform next steps, WHO commissioned a systematic gender assessment of the Emergency Response to Artemisinin Resistance (ERAR) programme in 2016 (106). The objective was to evaluate ERAR's capacity to integrate gender in developing and implementing its programme, strategies, approaches and actions.

<sup>6</sup> For the purpose of this example, the Greater Mekong Subregion is composed of Cambodia, Yunnan Province of China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam.

**Fig. 4. Women in Cambodia who alone make decisions about their health care (%)**



Source: KHM DHS /Gender Statistics, 2016

The gender assessment found good institutional commitment to gender. However, it also pointed to challenges, such as insufficient allocation of resources as well as limited staff capacity to practically and systematically integrate gender into situational analyses with the depth required to then operationalize gender-responsive programming. This threatened the effectiveness of the malaria programme.

Due to gender roles, men are more likely to be bitten by mosquitoes because they are more likely to work and sleep outdoors, near fields and forests, which increases their exposure to mosquito bites. Gender norms may also determine dress codes including skin exposure, with men working shirtless in the field while women may be more covered and thus protected from bites (107). Nearly 90% of the malaria burden in the Greater Mekong Sub-region is among young adult men.

Access to needed preventive and treatment services might also differ between men and women. For example, Fig. 4 shows that less than half of all women in Cambodia make decisions related to their own health care alone. Women's relative lack of control over household resources, including money and means of transport, might limit their access to needed malaria services. Younger women may face particular information and education barriers as well as stigma or discriminating attitudes from health workers, particularly if unmarried.

Integrating a gender analysis can help to identify and analyse different biological and sociocultural (gender) factors affecting men and women's exposure to malaria, investment in nutrition, care and education, access to and use of health services, and the social impact of ill health. Understanding and addressing gender can strengthen programme planning and implementation, help with the identification and targeting of especially vulnerable groups, and maximize the use of programme resources.

To address gender-related challenges, the recently endorsed *Regional Action Framework for Malaria Control and Elimination in the Western Pacific 2016–2020* explicitly recognizes the need to improve access to malaria commodities and services in accordance with UHC, especially for remote and marginalized communities.

### **Gender assessment of ERAR as a milestone**

The assessment recommended visibly and explicitly integrating gender equality in malaria action plans in the future, and building the capacity of national malaria programme staff as well as health-care providers and community health volunteers on gender and health. In addition, the assessment called for the collection, analysis and use of disaggregated data to inform programming, monitoring and evaluation.



The ERAR programme accepted all recommendations from the assessment and took steps to ensure they were included in different components of the programme. The assessment was a significant milestone in changing the way the ERAR programme operated. It was an important step in ensuring gender is more systematically

addressed in programme design and implementation in order to better meet the needs of different population groups affected by malaria in the Greater Mekong Subregion and related donor requirements. Promoting gender equality and empowering women and girls are especially timely in the context of the SDGs.

## **LESSONS LEARNT**

- **Donors can trigger attention to gender, equity or human rights.**
- **Gender assessments provide an opportunity to review progress and strengthen the effectiveness of a health programme.**

# CONCLUSIONS

## CONCLUSIONS

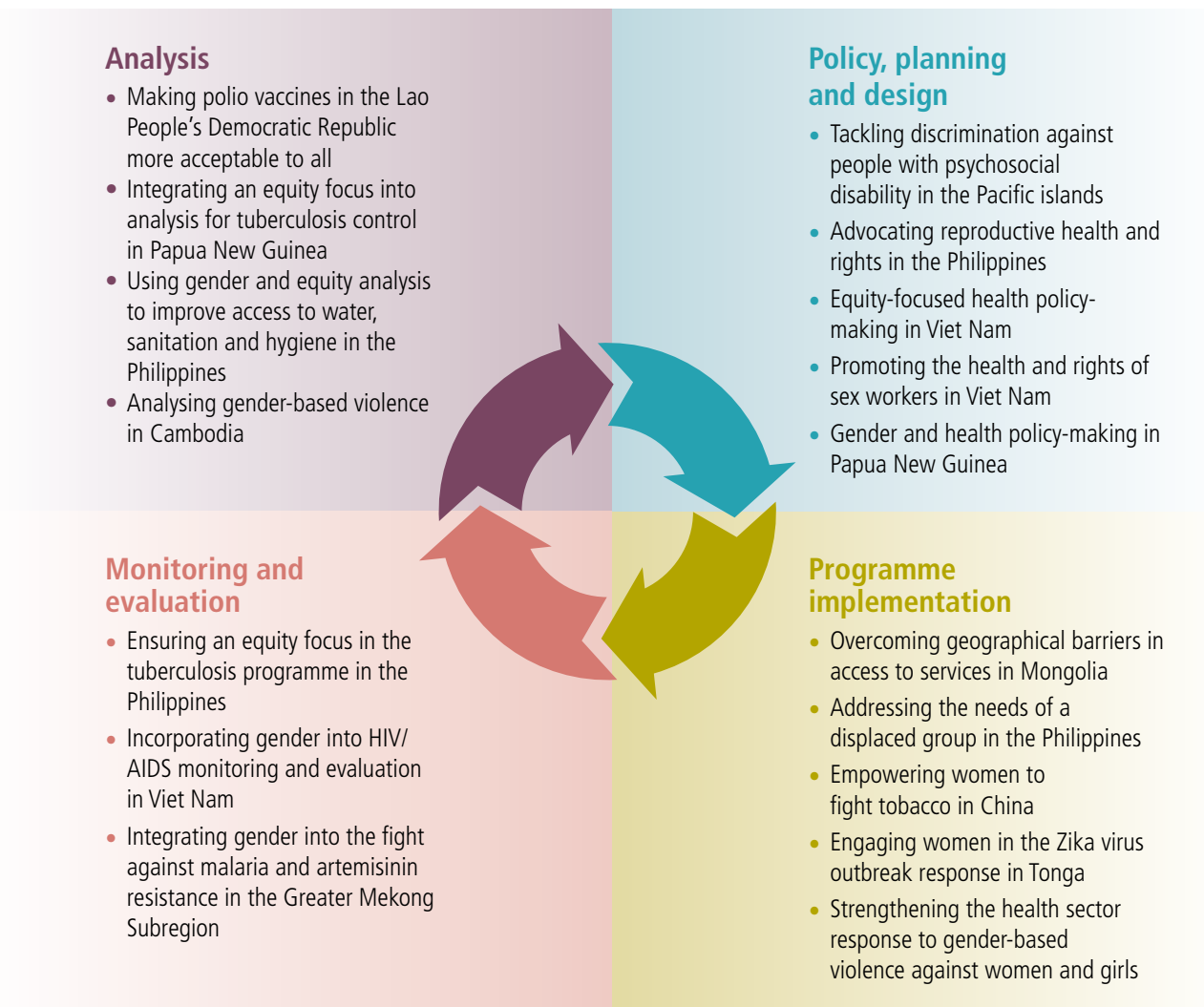
This report was produced at a time when there is strong acknowledgement – at least in the policy discourse – that social and economic justice depends on the participation of men and women from diverse groups and that development cannot be sustainable without reaching those left behind (*1, 10, 11*). The question is: how can health programmes lead this effort? Gender, human rights and/or equity concerns are, however, not new concepts. The importance of advancing health through attention to gender, human rights and equity has been affirmed in numerous global, regional and national instruments and consensus documents. This report has presented examples across various health topics and programmes and across different functions of WHO in the Western Pacific Region. The report is informed by and adds to the existing literature. It is written by staff members for staff members in the WHO Western Pacific Region, as part of a broader reflection process on contributing to action on gender, equity and human rights. It hopes to inform discussions on ongoing change and improvement within the Organization and beyond. This approach is consistent with work by others that frames attention to gender, equity and human rights as a “process” and stresses the need to reflect on and learn from experience (*108*).

### **How is attention to gender, equity and human rights relevant to health programmes?**

The examples included in this report highlight that gender, equity and human rights are relevant to the work of all technical programmes on health. The examples show that gender, equity and/or human rights linkages can be and have been identified in any and all health areas – whether related to health systems, communicable diseases, emergencies or any other programme area with which WHO engages. The report frames attention to gender, equity and human rights as a process of interprogrammatic collaboration that cuts across any specific technical issue. The examples also show the overlaps between these so-called cross-cutting or mainstreaming lenses themselves – for example between gender and human (or women’s) rights – and the potential for creating synergies to advance efforts.

Examples refer repeatedly to the benefits of paying attention to gender, equity and human rights, framing the achievement of gender equality, human rights and health equity not only as important goals in their own right to which the health sector contributes, but crucially as critical tools to improve the effectiveness and sustainability of achievements in health. For example, the TB programme in Papua New Guinea considered equity in an analysis to improve efficiency, while the effectiveness of interventions was a major concern in the example on TB in the Philippines and malaria in the Greater Mekong Subregion. This is in line with evidence pointing to the economic and business case for paying attention to gender, equity and human rights (*109, 110*). It recognizes that “development goals will not be met unless the needs and priorities of all stakeholders are identified and addressed” (*111, 112*) and the importance of “reaching those left furthest behind first” (*1, 11*). In Viet Nam, for example, attention to equity was seen as key to sustaining existing achievements in the health sector.

**Fig. 5. Entry points for gender, equity and human rights**



**When is attention to gender, equity and human rights relevant?**

The examples in this report also show that attention to gender, equity and/or human rights is not limited to a specific stage in the programme or project cycle but can rather be usefully integrated at any stage – from situation analysis, to policy and programme design to implementation and monitoring and evaluation (Fig. 5). The examples also highlight how the different stages overlap. Change can be initiated in one area and influence progress in another.

Several examples describe the added value of using a gender, equity and/or human rights lens to inform analysis. Gaps in the availability of good data and adequate analytical skills are undoubtedly crucial challenges. Nevertheless, the collection, analysis and use of data disaggregated by key social stratifiers such as sex, income, education and rural/urban residence are repeatedly found to be a critical foundation for action.

Disaggregation of programme data is particularly relevant in the context of efforts to monitor the SDGs and UHC, and can, in turn, be a powerful advocacy tool for health programmes (113). Examples also describe how integrating gender, equity and/or human rights perspectives can facilitate a move beyond quantitative data, including “different” or nontraditional data sources (qualitative, grey, anecdotal evidence) to fill data gaps.

Strong evidence exists on the added value of applying a gender, equity or human rights lens at the stage of project analysis, even in the absence of data and how this can help foster action at other project cycle stages, as several examples confirm. The policy process can provide another strategic entry point and help establish a mandate for action (113, 114). Human rights language helped inform advocacy on reproductive health and rights in the Philippines, the health of sex workers in Viet Nam, and non-discrimination against people with psychosocial disability in the Pacific islands. These and other examples describe different types of policy dialogue and policy design that provide opportunities for contributing to action on gender, equity and/or human rights.

As the examples show, entry points for paying attention to gender, equity and human rights also exist in the implementation stage. This is a growing area of concern, particularly in the context of UHC and the SDGs. Examples highlight how gender, equity and/or human rights have helped strengthen access to quality services, for example for marginalized groups in society in Mongolia. In China, women were empowered to fight against tobacco. A gender-responsive approach has helped strengthen the health sector response to gender-based violence in Cambodia, Papua New Guinea, Solomon Islands and other countries.

National stakeholders and international partners increasingly consider attention to gender, equity and/or human rights concerns a core component of good monitoring and evaluation processes. The report provides examples of how gender, equity and/or human rights have been integrated in health programme reviews. In the Philippines, equity was a core theme of the national programme review. A gender assessment provided valuable inputs into the malaria programme in the Greater Mekong Subregion.

An important message of the report is that health programmes can consider – and some are considering – gender, equity and/or human rights issues, where possible. Paying attention to and reflecting on linkages between gender, equity and/or human rights and a given health topic are important starting points. Starting with where programmes see an entry point – and then expanding that opening gradually – can be an important way forward.

### **How to trigger attention to gender, equity and human rights**

The examples compiled in this report outline a range of triggers for increasing the attention given to gender, equity and human rights, including champions within and outside WHO, the United Nations and development partners, as well as donor requirements and others.

Strong leadership and commitment by senior representatives are critical to initiate and sustain efforts (115). Visible and explicit support for gender, equity and /or human rights, for example during internal or public speeches by senior management and high-level mandates, is a well-known trigger for change (116, 117). Champions for gender, equity and human rights can come from within an organization, or be a respected external stakeholder or leader. Seniority plays an important role – the more high level the support, the more likely it is for the suggestion to bear fruit.

Given perceived sensitivities around gender, equity and/or human rights, champions for gender, equity and human rights can sometimes more easily be found outside the organization or health ministries. “Mainstreaming requires building alliances, consensus and momentum,” according to Theobald et al. “The involvement of different stakeholders from other sectors is very important to developing a critical mass” (113). Several examples in this report highlight the added value of collaboration across the United Nations system to advance health through attention to gender, equity and human rights (118). For example, in Viet Nam, the partnership between WHO, UN Women and the Joint United Nations Programme on HIV/AIDS facilitated action on gender-sensitive monitoring and evaluation for HIV/AIDS. Civil society and community leaders are also key collaborators, as several examples show (119). The example of displaced populations in the Philippines and sex workers in Viet Nam highlight the important role of peer educators, while village leaders or elders were important partners in the Lao People’s Democratic Republic.

The availability of resources for applying a gender, equity or human rights lens can act as a trigger, especially in resource-constrained environments, and help bring partners together and establish a foundation for action. Start-up funds mobilized specifically – for gender and tobacco work in China, equity in access in Mongolia and Viet Nam, and gender-based violence in the Western Pacific Region – provide an important incentive for paying attention to gender, equity and human rights. Similarly, international partners and donors – for example the Global Fund to Fight AIDS, Tuberculosis and Malaria, DFAT and others – have created an impetus by including attention to gender, equity and/or human rights as a funding requirement. Lastly, it is worth noting that WHO itself has at times played an agenda-setting role for gender, equity and/or human rights.

## **How to sustain attention to gender, equity and human rights**

Evidence suggests that it is “easy to sprinkle the necessary references”, but the real challenge lies in translating those references into practical actions that improve results on the ground (114, p. 9). Implementation gaps between stated intentions and operational reality are a well-known challenge of advancing health through attention to gender, equity and human rights (116, 120). While this report highlights a number of examples of how health programmes can make a difference, it is worth noting that these are only snapshots of success. In reviewing another compilation of examples, Rao & Kelleher (121) warn that “the problem is that these examples are not the norm”. Gender, equity and/or human rights are not always systematically integrated when implementing programmes; thus, successes remain at times ad hoc and are not always sustained. It is critical that attention to gender, equity and human rights remains an ongoing priority that is progressively expanded. In order to do so, the availability of clear and practical frameworks and tools is essential. For example, progress



on gender mainstreaming in Papua New Guinea and Viet Nam was partly facilitated through the use of WHO tools and training manuals on gender. WHO methodology for measuring violence against women was the basis for research in Cambodia and many other countries in the Region, and WHO policy, clinical guidelines and related tools continue to inform efforts in many countries to strengthen the health systems' response to gender-based violence (see Box 3).

**Box 3. Selected WHO tools on gender, equity and human rights**

- Manual on *Gender mainstreaming for health managers: a practical approach* (2011)
- Sourcebook series on *Integrating gender and poverty into health programmes* (2006–2010)
- Policy and clinical guidelines on *Responding to intimate partner violence and sexual violence against women* (2013); handbook on *Health care for women and girls subject to violence* (2014)
- Assessment tool on *Human rights and gender equality in health sector strategies: how to assess policy coherence* (2011)
- INNOV8 tool on *Reorienting health programmes to leave no one behind* (2016)

related tools continue to inform efforts in many countries to strengthen the health systems' response to gender-based violence (see Box 3).

Moser & Moser point out that “success in gender mainstreaming is still highly reliant on the commitment and skills of key individuals” (120, p. 16). Training is a common tool to create awareness and to build needed skills to apply a gender, equity or human rights lens. Many examples in this report integrate an aspect of training, often at the start of the process. While not an end in itself, training can provide “space for people to learn about, debate and come to conclusions” (119). Building

gender awareness and skills through training was an important milestone for progress in Cambodia, Papua New Guinea and other countries. While the literature acknowledges the value of capacity-building as a basis for action, it also warns that it is “difficult to change attitudes and promote ownership ... with one-off ... training” and calls for “creative approaches to mentoring, follow up and promoting ongoing cycles of learning and reflection” (113, p. 146). The development of this report was intended to initiate such a cycle of learning and reflection, having benefited from ongoing dialogue throughout 2016 between writers and technical teams at the regional and country levels.

Many examples describe collaboration between staff in the relevant technical (health) programmes and staff working on gender, equity and/or human rights, including focal points at the country level. The critical role of those focal points relates to a well-known challenge in encouraging attention to gender, equity and human rights – the risk that “Once you’ve mainstreamed ... it is everybody’s business and nobody’s business. Everyone is accountable and no one’s accountable” (122, p.125). Evidence suggests that a way to mitigate this risk is through a combined approach (123). A combined approach assigns, on the one hand, the responsibility for applying a gender, equity and human rights lens to everyone (all teams/programmes) and creates an accountability mechanism to foster collaboration and monitor progress. As the example of water and sanitation in the Philippines and others show, the integration of gender, equity or human rights into technical work on health often goes hand-in-hand with

institutional changes, for example changes to team composition and skills. Indeed, the development of this report itself took place under the auspices of the Technical Working Group on Gender and Social Determinants – an interdivisional mechanism to foster collaboration across programme areas of WHO (see Box 4) – and updates on the report were discussed at various interprogrammatic forums such as the bimonthly Technical Coordinators Meeting and the Consultation of WHO Representatives and Country Liaison Officers.

#### **Box 4. Technical Working Group on Gender and Social Determinants**

In the Western Pacific Region, gender, equity and human rights as well as the social determinants of health are increasingly being recognized as core dimensions of efforts to advance UHC and the SDGs. Nevertheless, a significant unfinished agenda remains. Addressing it requires continued commitment as well as a fresh and practical approach to framing actions on gender and social determinants of health, based on lessons learnt from examples of success. To facilitate a comprehensive and coordinated approach integrating gender, equity, human rights and social determinants, the WHO Regional Office for the Western Pacific established the cross-divisional Technical Working Group on Gender and Social Determinants.

The working group is co-chaired by the Director, Division of NCD and Health through the Life-Course (DNH) and the Director, Division of Health Systems (DHS) and enjoys membership from all technical divisions of the Regional Office. Each member acts as divisional lead for the interprogrammatic work of the group and ensures division-wide input and participation in the workplan, thereby framing attention to gender, equity and human rights as essentially relevant to all technical teams.

On the other hand, a combined approach recognizes the need to establish an engine or catalyst for action – usually a small team that can provide support for the day-to-day process (124, p. 8; 125), similar to the critical technical support that gender, equity and/or human rights focal points have provided in most, if not all, of the examples described in this report. Building the needed expertise within the Organization and creating opportunities for collaboration between programmatic or technical specialists and gender, equity and/or human rights staff are particularly important in resource-constrained environments with limited space to focus on competing priorities. As many reviews highlight, it is when different, complex factors come together that there is progress (114, 124). The ability of staff to identify the right mix of ingredients and opportunities is a precondition for taking action. For example, many examples in this report focus on gender (rather than human rights and equity) because WHO's well-established language and tools on gender and health, supported by decades of advocacy and capacity-building, are now bearing fruit in countries. The same entry points may not (yet) exist for equity and human rights – and might in fact be quite different. Understanding these nuances, identifying and applying the most appropriate tool from the gender, equity and/or human rights toolbox, and adapting it to the needs of the given health programme is critical for moving beyond lip service to operationalizing action on gender, equity and/or human rights and sustaining progress (113).

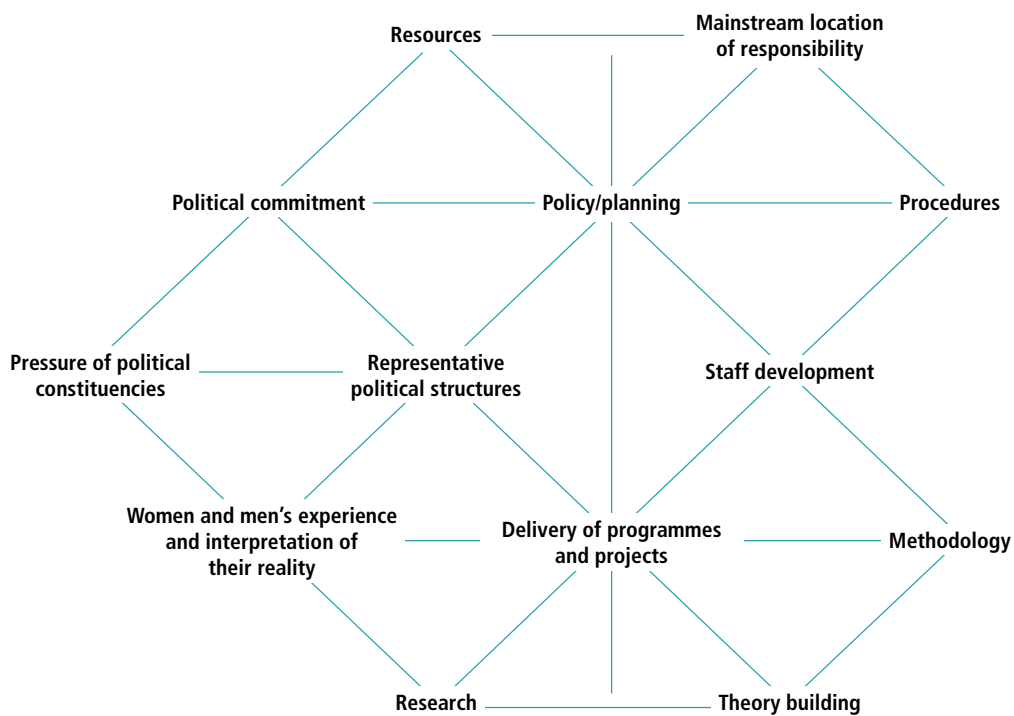
## How to advance health through attention to gender, equity and human rights

The SDGs provide new impetus and a platform for advancing health through attention to gender, equity and human rights in health. UHC provides a vision for health sector development that places people and communities at the centre of policy and action. As the various examples in this report reaffirm, there is no simple or one-size-fits-all approach for programmes to contribute to gender, equity and/or human rights. While broad guidance exists – and many lessons have been learnt by this and other reports and assessments – paying attention to gender, equity and human rights remains an ongoing challenge. It is by definition not a linear process but rather a complex web of multiple, multifaceted pathways, entry points and obstacles (126). The best way forward – and the best chance of success – for health programme action on gender, equity and human rights takes into account the given context, including but not limited to the objectives of the programme, time frame, audience, champions, resources and skills. Health programmes may wish to consider starting work on gender, equity and human rights where they can – and then expand the approach where and when possible.

It is important to set realistic aims, acknowledging that paying attention to gender, equity and human rights is a progressive and iterative undertaking that challenges many structural aspects of culture and power. This long-term framing might be in direct contrast to the sometimes short-term timelines of many activities in health and development. There is a need for a more nuanced understanding of how change happens, as many changes are “difficult to measure, happen in unexpected time frames and the outcomes are unpredictable” (127). Others have spoken of a “need to reinvigorate, repopulate, and reframe our strategies” (117, p. 550).

Levy’s web of institutionalization (128) provides a framework for institutionalizing or sustaining change, recognizing that attention to gender, equity and human rights needs to go beyond ad hoc or superficial actions and towards embedding changes in social norms and organizational culture. The framework identifies 13 key elements that can help to evaluate existing progress and inform next steps (128, 129). The concept of the web aptly highlights that these elements are interlinked and interdependent: they may be led by different people with different interest groups, and they can reinforce each other or create new stumbling blocks (Fig. 6). For example, an entry point might be at the policy level. This requires political commitment, which is influenced by pressure from political structures, such as mobilization of parliamentarians, and political constituencies, including communities themselves. For policies and plans to become a reality, resources and responsibilities for gender, equity and/or human rights need to be assigned. Implementation relies on having in place sound procedures as well as qualified staff to take action and deliver programmes that are equity enhancing, gender responsive and rights based. Delivery of programmes and projects requires a sound methodology and is informed by research as well as women’s and men’s experiences and interpretation of reality, including of affected communities themselves. This, in turn, informs and is informed by continuous processes of policy development, research and evaluation.

**Fig. 6. The web of institutionalization**



Source: Levy, 1996: 5.

This report is therefore not the end of a conversation, but rather a first milestone. Ongoing review and learning from experience, including the examples and issues highlighted by this report, provide a starting point for change. Programmes can start where possible by considering the issues, asking critical questions and identifying linkages between their health programme/topic and gender, equity and/or human rights. The report is intended to initiate a continuous process of reflection and learning, including future reports on progress planned in regular intervals. It is hoped that this will help inform and accelerate efforts to advance health through attention to gender, equity and/or human rights within the WHO Western Pacific Region. The SDGs and UHC challenge all of us to work towards inclusive societies that leave no one behind. Attention to gender, equity and human rights is at the heart of this effort.

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