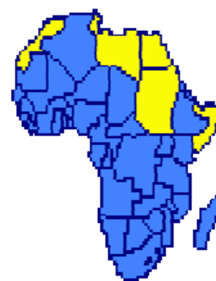
World Health Organization
REGIONAL OFFICE FOR Africa



Monitoring and Evaluation of WHO Gender Strategy Baseline Assessment Report for the African Region, 2008-2009

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ACRONYMS AND ABBREVIATIONS

AFRO; African Regional Office
AIDS: Acquired Immune Deficiency Syndrome
BFM: Budget and Finance Management
BHA: Emergency and Humanitarian Action
CAH: Child and Adolescent Health
CAS: Country Analysis & Support (CAS +I SZS)
CCS : Country Cooperation Strategy
CDS: Communicable Disease Surveillance
CPC: Communicable disease Prevention and Control (+ NTD)
CRD: Communicable Diseases Research
DD: Divisional Director
DPM: Director Programme Management
DRH: Division of Family and Reproductive Health
EDM: Essential Medicines
EPR: Epidemic & Pandemic alert and Response
ETR: Ethics, Equity, Trade and Human Rights
FAN: Food safety (including zoonoses and food-borne diseases) and Nutrition
GA: Gender Analysis
GBS: Governing Bodies
GM: Gender Mainstreaming
GRA: Gender Regional Adviser
GSM: Global Management System
GSS: General Staff Services
GWH: Gender Women and Health
GWHN: Gender, Women and Health Network
HFS: Health Financing and Social Protection
HPR: Health Promotion
HRD: Human Resource Development
HRH: Human Resources for Health
HRM: Human Resources Management
HPS: Health Policy and Service Delivery
HSA: Health Situation Analysis and Trends
HSD: Policy-making for Health in Development
HTL: Health Technologies and Laboratories
ICT: Information and Communication Technologies
IER: Health Information, Evidence and Research Policy
ICTS: Inter-country Support Teams
IPS: International Professional Staff
IVD: Immunization and Vaccine Development
KAP: Knowledge Attitudes and Practices
KMS: Knowledge Management and Sharing
MAL: Malaria
MDG: Millennium Development Goal
M&EBA: Monitoring and Evaluation Baseline Assessment
MNH: Mental Health and Substances Abuse
MPS: Making Pregnancy Safer
NDM: Non-communicable Disease Management
NDS: Non-communicable Disease Surveillance
OCH: Occupational Health
OSERS; Office Specific Expected Results
PB: Programme Budget
PHE: Protection of the Human Environment (ENV+ VBC+ OCH)
PME: Planning, Monitoring and Evaluation
PRM: Partnership and Resource Mobilization (+ TIN Reform)
PSS: Procurement and Supply Services
RAS: Regional Office Administration Services
RD: Regional Director
RDO: Regional Director's Office
RPC: Research Promotion and Coordination
SD: Strategic Direction
SDD: Sex Disaggregated Data
SRH: Sexual and Reproductive Health
TOB: Tobacco Free Initiative
TPL: Translation, Interpretation, Printing & Library Services
TUB: Tuberculosis
VBC: Vector Biology and Control
VID: Violence, Injuries and Disabilities
WCO: WHO Country Office
WGP: WHO Gender Policy
WGS: WHO Gender Strategy
WHO: World Health Organization
WRs: WHO Representatives
WLOs: WHO Liaison Officers

EXECUTIVE SUMMARY

In May 2007, the World Health Assembly adopted Resolution 60.25, noting with appreciation the *Strategy for integrating gender analysis and actions into the work of WHO* (document EB120/6; WHA60.25). In order to monitor progress and ensure that the implementation of the WHO Gender Strategy is on track, the WHO Department of Gender, Women and Health and the network of Gender Regional Advisers developed a monitoring and evaluation (M&E) framework. The first step in the M&E framework was to conduct a baseline assessment with the following two objectives:

To determine the current status of the four strategic directions of WHO Gender Strategy;

To identify gaps and actions to help WHO implement the gender strategy

This Report represents an overall picture of the extent to which the WHO Gender Strategy (WGS) is currently being implemented in the African Region. The findings in the Report are aimed at providing the basis against which progress in the implementation of the WGS will be monitored and evaluated. The report will also provide guidance for senior management in strengthening the implementation of the Strategy over the next five years.

The organizational structure of the WHO African Region (AFRO) comprises of 46 Member-States, 46 WHO Country Representations and 3 inter-country support teams. Several health-related programmes are managed through 6 clusters, as well as the offices of the Director of Programme Management and Regional Director. Although **GENDER** considered as a cross-cutting issue; it is however presented as a specific programme under the Family & Reproductive Health Cluster(FRH), together with Women's Health and is referred to as 'Gender, Women and Health' (GWH).

The results of the Monitoring and Evaluation of Baseline Assessment (M&EBA) in AFRO are related to the 4 Strategic Directions (SD) of the WGS using indicators developed to measure each SD. The strategic directions are as follows:

- SD1-Building WHO capacity for gender analysis and planning;
- SD2-Bringing gender into the mainstream of WHO's programme management;
- SD3-Promoting use of sex-disaggregated data and gender analysis; and
- SD4-Establishing accountability.

SD 1: Building capacity for gender analysis and planning

The greater proportion (71%) of Staff believes in the relevance of gender to their work. They are aware of the institutional policy and strategy that have been adopted and are already engaged in applying gender concepts in their work. However, they require institutional support to be able to optimally integrate gender concepts in their work. The major challenge however reported was **"gender blindness"** approach to the work of over 50% of the Staff. This challenge is based on the assumption that gender inequalities will naturally be addressed in the overall programming. This understanding explains the lack of institutional support for the application of gender concepts in their daily work of the majority of the Staff. The most frequently cited facilitating factor to resolve this wrong understanding according to the report is the **organizational push** to address gender inequities.

SD 2: Bringing Gender into the mainstream of WHO's programme management

Overall, the report indicates that integration of gender in programme planning, implementation, monitoring and evaluation is weak. The major challenges for the **integration of Gender in operational planning** include: **gender blindness, lack of technical capacity and inadequate funding**. The alleviating factors which are reported in the assessment report were the (1) **organizational setup** that increasingly allowed for greater collaboration between clusters and units and across strategic objectives; (2) increasing **gender sensitivity** within the organization and from country partners; and (3) the increasing **availability of data** and growing **technical capacity**. In addition, institutional arrangements permits gender sensitive approaches to be adopted and the development of gender sensitive data collection systems are other facilitating factors cited in the report.

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

The results of the assessment show that most AFRO publications do not recommend and/or use sex disaggregated data. Of the 4 documents studied, only 2 actually used or promoted sex disaggregated data by referring to gender inequities and implicitly referring to differential roles in health promotion. Fewer Country offices have achieved sex parity. A significant number of WCOs are composed of only male Staff. The 2008 AFRO Annual Report indicatesthat in 2007 only 17% (8/46) WCOs showed sex parity. The second challenge relates to the level of gender awareness and of **gender competence** within the Organization.

SD 4: Establishing accountability.

The results of the analysis state that although in 2007 most of the Regional Director's (RD's) speeches had been instrumental for stimulating integration of the sex/gender dimension used at all levels of implementation within the Region. It is recommended that for gender accountability several specific actions must be taken at country levels to involve WRs in the next assessment. In addition, the involvements of the ICST Coordinators in the next AFRO-M&EBA will be critical for the expansionof accountability organisation-wide.

In conclusion, bringing gender into the mainstream of WHO's Programme Management is faced with challenges originating primarily from gender blindness approach to health and health interventions to institutional arrangements that should impede joint planning in all SOs and not only SO4 and SO7. Collaboration with Gender and women's Health Network (GWHN) is also instrumental for overcoming these challenges.

The Report highlights several issues that had been overlooked, notably the interrelation of Knowledge-Attitudes-and-Practices and Gender integration into the work of WHO in terms of knowledge-based receptiveness, attitudinal perception in gender dimension and application of gender into programme implementation, monitoring and evaluation that could be reflected in country work plans. Henceforth, the processes of integration gender into the work of AFRO will require in-depth gender analysis at all levels of programme lifecycle.

The Report came up with the following recommendations:

1. Intensify the development and use of tools, guidelines and indicators in order to greatly facilitate the processes of translating awareness of WGP/WGS into gender sensitive and responsive management.
2. Increase attention for the promotion and use of sex disaggregated data and gender analysis at all stages of programme management lifecycle to ensure that the gender implications of observed public health concerned are addressed.
3. Establish gender analysis as a major managerial and operational tool for better accountability for the attainment of MDGs.
4. Ensure that a programme officer for Gender is represented at each level of sub-regional offices in Harare, Libreville and Ouagadougou.
5. Strengthen collaboration with GWHN and innovative approaches for joint planning across OSERs.
6. Propose and/or establish periodical agenda for M&EBA during bienniums PB2010-2011, PB2012/2013 and PB2014/2015 with allocation of appropriate resources.

INTRODUCTION

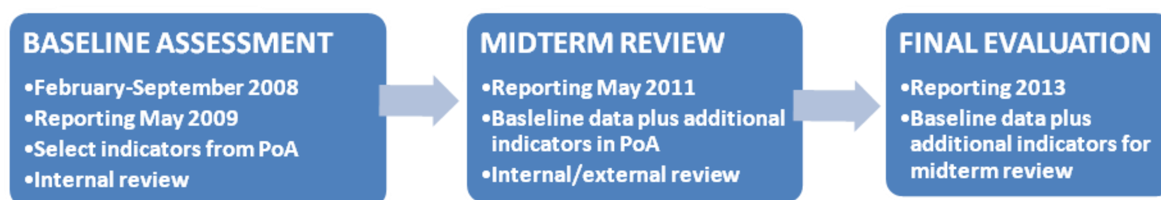
WHO Gender Policy (WGP) was adopted by WHO Secretariat in 2002. At the 60th World Health Assembly in 2007, the WHO Gender Strategy (WGS) 2008-2013 was presented and approved by Member-States with a request for reports every two years on the status of implementation of the Strategy. The aim of WGS is to enhance, expand and institutionalize WHO's capacity to analyze the role of gender and sex in health, and to monitor and address systemic and avoidable gender-based inequalities in health. The entire WHO Secretariat, including headquarters and regional and country offices, is responsible for implementing the WHO gender strategy

Consistent with the UN system-wide Policy on Gender Equality and Strategy on Gender Mainstreaming, WGS will strengthen WHO's role in achieving the health-related goals using 4 Strategic Directions (SD):

(1) Building capacity for gender analysis and planning (SD1);
(2) Bringing gender in the mainstream of WHO's Programme Management (SD2);
(3) Promote the use of sex-disaggregated data and gender analysis (SD3); and
(4) Establishing accountability (SD4).

In 2007 the Gender, Women and Health Network (GWHN) developed a monitoring and evaluation framework to support the implementation of the WHO gender strategy as present in Figure 1.

Figure 1: The WHO gender strategy monitoring and evaluation framework



The first step in monitoring and evaluation (M&E) framework baseline assessments was undertaken at Headquarters and in the 6 Regional Offices. The processes that lead to the definition of the M&E framework and methodology were therefore applied by all the 6 Regions. Although each regional office had produced its regional report, the compilation of the global baseline assessments were undertaken at Headquarters.

Purpose

The overall purpose of the M&E baseline assessment is to assess the extent to which AFRO managers and staff are incorporating gender analysis and actions in the preparation of health policies and guidelines, policymaking and programme implementation.

The M&E baseline assessment will specifically collect data and forms a minimum data set which reflects the current status for implementing the four strategic direction of the WHO Gender Strategy 2008-2013. In AFRO, it is the preliminary step in identifying where strategic actions to strengthen the implantation of the WHO Gender Mainstreaming Strategy are needed.

Objectives

Most specifically, the objectives of the baseline assessment are to assess:

1. Strengthen AFRO capacity for gender analysis and actions (SD1);
2. Improve AFRO management for integrating gender (SD2) by:
   - examining proximity to achieving sex parity in staffing in 2007
   - measuring the extent to which AFRO's operational planning and programme cycle integrate gender; and
   - assessing whether Country Cooperation Strategy documents and country work plans address gender;
3. Determine the extent to which key AFRO publications for Member States (including tools, guidance documents, and evidence-based publications), promote and use sex disaggregated data and gender analysis (SD3);
4. Investigate the accountability of senior management (i.e. Regional and Assistant Directors) in AFRO to supporting gender equality by examining whether their speeches reflect commitment to gender equality (SD4)

ORGANISATIONAL STRUCTURE OF WHO IN THE AFRICAN REGION

As indicated on the *map below*, the **WHO in the African Region** (AFRO) has 46 Member-States. The regional office is located in Brazzaville, Republic of Congo.

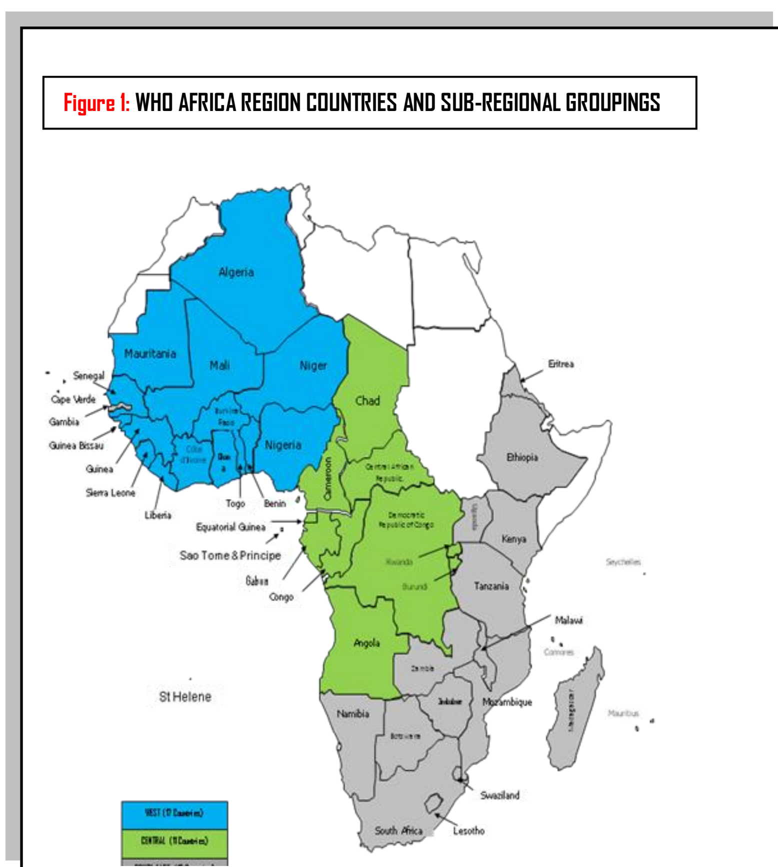


Figure 1: WHO AFRICA REGION COUNTRIES AND SUB-REGIONAL GROUPINGS

At regional level, the head is the Regional Director (RD), followed by the Director of Programme Management (DPM) and 6 divisions. There are 46 WHO Country Representatives (WRs) and Liaisons Officers (WLOs) overseeing the work of the Organisation in countries.

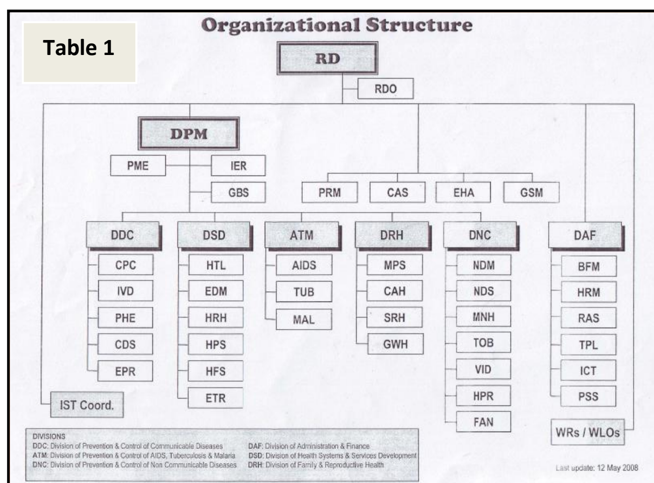
There are 3 sub-regional inter-country support teams (ICST) (*Figure1*). The IST Offices are located in Burkina Faso, Gabon and Zimbabwe. ICST West Africa is located in **Ouagadougou** and covers 17 countries (*Blue*). ICST Central Africa is located in **Libreville and** has 11 countries (*Green*). ICST Eastern and Southern Africa is in **Harare** covering 18 countries (*Grey*).

The organizational structure[1] is illustrated in *Table1*. In addition to the offices of RD and DPM, 6 technical Divisions are headed by Divisional Directors while the ICST are headed by Coordinators.

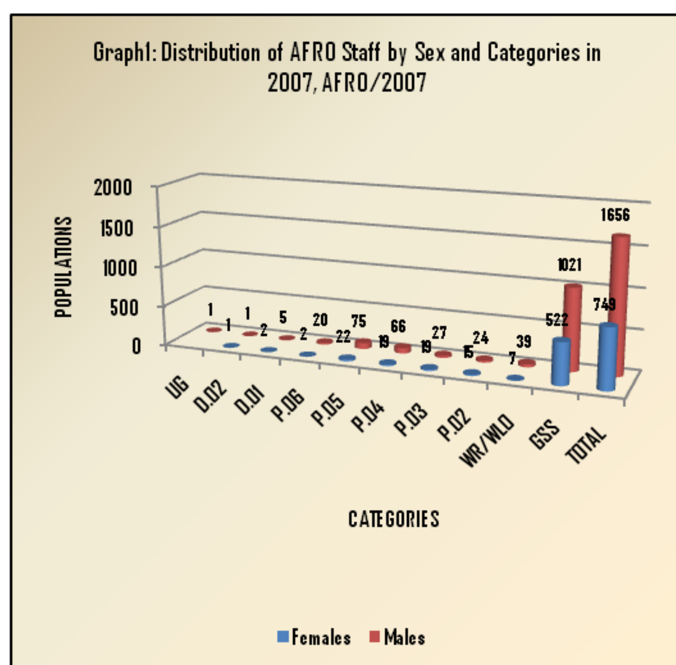
The GENDER issues in the work of WHO African region are addressed under 2 strategic objectives

SO4: *to reduce morbidity and mortality and improve health through key stages of life including pregnancy, childbirth the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.*

SO7*: to address the underlying social and economic determinants of health through policies and programmes that enhances health equity and integrate pro-poor, gender-responsive and human rights based approaches.*



Integrating gender perspectives into health policies and programmes is important for the achievement of all the Millennium Development Goals (MDGs), and not merely MDG 3 on Gender equality and Women's empowerment.



In 2007 Staff Data situation analysis in the WHO African Region is represented in *Graph1***.** From this graph, out of a total of 2405 Staff (749)31% were females and (1656) 69% males. Further analysis shows the following:

- **General Service Staff** (GSS) were (1543) 64% of which (522) 21% females and (1021) 43% males.

- **National Professional Officers** (NPO) were (360) 15%, of these (103) 4% females and (257) 11% males.

- **International Professional Staff** (P*01*-P*06* and D1-D2) were (502) 21% of which (124) 2% females and 378 (16%) males.

[1] Full descriptive Acronyms and Abbreviation are in the related section

METHODOLOGY

ASSESSMENT DESIGN

A variety of quantitative and qualitative methods including an all-Staff survey, interviews with planning focal points from selected departments and content analysis of key AFRO publications[2], workplans and senior management speeches were used. An overall total of 10 indicators relevant to the 4 Strategic directions were identified (*Annex 1*). Each individual SD had specific subsets of indicators described hereafter.

1. ***Building capacity on gender analysis and actions (SD1)***

In SD1, 6 subset indicators were identified and are described in *Annex2*. Knowledge of gender concepts was scored based on the scale which ranged from 0-4. Four knowledge questions were used. Relevance of gender concepts to their work was based on "yes/no/don't know" answers to 2 questions. This SD was analysed using the following subset of indicators:

1.1. Percentage of all WHO staff with awareness of at least one WHO gender policy or strategy
1.2. Percentage of all WHO staff with a good knowledge of gender concepts
1.3. Percentage of all WHO staff who say Yes, gender is relevant to the work of their units
1.4. Percentage of all WHO staff who say Yes, gender is relevant to their own work
1.5. Percentage of all WHO staff who are at least moderately applying gender analysis and actions into their work
1.6. Percentage of WHO staff who report at least some institutional support for integrating gender issues into their work

2. ***Integration of gender in WHO management strategic and operational planning (SD2)***

With regards to SD2, 3 subset indicators were also identified and are described in *Annex3*. Country workplans were randomly selected and analyzed using word search criteria. Interpretation of how strongly the country workplan integrated gender was based on the scores and qualitative interpretation of the content of the workplans. Moreover, the use of Country Cooperation Strategy (CCS) documents was analysed. The subset of indicators used to analyse SD 2 were :

2.1. Percentage of AFRO planning focal points whose responses reflect strong gender integration during the planning and programme cycle process as indicated by their response to quantitative and qualitative questions, by sex, category, and grade level.

2.2. Percentage of all professionals and administrative Staff in 2007 by sex, category, and grade; and,

2.3. Number of biennial (2006/2007) country workplans, that strongly integrated gender out of sampled countries.

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

Content analysis was applied to WHO publications and tools selected from the sampling frame of all WHO publications in English. One document from each of the 4 broad categories, i.e. Regional Health report; policy/World Health Assembly document; evidence type publication; or tools/normative guidelines, were selected for review.
Each document was chosen to reflect a different health topic or disease category in order to ensure diversity in the publications as much as possible. The assessment was based on the use of set criteria "yes" or "no" responses. The sub set of indicators used were:

[2] AFRO publications include Tools and Guidelines documents, evidence-based and policy documents

3.1. Number of new AFRO publications out of those sampled that promote and use sex disaggregated data;
3.2. Number of new AFRO publications out of those sampled that strongly promote and use gender analysis in health.

4. ***Establishing accountability: (SD4)***

This strategic direction was assessed by examining the extent to which senior management are publicly committed to gender equality. The sampling frame consisted of all speeches made by the Regional-Director during 2007. Speeches by the Director-General and Regional Directors in which there is at least one reference to gender, using a word search for 13 words or phrases related to gender were totalled. The Indicator used was the number of speeches by the AFRO Regional Director out of those sampled that included references to gender.

SAMPLING PROCEDURES AND DATA COLLECTION

In order to measure integration of gender into operational planning and programme cycle, face-to-face and phone interviews were conducted with the planning focal points involved in the strategic and operational planning in 2007. The interviewers used structured and open-ended questionnaires. Structured questionnaires and open-ended questions were used consisting of 35 questions.

The responses were entered into a *datacol* (online data entry software), scored on a range of 0-8 for operational planning questions; a scale of 0-12 for programme implementation questions; and a scale of 0-25 for programme monitoring and evaluation. In all the 3 groups of responses, the overall scores were classified as “weak”, “moderate” or “strong” depending on the level of the score. The instruments were then refined based on the field-test experience.

ETHICAL CONSIDERATIONS

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

For the online survey, the link was made available on the AFRO/INTRANET website, which can be accessed by all AFRO Staff from a WHO computer anywhere in the world without having to login. This protected their usernames or any way of identification when they accessed the online survey form and submitted their responses. For the planning officers, interviews were conducted by consultants face-to-face privately in the office of the respondent with no other person present or separately or, over the phone again from a place where the interview could not be overheard by anyone else. Once again no names were recorded in the database. Access to the database for both interviews was only made available to the administrator of the project and the consultants who were conducting the survey.

Consultants were provided with information on WHO Harassment Policy and Actions in case any such reports were made to them during the course of the interviews. However, identities of the persons reporting such incidents were kept confidential.

RESULTS

In *Table2* 1,462 of AFRO Staff voluntarily participated in the survey, comprising of 561 Professionals[3] (166 (29.6%) females and 395/(70.4%) males). In addition, there were 901 General Staff (386/(43%) females and 515/(57%) males). The overall response rate was 397 (212/(23.3%) males and 185/(33.5%) females). Hence the overall response rate was 27%.

Table 2: Online Survey Response Rates, M&EBA/AFRO												
CATEGORIES	SURVEY SAMPLES						RESPONSE RATES					
	Females		Males		Total		Females		Males		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Directors/Professional Staff	166	29.6	395	70.4	561	38.4						
General Staff	386	42.2	515	57.2	901	61.6						
TOTAL	552	37.8	910	62.2	1462	100	185	33.5	212	23.3	397	27.2

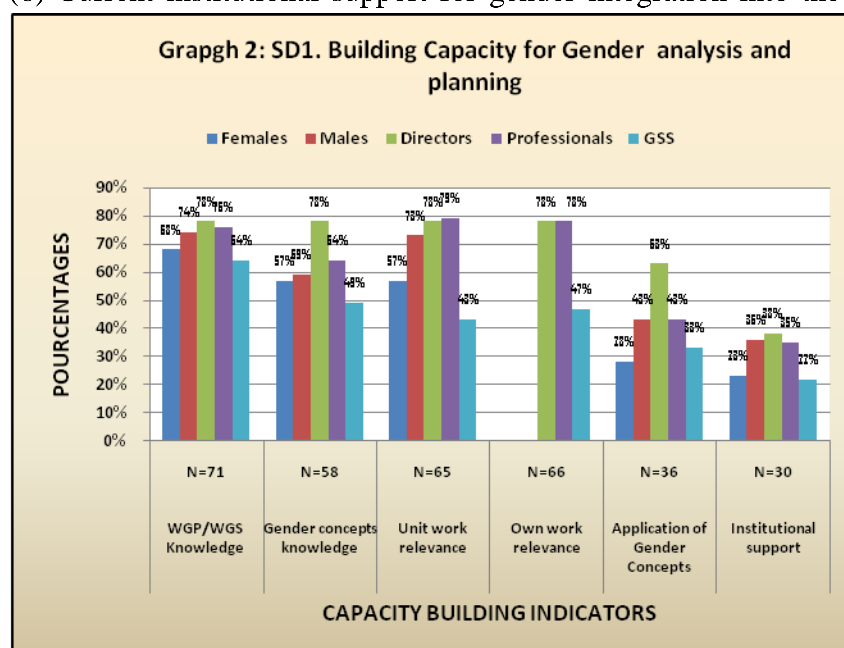
The findings below are for each of the 4 Strategic Directions (SD) as stated in the assessment objectives. Challenges and opportunities for each SD were equally explored as to how they contribute to the way-forward for future Assessment.

SD1: BUILDING CAPACITY FOR GENDER ANALYSIS AND PLANNING

This aspect was assessed based on 6 issues:

***Objective 1**: Assess the capacity for Gender analysis and actions in AFRO and its Country offices*

(1) Awareness of at least one WHO gender strategy or policy;
(2) Level of knowledge on the gender concepts;
(3) Relevance of gender to the work of the unit workplan;
(4) Relevance of gender to the Staff members;
(5) Application of gender concepts in the work of the Staff Members; and,
(6) Current institutional support for gender integration into the



In *Graph2*, 6 sub set of indicators are captured (detailed in *Annex2) and together* they provide a glance at the knowledge-

[3] 'P' includes International and National Professional categories

based awareness in SD1.

The response rate of of awareness of at least one WHO gender policy (WGP) or WHO Gender Strategy (WGS) was the highest for the professional group, including 'D' and 'P' levels Staff.

With regard to be **aware of at least one WGP and/or WGS** there were a total of 71 respondents (*Graph2*). 76% of the respondents among Directors were **aware of at least one WGP/WGS.** With regard to sex differential, male respondents were 74% while 68% of female were aware of WGP/WGS.

58 respondents did respond to **gender concepts** (*Graph2*), 58% of all Staff have "good" knowledge whileer 38% has "some" knowledge. Only about 4% of respondents were assessed as having no knowledge of gender concepts. More professional Staff (P and D levels) report good knowledge concepts than the GSS.

65 respondents on question of **Gender relevance to Unit work** (*Graph2*) more than 2/3 of the responded Staff felt that it was relevant to their work plan. However, the relevancy was felt higher among professional (79%) than among the directors (78%). Within sex disparity, there were 72% males compared to 56% females stated the relevance of gender to their units.

Among the 66 respondents about relevance to **their own work** (*Graph2*)**,** the Directors and Professionals rated equally at 78%. Only 47% of the GSS agreed on the relevant of gender issues to their work. In this aspect upper levels appeared to give more importance to gender than lower levels. More inquiries are needed.

Regarding the actual **application of gender concepts in the work of Staff members** (*Graph2*), only 36 respondents reported moderately applying gender concepts in their work. Hence, 43% males and 28% females indicated strong level of application. However, there were variances between little to some level of application. Directors (63%) and Professional Staff (43%) said applying gender concepts in their work, and responses from a significant 33% of GSS indicated some application. Nonetheless, sex disparities were evident: males were more aware of the gender policies and strategies and more convinced of the relevance of gender to their work than females. Males also reported the availability of institutional support for their work more frequently than females. However, the **sex disparity** in appreciation of relevance and application of gender concepts, and the need for institutional support is most likely a function of the structural gender imbalance between the different Staff categories.

Very few Staff indicated that **institutional support for gender integration** (*Graph2*) was strong (10%). Despite this, 20% indicated that they did have access to some institutional support. Interestingly, at the level of Directors 38% cited to be good.. The numbers in this category are too small for this finding to be statistically significant. However, 65% Professionals and 78% GSS cited no institutional support. With regard to institutional support for integration of gender into the work of WHO Staff, there were differences between the Staff categories and were all statistically significant, pointing out that gender disparity by which females were more likely to lack institutional support.

Challenges and Facilitators factors for Building the Capacity in Gender Analysis and Planning

The next most frequently cited challenge was the **"gender blindness"** approach to the work of WHO Staff. The assumption is that gender inequalities will naturally be addressed in

general programming. This attitude might explain the lack of institutional support for the application of gender concepts in the work of the Staff.

Objective 2: Assess the extent to which AFRO's management has integrated Gender through sex parity in Staffing, strategy and operational planning and programme cycle processes and Country workplans and Country Cooperative Strategy documents. XXXX take this below

The most frequently cited facilitating factor was the organizational push to address gender inequities. This may account for the **higher levels of knowledge and skills** amongst the professional Staff as compared to the GSS. It was interesting to note that the countries themselves pushed for more attention for gender integration into health programmes, perhaps a testimony of the impact of increased advocacy from NGOs at country levels.

SD2: BRINGING GENDER MAINSTREAMING INTO WHO'S PROGRAMME MANAGEMENT

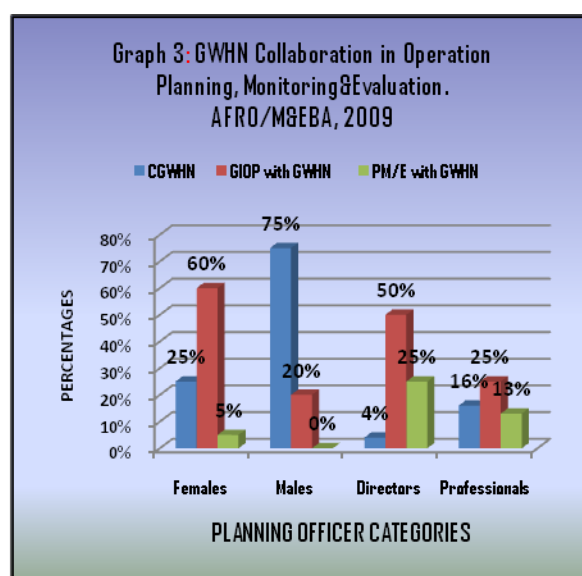
AFRO's strategic and operational planning and programme cycle processes for integrating gender were pursued in **3 different direction** so as to reflect Gender Mainstreaming (GM) (*Annex3*):

(1) The integration of gender into AFRO's operational planning and Programme cycle process for the Medium Term Strategic Plan (2008-2013) and in the implementation of the 2006-2007 biennial work plans as well as in the monitoring and evaluation of work plans covering 2006-2007;
(2) The extent to which AFRO has integrated gender in country work plans; and
(3) The extent to which AFRO has achieved sex parity in Staffing.

The **1st diection** was the case whereby the Planning officers **cited collaboration** with the Gender, Women's Health Network (GWHN) and the other case where they had **had no collaboration**, or were not aware of any, with the GWHN in 2006-2007 biennium. The **2ND direction** was **the analysis of the country work plans** based on 4 randomly selected country work plans using word search and the findings of the Consultant on the work plans. The **3 direction** involved the **human resource** statistics which were obtained from the WHO Human Resource Annual reports 2007 and 2008 periods.

The extent of collaboration with Gender, Women and Health Network (GWHN)

Graph3 presents the levels of collaboration with GWHN in term of programme cycle processes: operation planning, monitoring and evaluation. It must be noted that the small size of Programme Officers (POs) does not allow statistical significance in variances cited.



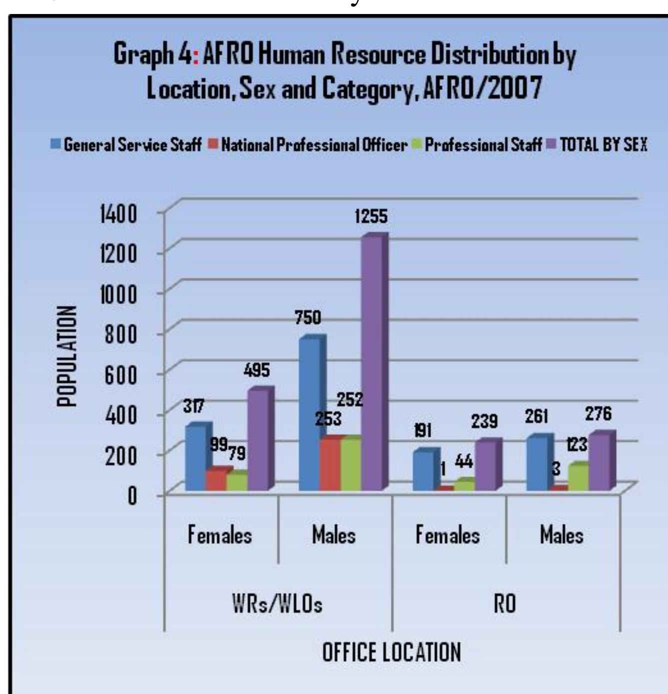
Twenty AFRO/POs were interviewed[4] and comprised of 5 (25%) females and 15 (75%) males on their collaboration with GWHN. Respondents were also asked to identify challenges and facilitating factors they observed in the process of gender mainstreaming in relation to the collaboration with GWHN. In *Graph3*, all 20 POs reported some degrees of collaboration with GWHN

[4] All data were recorded in *datacol, online data entry software*

which appeared to have had a positive impact; one PO rated '*strong*' collaboration. Ten 10 POs rated collaboration '*moderate/weak*' collaboration and 9 had none. About 75% of males said had some collaboration. 'D' and 'P' levels, 4% and 16% respectively responded their collaboration with GWHN.

The extent of Gender integration into operational planning): In *Graph3* operational planning scores were based on responses to the structured questionnaire. It was revealed that an absent or low level of gender integration in the planning process was consistent with the result during planning, 40% of males were more likely to perform poorly compared to 60% of female responses. As was the case for the planning stage l, the assessment of responses by grade showed that D Staff performed better than 'P' Staff: of the 4 respondents in the D-grade, 50% (2) were assessed as weak in their integration; 1 was classified in the 'Moderate' category and 1 in the 'Strong' category. Of the 16 respondents in the P-grade, 56% (9) were classified as 'weak'.

The extent to which Gender was integrated into programme monitoring and evaluation: The findings in the planning and the implementation processes are also reflected in the monitoring and evaluation scores (*Graph3*). Among female POs 5% noted M&E collaboration with GWHN. As for male POs none mentioned any form of collaboration. However, 25% of D-level and 13% P-level mentioned some form of M&E collaboration. Hence, males were more likely to perform poorly than females in terms of collaboration.



Assessing AFRO's proximity in achieving sex parity in 2007

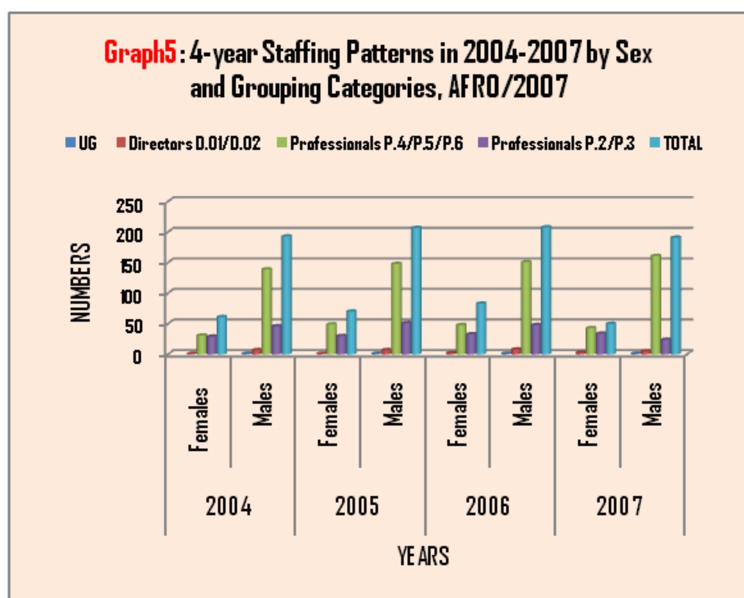
Staffing Pattern and sex distribution

Due to the small sampling size the present Report used AFRO Resource Database (HRD) to evaluate the Staffing patterns in the Region, describing the distribution of sex parity by 2007 (*Graph4*).

The Percentages of P-Staff and GSS Staff disaggregated by sex and grade have been analyzed to assess the level of sex parity in AFRO Region, indicating that in 2007 with only 17% (8/46) Country offices showing sex parity and an increased number 22% (10/46) of single-sex stations with all male Staff members.

In 2006-2007, the size of the country offices varied from as low as 1-female Staff member (in Comoros, Lesotho and Swaziland) to a 19 female Staff members (in Rwanda). There were 30 WCO with less than 10 Staff members who are females. Few offices have achieved sex parity. In fact, a significant number of WCOs are composed of all male Staff. .

Based on AFRO/HRD the percentages of Professional and GSS posts disaggregated by sex and grade had been analysed to assess the level of sex parity in the Region. In *Graph4,* AFRO had significant number of male Staff. Interesting to note, sex parity was common in the group of the country offices with 27% (10) Staff members, more than in the group of offices with

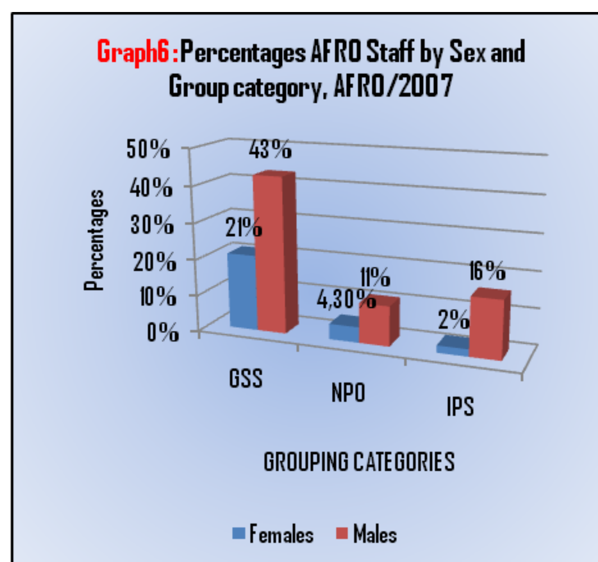


less than 10 members (23%) of the country offices, indicating that the size of the country office may positively influence the level of sex parity in the Staffing pattern.

Graph5 shows the **Staffing pattern** during 2005-2007 in AFRO. It was characterized by the existence of appointments both short-term limited to 11 months, and long-term up to 24 months renewable. In all categories males are the dominant. Professional female Staffs are more at country level. At country and regional levels, GSS are most numerous.

Scrutinising AFRO/HRD 2004-2007 data shows that increases occurred across all Staff categories.

Though not strictly stipulated as a component of M&EBA, the data allow for an analysis of the sex breakdown of appointments made during the 4 year period. Long-term service appointment (usually a 24-month contract) females comprise a little over a third of long-term appointment (34% in 2006 and 38% in 2007).



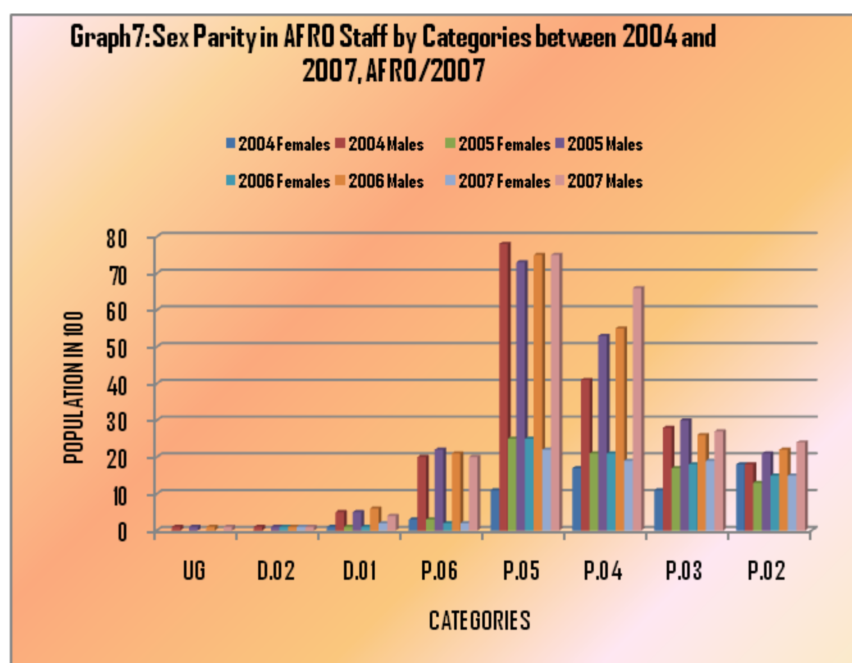
Although 4-year period might be relatively a short time in establishing trend; the indication is that among professionals, female appointments had remained lower compared to males. It is also observed, a decrease among professional Staff in 2007. However, such decrease was more notable among the males.

With regard to **sex distribution** and by categories (*Graph6*) most Staffs are at country levels with some variations in terms of quantity. GSS remain the highest both at country and regional levels.

The available data showed that by and large males remained dominant. Hence female NPOs, International Professional Staff (IPS) and GSS are relatively in smaller numbers within the respective categories.

There had been increased of females in D-grade. It also give some indication for future direction in sex distribution of professional Staff; there the overall Staffing pattern and sex parity.

Sex parity



Data supplied from AFRO-HRS were also used to establish sex parity analysis for Staff, taking into account temporary Staff for the period 2004-2007. In *Graph7,* females constitute about ¼ of all Professional Staff and this proportion is not markedly different in 2006 and 2007, 29% and 24% respectively.

Female recruitment at “D” is on the increase. However, “P” and GSS Staff are evenly distributed. It is also interesting to note that the proportion of females amongst the D-Staff increased by 8% in 2007 compared too much smaller increases of between 1% and 2% in the other grades in 2004.

The same correlation between office size and sex parity did not hold; instead offices with 5-to-9 Staff experienced the highest frequency of sex parity. The 2007 AFRO Annual Report indicated that in 2006, 10 (22%)) of the 46 country offices had achieved sex parity.

Integration of Gender in Country Cooperative Strategy (CCS) work plans

There were no new CCS documents produced after the adoption of the WGS in 2007 in the AFRO Region. In this regard, AFRO-M&EBA confined itself to a review of 4 randomly selected country work plans for 2007-2008: Eritrea, Ghana, Tanzania and Mozambique. Word-search of the 4 documents revealed that none of the documents mentioned any of the key words selected for the conduct of the baseline assessment. None of the documents stated directly “*gender*” or “*gender inequality*” in its introductory statement. Although reference was made to working with community groups especially in the area of health promotion with women’s groups, few actually referred to the “*women’s empowerment*” concept.

Challenges and facilitating factors for integrating Gender into AFRO operational planning and programme cycle process;

The integration of gender issues into programme planning, implementation, monitoring and evaluation is relatively weak regardless of the levels of knowledge and planning skills. The most frequently cited challenge for gender mainstreaming (GM) is related to human resource constraints including the lack of an adequate number of female Staff. The challenges are in 3 categories: **gender blindness, lack of technical capacity and inadequate funding**.

The facilitating opportunities most frequently cited were the (1) **organizational setup** that was increasingly allowing for greater collaboration between divisions and units and across Strategic objectives (SO); (2) increased **gender sensitiveness** within the organization and from country partners; and (3) increased **availability of data** and growing up **technical capacity**, and (4) the need **for dedicated fulltime Staff.**

SD 3: PROMOTING USE OF SEX-DISAGGREGATED DATA AND GENDER ANALYSIS

***Objective 3**: Map the extent to which key AFRO Publications for Member-States (including tools, guidance documents and evidence-based publications) promote and use sex disaggregated data and gender analysis.*

Two subset of indicators were used for the evaluation this SD and included:

(1) The number of WHO new publications among those sampled that promote and/or **use sex-disaggregated data**; and,

(2) The number of new WHO publications among those sampled that strongly promote or use **Gender analysis** in health

There were 69 AFRO publications listed on the AFRO website for 2007. Of these 16 publications one was an institution wide publication, one was a policy/World Health Assembly document; 6 were classified as evidence type of publications and 8 classified as Tool/Normative Guidelines. A random selection from the categories with at least 1 of the 2 indicators was investigated In addition to the two single document categories the sample size of 4 documents were considered

Promotion and/or use of Sex-disaggregated Data

The scores obtained from the answers to the two key questions: (i) "does the document recommend the use of sex disaggregated data?" and (ii) "does the document use/present sex disaggregated data?" were used to assess the four documents.

The result indicates that AFRO publications do not use much sex-disaggregated data. Of the 4 documents studied, only 2 actually strongly promotes sex disaggregated data by referring to gender inequities and hence supporting the promotion or use of gender analysis in health. Based on this finding the promotion of sex-disaggregated data is to be intensified in the Region.

Promotion and/or use of Gender Analysis in Health

The Tanzania document did state that *"for most types of injuries, death rates are higher for males whereas females are at higher risk for burns, nonfatal sexual violence or injury from an intimate partner"*. That document also noted the differential or specific needs/outcomes of women more frequently than the others.

Challenges and facilitators in the use of sex-disaggregated data and Gender analysis;

The most frequently cited challenge mentioned under sex-disaggregated data and gender analysis is **the nature of the existing data collection systems** which failed to capture gender inequalities. The lack of gender disaggregated data, insufficient budget allocation for gender analysis combined with the vertical health programme within the organization also contributes to a failure to integrate gender in each Staff member's work. The 2nd most frequently cited challenge relates to the low gender awareness and **gender competence** within the Organization.

Few offices have achieved sex parity and a significant number are composed of all male Staff. Contrary to expectations, the size of the country office does not appear to influence the sex disparity. **Institution arrangements** that allowed for gender sensitive approaches to be adopted and the development of gender sensitive data collection systems were the other two facilitating factors cited.

SD 4: ESTABLISHING ACCOUNTABILITY.

Objective 4: Map the accountability of senior management (i.e. Regional and Assistant Directors) in AFRO to supporting gender equality by examining whether their speeches reflect commitment to gender equality.

Senior level accountability at WHO Regional Office for Africa

A total of 10 speeches made by the AFRO Regional Director (RD) during year 2007 were selected. A sample of 8 was analyzed for the baseline assessment using the word search criteria already established for SD2 “Gender” and “Gender inequality”.

Hence, the number of times the words/phrases were mentioned in the document was taken into account. Comments on the use of gender issues in the speeches are summarised in *Table3.*

Table 3: LIST OF SPEECHES OF THE REGIONAL DIRECTOR IN 2007

SPEECH TOPICS	COMMENTS
1. Message of RD for Africa, World AIDS Day 2007	➢ Mentions only MDG 4,5 and 6 and the need for MDG3 to halt the epidemic
2. Opening remarks by RD to 24th Session of African Advisory Committee on Health Research and Development, Brazzaville, 26 September,2007	➢ Sex disaggregated data would be an integral part of gender sensitive health research was mentioned
3. Statement by RD at Opening ceremony of the 57th Session of the WHO Regional Committee for Africa, Brazzaville 27 August, 2007	➢ “Priority to women’s health” in the light of high maternal mortality was mentioned.
4. Message of RD for Africa on the occasion of World Blood Donor day, 14 June 2007	➢ Theme is “Safe blood for Safe Motherhood”. Male contribution/responsibility was mentioned.
5. Statement of the RD for Africa on the Occasion of World No Tobacco Day, 31 May 2007	➢ Sex disaggregated data could help the design and execution of focused behaviour change communication campaigns was indicated in the speech
6. Statement by RD at 3rd meeting of health ministers of the African Union, 11 April 2007	➢ The statement “to improve the health of Africans and the health of women in particular” was included in the speech.
7. Message of RD on the Occasion of World TB Day	➢ A call for data on TB to be disaggregated by sex was made in the speech.
8. Speech delivered by RD for Africa at health Partners Forum, 7-8 March, Nairobi, Kenya, 10 March 2007	➢ Given existing gender dynamics favouring gender inequities and the underlying role of MDG 3 in health patterns in the region, an appeal for gender-based health research was made
9. Message of RD to all AFRO Staff on the negative impact sexual and gender-based violence with emphasis on health and socioeconomic development on ZERO-TOLERANCE/FGM on 6 February 2007	➢ Given existing gender dynamics favouring gender inequities and the underlying role of MDG1, MDG2, MDG3, MDG5 and MDG6 in health appeals were made for special attention to conditions in which both women and men are responsible partners
10. Message of RD to all AFRO Staff straightening the roles women and men play in health and socioeconomic development on Women’s International Day 8 March 2007.	

Senior level accountability at WHO Country Offices;

At least 15 (25%) of the 46 Member-States had institutionalised gender mainstreaming (GM) within their national policies, programmes and actions such as National Gender Policies,

professional training in GM, law and legislature revisions and advocacy at all levels. However, GA is needed to assist in gender integration into national work plans.

Challenges and facilitators in establishing accountability;

From the above analyses, it was concluded that although in 2007 most RD's speeches may not have made specific reference to "gender mainstreaming" in the Region, they are nonetheless instrumental for stimulating integration of the sex/gender dimensions which can be used at all levels of implementation within the Region. The facilitating factors include high level of gender awareness but the challenge is lack of capacity building in gender analysis.

LIMITATIONS

One limitation of the findings of the online survey is the low response rate. This means that the findings are limited by a self-selection bias i.e. those who participated in the survey may have been more interested in gender and, hence, more likely to have good knowledge and report relevance of gender and application of gender analysis skills to their work. The actual levels of knowledge on gender may potentially be lower than those reported in the baseline.

Moreover, online survey can be limited by the quality of the communication techniques, e.g. language difficulties, English vs. French as most documents were in English. Computer word-searching for "GENDER" in analysing speeches and/or documentations may be misleading. Initially the assessment was conducted specifically at regional office countries inputs were minimal.

These methodological limitations constrained the ability to fully measure integration of gender in AFRO in several ways. However, these limitations can potentially be addressed with methodological adjustments in the assessment instruments to be used for mid-term review and final evaluation.

DISCUSSIONS AND CONCLUSION

This1st AFRO-M&EBA Report highlights several issues with regard to integrating gender analysis and actions into the work of WHO in the African Region. These issues had been overlooked, notably the interrelation of Knowledge-Attitudes-and-Practices in gender issues..

With respect to '**knowledge**' building capacity for Gender mainstreaming (GM) in AFRO is a start from knowledge-based receptiveness. The great proportion of Staff believes in the relevance of gender to their work and is aware of some institutional policies and strategies that have been adopted. These staff are already engaged in applying gender concepts. However, this application requires institutional support to enable optimum integration of gender concepts in their work. Hence, capacity building in gender competency for all Staff categories and levels is needed to acquire the necessary knowledge for GM.

'**Attitudes**' related to GM is viewed from the sex disparity angle and the application of gender concepts with respect to gender imbalance between the different Staff categories. The goal of sex parity in country office Staffing has not yet been met. However, increasingly trends in female recruitment and contract conversion at professional levels suggest a positive direction to accelerate its attainment. In this regard, further investigations on institutional support are needed with a larger sampling size.

In terms of '**Practices**' weak integration at the planning stage has had a spill over effect on programme implementation, monitoring and evaluation and this is reflected in country work plans that fail to specify products, activities and services that involve collection of sex disaggregated data, therefore, failed to capture gender inequalities. The promotion and/or use of sex disaggregated data in the work of AFRO are fundamental in gender analysis.

Consequently, bringing gender into the mainstream of WHO's Programme Management is faced with challenges which stem from a gender blindness approach to health and health interventions to institutional arrangement that have impeded joint planning most Strategic Objectives and not only under SO4 and SO7. Accountability for GM should be made by all senior management and at all levels of the Organisation. Collaboration with GWHN is also instrumental in overcoming these challenges.

AFRO-M&EBA response rates of 27% supports the limitations described in the result section. However, these can be mitigated with adjustments in the next AFRO-M&EBA which will be conducted as mid-term review in 2011 and/or final evaluations in 2013 taking into account the following concerns:

- A key area of measurement related to integration of gender in WHO management in terms of operational planning could not be measured at the time of the AFRO-M&EBA. Yet, this measure captures the extent to which gender is integrated as an outcome of operational planning process in WHO/OSERs and products which form the concrete operational outcomes on the basis of which WHO conducts its work at all levels of the Organisation.
- Clear indicators must be established for all level management accountability. The selected indicators could be measured by next few layers of senior management such as Divisional Directors (DDs), Unit Programme Managers and/or Programme Coordinators.
- Opportunities should be given to all DDs and Programme Managers to reflect gender in speeches which can be support to translate verbal commitment into action of greater devotion of resources and actual institutional inputs/outputs. Alternate areas of measurement can include whether gender issues were reflected in the terms of reference and/or the PMDS.

- WHO/OSERs and Products must address Gender issues across all AFRO-based Programmes. Therefore, it is expected that for the next mid-term and final AFRO-M&E assessments correct information and integration measures on GM be reflected into the operational planning processes.
- GSS participation in GM should be tailored to adequately measure G-Staff knowledge and attitudes in gender integration at all levels of the Organisation.
- Because healthcare systems require knowledge-based skills and technicality, sex parity appointment will be subjected to the level of competency of the incumbent to be gender-neutral. Hence, sex parity data should be equally available especially for SD3.
- Measure related to the allocation of budgets to gender work should be considered as an added-value and investment into improving healthcare system locally, national and globally. Financial, administrative and human resource needs should be allotted wisely taking into account time-bound and logistical constraints.
- Lack of statistically significant due to the small sampling size of the present AFRO-M&E baseline assessment Report call for another survey with better strategized approaches using the existing AFRO-based organisational structure as described in page 8 of the present version of the document.

RECOMMENDATIONS

The Report made the following recommendations.

1. Intensify the development and use of tools, guidelines and indicators in order to greatly facilitate the processes of translating awareness of WHO Gender policy and WHO Gender Strategy into gender sensitive and responsive management.
2. Advocate for the promotion and use of sex disaggregated data as well as gender analysis at all stages of programme management lifecycle in order to identify and address the gender implications of observed health needs through appropriate gender responsive interventions.
3. Establish Gender analysis as a major managerial and operational tool in reaching all MDGs and not only MDG3, to ensure better accountability within AFRO.
4. Ensure that a programme officer for gender is represented each level of sub-regional offices in Harare, Libreville and Ouagadougou.
5. Strengthen the collaboration between Gender, Women and health Networks and innovative approaches for joint planning across OSERs.
6. Propose and/or establish a periodical agenda for M&E baseline assessment during the periods 2010-2013.

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Annex1: BASELINE ASSESSMENT INDICATORS BY STRATEGIC DIRECTION*	
SD1	**Building capacity for gender analysis and planning**
1.1.	Percentage of all AFRO Staff (*by sex, grade*) who have a basic understanding of gender and health
1.2.	Percentage of all AFRO Staff who are applying gender analysis and actions in their workplan (*by sex, category, grade*)
1.3.	Percentage of all AFRO Staff who report institutional support for gender integration into their work (*disaggregated by sex, category, grade*)
SD2	**Bringing gender into the mainstream of WHO's programme management**
2.1.	Percentage of AFRO planning focal points whose responses reflect strong gender integration during the planning and programme cycle process as indicated by their response to quantitative and qualitative questions
2.2	Number of (2006/2007) biennial country work plans out of those sampled that strongly integrate gender
2.3i	Percentage of all professional and long term administrative Staff, by sex, category, and grade level(cumulative) till Dec 31, 2007
2.3ii	Percentage of all long-term new appointments in 2007 by sex, category, and grade (Professional, National Professional Officers, and General Service).
SD3	**Promote the use of sex-disaggregated data and gender analysis**
3.1.	Number of new AFRO publications out of those sampled that promote and use sex disaggregated data(SDD)
3.2.	Number of new AFRO publications out of those sampled that strongly promote and use gender analysis in health
SD4	**Accountability**
4.1.	Number of speeches by the AFRO Regional Director of those sampled which include reference to gender

Annex2: SD1: BUILDING THE CAPACITY FOR GENDER ANALYSIS AND PLANNING	
INDICATORS	**N**
T4.1 Percentage of AFRO Staff who report awareness of at least one WHO Gender policy or strategy	**71**
By sex: Male Female	74% 68%
By WHO grade/category: Director Professional GSS	78% 76% 64%
T4.2 Percentage of AFRO Staff who report good knowledge of gender concepts= 58	**58**
By sex: Male Female	59% 57%
By WHO grade/category: Director Professional GSS	78% 64% 49%
T4.3 Percentage of AFRO Staff who report that gender is relevant to the work of the unit	**65**
By sex: Male Female	73% 57%
By WHO grade/category: Director Professional GSS	78% 79% 43%
T4.4 Percentage of AFRO Staff who report that gender is relevant to their own work=66	**66**
By sex: Male Female	
By WHO grade/category: Director Professional GSS	78% 78% 47%
T4.5 Percentage of AFRO Staff who are at least moderately applying gender concepts to their work	**36**
By sex: Male Female	43% 28%
By WHO grade/category: Director Professional GSS	63% 43% 33%
T4.6 Percentage of Staff that report at least some institutional support for gender integration in their work	**30**
By sex: Male Female	36% 23%
By WHO grade/category: Director Professional GSS	38% 35% 22%

Annex 3: SD2-Bringing Gender into the Mainstream of WHO's programme management	
INDICATORS	**N**
T5.1 Number of AFRO Planning Officers interviewed by sex, Staff category levels and by collaboration = 20	**20**
By sex: Male Female	75% 25%
By WHO grade/category: Director Professional GWHN	4% 16% 8%
T5.2 Percentage of AFRO Planning Officers reporting a "strong level of gender integration" in the Operational planning process N=30	**30**
By sex: Male Female	3% 3%
By WHO grade/category: Director Professional GWHN	2% 4% 5%
T5.3 Strong level of Gender Integration in Programme Monitoring and Evaluation Process N=20	**20**
By sex: Male Female	1% 3%
By WHO grade/category: Director Professional GWHN	25% 0% 13%

Annex4:

GENDER LEXICON

CONCEPTS	GENDER-RELATED CHARACTERISTICS
GENDER	➢ Describes those characteristics of women and men, which are socially constructed, while sex refers to those which are biologically determined. ➢ People are born female and male but learn to be girls or boys who grow into women and men. This learned behaviour makes up Gender identity and determine Gender roles.
GENDER ANALYSIS	➢ Identify, analyse and inform action to address inequalities that arise from the different roles of women and men, or the unequal power relationships between them and the consequences of these inequalities on their lives, their health and well-being. ➢ The way power is distributed in most societies means that women have less access to and control over resources to protect their health and are less likely to be involved in decision-making. ➢ **GA** in health often highlights how inequalities disadvantage women's health, constrains women face to attain health and ways to address and overcome these. **GA** also reveals health risks and problems which men face as a result of the social construction of their roles.
GENDER MAINSTREAMING	➢ A strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between women and men is not perpetuated. The ultimate goal is to achieve gender equality. ➢ **GM** is both a technical and political process which requires shifts in organisational cultures and ways of thinking as well as in the goals, structures and resource allocations. **GM** requires changes at different levels within institutions, and. in agenda setting, policy-making, planning, implementation and evaluation. Instruments for **GM** effort may include new Staffing and budgetary practices, training programmes, policy procedures and guidelines.
GENDER EQUITY	➢ Fairness and justice in distribution of benefits and responsibilities between women and men ➢ Recognising that women and men have different needs and power ➢ Identify and address these differences in manner that rectifies the imbalance between the sexes
GENDER EQUALITY	➢ Absence of discrimination on the basis of a person's sex ➢ Equal opportunities in the allocation of resources and benefits ➢ Increase access to services for women and men
GENDER INEQUALITY	➢ Privilege men over women ➢ Inequalities are clear and undisguised ➢ Deny women's and girls' rights ➢ Give men rights and opportunities that women do not have
GENDER BLINDNESS	➢ Ignore gender norms ➢ Not intentionally discriminatory ➢ Reinforce gender discrimination ➢ Ignore opportunities and/or discrimination
GENDER NEUTRAL	➢ Ignore discrimination ➢ Absence of concern with regard to inequity ➢ Indifference by design to inequality between women and men ➢ Not involve in identify discrimination and/or promoting equality
GENDER SPECIFIC	➢ Recognise differences in gender roles, responsibilities and access to resources ➢ Take into account these differences in designing intervention ➢ Policies and programmes do not change these gender differences ➢ Policies and programmes do not try to change these gender differences
GENDER INTEGRATION	➢ Take into account women's and men's concerns and experiences an integral dimension in the design, implementation, monitoring, and evaluation of policies and programmes in all political and social spheres such as inequality between women and men is not perpetuated
GENDER TRANSFORMATION	➢ Recognise differences in gender roles, responsibilities and access to resources ➢ Promote active gender equity through changes of these differences ➢ The most preferable outcome