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WHAT WORKS

IN GENDER AND HEALTH IN THE UNITED NATIONS

Lessons Learned from Cases of Successful Gender Mainstreaming across Five UN Agencies

Gender & Health Hub

Knowledge. Policy. Action.

Suggested citation: Johanna Riha, TK Sundari Ravindran, George A Atiim, Michelle Remme, and Renu Khanna (2021). What Works in Gender and Health in the United Nations: Lessons Learned from Cases of Successful Gender Mainstreaming across Five UN Agencies. United Nations University International Institute for Global Health. Kuala Lumpur.

DOI: 10.37941/RR/2021/4
Copy-editor: David Cann
Design: The Equality Institute

United Nations University International Institute for Global Health (UNU-IIGH), Kuala Lumpur, Malaysia, is the designated UN think tank on global health. It builds global health knowledge and decision-making capacity and advances evidence-based policy on key health issues of sustainable development, peace, and global security.

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Acknowledgements

This report would not have been possible without the cooperation of partner agencies. We are indebted to many colleagues at the **UNAIDS Secretariat**, **UNDP**, **UNFPA**, **UNICEF**, **WHO**, as well as other key informants, who generously gave their time to share their knowledge, expertise, and decades of experience coordinating gender and health initiatives in the UN system. To maintain confidentiality, we do not list them here by name but wish to acknowledge their substantial contributions in the co-production of this work. We also want to express immense thanks to the following agency-specific focal points for coordinating and facilitating the co-production of this work: **Maria Jose Alcala Donegani** (UNAIDS), **Kenechukwu Esom** (UNDP), **Ingrid Fitzgerald** and **Nafissatou Diop** (UNFPA), **Sagri Singh** and **Lauren Rumble** (UNICEF), **Joanna Jessie Vogel**, **Evelyn Boy-Mena**, and **Min-Whee Kang** (WHO). We also thank **Nazneen Damji** (UN Women) for her consistent support over the course of this project.

We express our deep appreciation to senior consultants, **Joanne Sandler**, **Zineb Touimi-Benjelloun**, **Aruna Shree Rao**, **Nandini Oomman** and **Kathryn Conn**, for their significant contributions at various stages of the project. In addition, we thank **Avni Amin**, **Asha George**, **James Lang**, and **Franz Wong**, for their strategic input and guidance on the study design and/or analyses.

We also thank **UNU-IIGH** colleagues who provided administrative and logistical support for this work: **Galila Esam Al-Samawi**, **Shiau Yun Chong**, **Amanda Dorsey**, **Fatima Ghani Gonzalo**, **Cecilia Hyeinn**, **Rebecca Lee**, **Vidisha Mishra**, **Aisling Murray**, **Zaida Orth**, **Vithiya Sathivelu**, and **Lavanya Vijayasingham**. Finally, we are grateful to our Director, **Pascale Allotey**, for her exemplary leadership and commitment to generating policy-relevant evidence that supports UN sister agencies in their approach to addressing gender inequalities in health.

List of abbreviations

AGYW	Adolescent Girls and Young Women
AoR	Area of Responsibility
CEDAW	Committee on the Elimination of Discrimination against Women
C-M-O	Context, Mechanism, Outcome
CSDH	Commission on Social Determinants of Health
CSOs	Civil Society Organisations
FGM	Female Genital Mutilation
GA	General Assembly
GAP	Gender Action Plan
GBV	Gender-Based Violence
GER	Gender, Equity and Rights Unit
GPR	Gender Programmatic Review
GPW13	13th General Work Plan
GWH	Gender, Women and Health
HRP	Special Programme of Research, Development and Research Training in Human Reproduction
IANWGE	Inter-Agency Network on Women and Gender Equality
IEP	Independent Expert Panel
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
LMICs	Low- and Middle-Income Countries
MENA	Middle East and North Africa
MHH	Menstrual Health and Hygiene
NGOs	Non-Governmental Organisations
PAHO	Pan American Health Organization
PCB	Programme Coordinating Board
PoA	Programme of Action
SDGs	Sustainable Development Goals
SRH	Department of Sexual and Reproductive Health and Research
TDR	Special Programme for Research and Training in Tropical Diseases
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN-SWAP	UN System-Wide Action Plan
UNU-IIGH	United Nations University International Institute for Global Health
VAW	Violence Against Women
WASH	Water, Sanitation and Hygiene
WGEKN	Constitution of the Women and Gender Equity Knowledge Network
WHA	World Health Assembly
WHO	World Health Organization
WHO/AFRO	World Health Organization. Regional Office for Africa
WHO/EURO	World Health Organization. Regional Office for Europe
WHO/PAHO	Regional Office for the Americas of the World Health Organization
WHO/WPRO	World Health Organization. Regional Office for the Western-Pacific
WLHIV	Women Living with HIV

Executive summary

Recommendations for multilateral and bilateral organisations to meet the challenges and opportunities of advancing gender equality in health

- **Invest** in high-quality, strategically positioned gender experts with decision-making power at headquarters, as well as regional and country offices. These positions should be core funded to ensure their sustainability.
- **Combine** well-crafted organisational mandates with robust accountability mechanisms that publicly track and report outcomes, and support gender equity goals both institutionally and programmatically, and move funding and spending beyond marker allocations.
- **Identify** and seize expected and unexpected changes in contextual factors, such as exceptionally committed senior leadership, savvy gender experts and leaders, strong donor interest, disruption due to crises, positive shifts in strategic advantage, and organisational restructuring, which present opportunities to create more gender-responsive programmes, put gender and health issues on the global agenda, and strengthen institutional practices that prioritise gender equality in health and other programming.

The COVID-19 pandemic, alongside a looming economic crisis, political fragility, and climate change, are eroding progress on hard-won but fragile gains in improving health and addressing gender inequalities. The silver lining of the pandemic is the opportunity it presents to do things differently, with a heightened urgency to learn from past experiences and build on successes. Promisingly, political commitments to prioritise gender equality are emerging. However, the global nature of many of the challenges means that a response that is supported via an effective multilateral system is needed, with the United Nations (UN) and its agencies strategically well-placed to provide direction and lead the agenda of gender equality in health.

In this vein, the United Nations University International Institute for Global Health (UNU-IIGH) worked with five UN agencies that operate under a health mandate[1] to document and analyse what has worked institutionally and programmatically to promote gender equality in health over the last 25 years. Through a collaborative practice-based learning approach, the project studied 14 cases deemed successful, and identified the contextual elements that enabled their success, triggered change, and sustained positive shifts over time.

Three overarching types of positive outcomes were observed, reflecting the different levels that UN agencies work on and showcasing the capabilities and strengths of the UN system in promoting gender equality in health, namely:

1. operational functions – agencies empowered women, girls and other marginalised groups to resist oppressive gender norms affecting their health;
2. global agenda-setting work, including convening, thought-leadership, evidence generation, advocacy and technical support – agencies directly shaped global agendas to prioritise and invest in specific gender and health issues; and
3. institutional processes and structures – agencies successfully embedded gender equality into their own institutional processes and structures, with improvements in gender equality at the organisational level and in health programmes.

Key contextual enablers, either external or internal to the agencies, facilitated successful outcomes.

External contextual enablers included:

- **strong feminist** civil society actors;
- **UN conventions**, declarations and resolutions on gender equality;
- **Member State pressure or support** for particular issues related to gender equality and health; and
- **interagency collaboration** that leveraged complementary agency strengths.

Internal contextual enablers specific to each agency consisted of:

- **high-calibre**, competent gender experts;
- **supportive governance** structures that provided autonomy; and
- **strong performance** accountability frameworks (in specific cases).

Across all cases, a change in the internal or external context opened windows of opportunity, which were identified and seized by either senior leadership or high-calibre gender experts with technical expertise and political astuteness within the organisation. These individuals leveraged opportunities and set off a series of actions that contributed to successful outcomes.

Progress was sustained when:

- **gender equality work** was institutionalised in strategies, action plans and other frameworks;
- **internal and external accountability mechanisms** were created and strengthened through reporting to executive bodies;
- **dedicated and sustained funding** was mobilised;
- **internal and external capacity** to advance gender equality work in health was strengthened;
- **high-quality guidance materials** to provide technical support were developed;
- **internal and external partnerships** were built; and
- **structures** linked work on gender equality to planning and budgeting functions.

It is important to note that the process of change, which culminated in the successful outcomes reported, was not linear. Many challenges were encountered, and sustained efforts were required to advance the gender equality in health agenda.

[1] World Health Organization (WHO), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and the Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Five key elements critical to leveraging opportunities and creating substantial and sustainable gains in gender equality within health programmes and institutional structures were identified from the analyses:

1. **The power of leaders and gender experts**. Supportive leadership at the highest levels and gender experts at all levels (headquarters, region and country) were key to the positive outcomes seen across cases. Senior leadership and in-house gender experts were pivotal in terms of catalysing, accelerating and sustaining positive changes that led to the successful outcomes observed. In particular, successes were sustained when leadership support was coupled with investment in gender architecture, especially through dedicated core funds. Health area-specific gender expertise was critical in developing normative documents, tools, and training manuals, which contributed to considerable advancements in gender equality within specific fields.

2. **The power of institutional structures**.
To translate leadership commitments into concrete action, institutions have to be ready with sufficient organisational infrastructure to advance the gender equality agenda. Internally, institutional preparedness involved:

   - ensuring direct links between the gender team and the budget/planning teams, bringing the gender mainstreaming agenda directly into the decision-making arena;
   - building strong performance accountability mechanisms at headquarters, and regional and country offices; and
   - making gender equality in health part of the organisation's core business, reflected not just in gender action plans, but in all broader organisational strategy documents and programme budgets, with measurable outcome and output indicators.

3. **The power of feminist civil society**. Forming effective partnerships with women's rights organisations ensured grounding in ethical principles, strategically positioning work within national priorities, and fostering local ownership and sustainability. The significant contribution of feminist civil society organisations was particularly notable where agencies built meaningful partnerships whereby programmes and priorities were jointly defined and shaped. Agency investment in strong partnerships with women's movements involved building trust, creating processes for feedback, external accountability, and sustained engagement. Simply having civil society representation alone was not enough. Partnering with the right civil society organisations was important for ensuring that genuine representation of specific groups was grounded in feminist ethics.

4. **The power of evidence**. Evidence and programmatic learning were central to driving action and change in the cases examined. Successful examples illustrated how data and evidence were used not only to showcase the problem, but also to demonstrate what works. Evidence-based reflexive learning pushed programme implementers to prioritise approaches that met the practical needs of constituents while challenging harmful gender norms.

5. **The power of the collective**. Several cases highlighted the impacts that joint interagency efforts can achieve on the ground. Successful interagency collaboration occurred when the comparative advantages of the agencies involved – their unique agendas, expertise and partnerships with government sectors and different feminist civil society movements – were fully leveraged.

This report fills a major gap at a critical juncture in time, providing an evidence-base of what has worked, where, for whom, why and how, to promote gender equality in health, institutionally and programmatically, in a multilateral system. The next step is to collectively work towards integrating this evidence into existing health programmes and organisational structures with the ultimate dual goals of improving health and ensuring gender equality.

List of successful cases:

Case study 1:	Empowering girls and women to challenge harmful gender norms to improve menstrual health and hygiene, implemented as part of a Water, Sanitation and Hygiene programme (UNICEF)
Case study 2:	Empowering women and girls to resist gender and social norms that encourage female genital mutilation, promote positive masculinities, and strive for more equal gender power relations (phase 3 of UNFPA-UNICEF Joint Programme on the Abandonment of FGM)
Case study 3:	Empowering women and marginalised groups living with HIV in Middle East and North Africa (UNAIDS Secretariat, regional team)
Case study 4:	HIV reduction and the empowerment of adolescent girls and young women in decision-making through the adoption and implementation of comprehensive HIV programmes in South Africa (UNAIDS Secretariat country office)
Case study 5:	Violence against women acknowledged as a global public health priority, and Member State health sectors have implemented programmes responding to the health consequences of VAW through sustained strategic leveraging of opportunities by WHO gender experts
Case study 6:	Gender-based violence in humanitarian settings prioritised in the global agenda through UNFPA's leadership and advocacy
Case study 7:	Enabling the rights of women and girls through enhanced legal, policy and regulatory environments in the context of HIV (UNDP)
Case study 8:	Institutional integration of gender across all technical programmes, Member State health programmes, and the Pan American Health Organization (WHO)
Case study 9:	Institutional integration of gender at global, regional and country levels, including in health (UNICEF)
Case study 10:	Member State implementation of gender-responsive programmes, including in the health sector, through the strategic use of Gender Programmatic Reviews (UNICEF regional and country offices, Europe and Central Asia)
Case study 11:	Changes in institutional culture within UNAIDS Secretariat to support gender equality brought about by the Independent Expert Panel
Case study 12:	Adequate financial allocations for programmes advancing gender equality and women's empowerment through effective use of the Gender Equality Marker (UNFPA)
Case study 13:	Integration of gender into the Special Programme for Research and Training in Tropical Diseases (WHO)
Case study 14:	Improved institutional and programmatic gender mainstreaming through increased participation in the Gender Equality Seal (UNDP)

1

Introduction, rationale and aims

Global health has risen to the top of political agendas as the devastating health, economic, and social impacts of the COVID-19 pandemic continue to be felt across the world (1,2). Accompanying this rise is an opportunity for leaders and the global health community to make transformative changes to health systems, with gender equality being a central tenet of that change (3). Given its global reach, mandate for setting norms and standards, and operational function in supporting Member States in the delivery of health programmes, the UN is uniquely positioned to take a prime leadership role on gender equality in health, especially given the extensive body of knowledge and experience on gender and health amassed across its agencies and programmes. This report is situated against this backdrop, and aims to identify what drives gender equality in health.

The COVID-19 pandemic reminds us that social and economic inequalities are inextricably linked to public health, not only in terms of the disproportionate health impacts experienced by the most vulnerable groups, but also – yet less widely acknowledged – by highlighting the health system's role in perpetuating such inequalities (4, 5). Public health measures to mitigate the spread of COVID-19 (e.g. lockdowns) have had major repercussions that disproportionately affect women and girls, further deepening gender inequalities (5). Over the last 18 months, gender-based violence (GBV) has risen sharply as many women have remained confined at home with their abusers (6). At the same time, services for survivors were severely disrupted or, in some cases, completely inaccessible (5,7). Similar disruptions were experienced in contraceptive services, resulting in over 1 million unintended pregnancies among women and girls in low- and middle-income countries during 2020 (8, 9). Such figures do not capture the likely increase in maternal morbidity and mortality, infection rates of sexually transmitted diseases, or the economic and social costs borne by the most vulnerable.

A further example of the health system's role in exacerbating gender inequalities is linked to human resources for health. Women constitute two-thirds of the health workforce, predominantly working as nurses, midwives or community health workers; they also comprise the majority of cleaners, caterers, and laundry staff (5,10). These women are at increased risk of contracting SARS-CoV-2 as frontline workers and are disproportionately affected in terms of the psychological impact (5,11). The severe underrepresentation of women in national and global decision-making bodies during the pandemic further illustrates the extent of gender inequalities within health systems (12).

In many ways, the pandemic has forced the health sector to confront certain issues that have long been considered as being outside its remit, particularly its role in promoting gender equality. The apparent reluctance of the health sector to engage, lead, and promote gender equality can be traced to several issues. First, the active resistance within the medical and public health fields to engage with more complex social forces, especially the ways in which power structures impact health and the delivery of health services, is largely a result of the dominant biomedical framing that underpins so much of medicine and public health (13). This framing is structured around a rigid hierarchy of what is considered "scientific", and health actors are often reluctant to engage with the concept of gender as something more than biological sex (13). As a result, gender-related differences in health are often simply – but falsely – attributed to biological differences (14). It is worth noting that even biological sex is poorly integrated into health systems, as demonstrated by the scarcity in sex-disaggregated analyses in biomedical and pharmaceutical research, reporting, regulation, and commercialisation (15–17).

Second, prioritising the health needs of women, girls and gender-diverse persons – groups that are systematically oppressed – is often challenged by those working in the health sector, since men, on the whole, access healthcare less often than women and have poorer health outcomes (18–21). This argument, however, fails to consider several issues. Most importantly, gender equality in health is not about equal health outcomes – it is about having equal opportunities to optimise one's health[2]. The Constitution (22) of the World Health Organization (WHO) states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Achieving this goal centres around addressing inequalities in power at a social level – control over resources, decision-making, access to services, information, and opportunities – all of which impact health and wellbeing and the ability to lead fulfilling lives. In this regard, women, girls, and gender-diverse persons are overwhelmingly excluded or disadvantaged in decisions regarding access to economic and social resources, features that health systems often reproduce (5,19,23). Working towards gender equality in health also requires careful consideration of how power intersects across various social domains (gender, class, sexual orientation, race, age, and (dis)ability).

Third, unequal gender norms, particularly those associated with masculinity, also disadvantage men, increasing their exposure to certain risk factors, such as tobacco use, and underusing healthcare services (18,24,25). Therefore, tackling unequal gender norms also presents an opportunity to improve health outcomes for men.

The impact of the pandemic, alongside a looming economic crisis, political fragility, climate change, and an alarming rise in transnational populist movements, have made urgent the need to keep gender equality on the global health agenda and for leaders to take corrective action. There are already some signs of political commitment towards a concerted push for gender equality in health from Member States, as well as heads of UN agencies (3,26). There are several compelling reasons why the UN, including its agencies and funds, are particularly well poised to lead this effort.

Since 1975, the UN has played an important agenda-setting role with respect to gender equality and women's empowerment (27). Many agencies have implemented programmes addressing gender issues in health in partnership with Member States, such as programmes that address GBV and harmful practices, menstrual health and hygiene, and HIV/AIDS among women and girls. Moreover, for decades the UN has set norms and standards in gender mainstreaming, including in health, and developed a wide range of tools and manuals for use in diverse settings (27). Consequently, there is a vast amount of experiential knowledge vested in agencies and actors within the UN system on how to address gender disparities in health for communities, countries, and regions.

Another unique feature of the UN system is that it represents a nexus of technical and political cooperation. Thus, it is well-positioned to transform evidence and lessons learned into changes on the ground through its convening power via the General Assembly (GA), the World Health Assembly (WHA), and other intergovernmental forums. The UN's current leadership has championed gender equality and women's empowerment within the UN system and among Member States (3,26). Moreover, the UN system has been relatively quick to recognise and respond to the gendered impact of COVID-19, compared with previous health emergencies (5). This early recognition suggests that there is a positive climate within the UN system to act on lessons learned regarding how best to advance gender equality in health.

Although there is a wealth of experiential knowledge that exists within agencies, evidence of what works to drive gender equality in health has not been systematically compiled. Several evaluations have, for example, pointed to the lack of knowledge management strategies within many UN agencies (28,29). In addition, formal assessments of gender mainstreaming in UN agencies and Member States have, by and large, been a stock-taking exercise of what has or has not been done, missing opportunities to identify the critical factors necessary for successful gender mainstreaming into health programmes and institutional structures (29–33).

This report, therefore, aims to fill a major gap at a critical juncture in time, providing an evidence base of what has worked in gender mainstreaming within the UN system.[3] Through an analysis of successful cases of programmatic[4] and institutional[5] gender mainstreaming across five UN agencies working in global health, this report:

- **documents** the types of outcomes UN agencies have been able to achieve through successful programmatic and institutional gender mainstreaming in health;
- **identifies** the contextual factors and mechanisms that led to the outcomes in successful cases of programmatic and institutional gender mainstreaming in health; and
- **distils** commonalities and lessons learned across successful cases to constructively inform future work on gender mainstreaming within the UN system and other bilateral and multilateral organisations working in health.

[2] Health is defined as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (22).

[3] This study uses the UN Economic and Social Council definition of gender mainstreaming: "Mainstreaming a gender perspective is the process of assessing the implications for women and men [and people of diverse gender identities] 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 [and people of diverse gender identities'] 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." (34)

[4] Programmatic gender mainstreaming in health means achieving gender equality by putting in place policies, programmes, and interventions that aim to achieve better health outcomes for all through advancing gender equality in health.

[5] Institutional gender mainstreaming involves addressing gender equality through internal organisational changes, such as resource allocation, strategic planning, policies, culture, human resources, staff capacity, leadership, management, accountability and performance management (35).

2

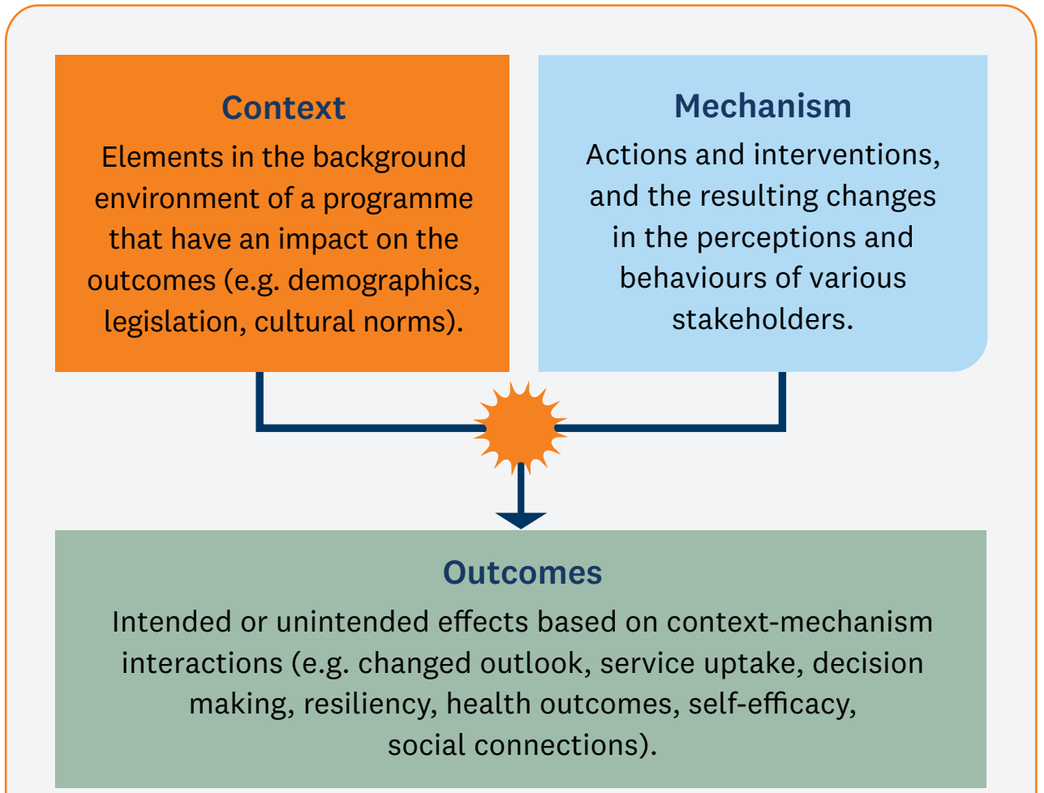
Conceptual framework and methodology

2.1 Conceptual framework

The approach used in this project, informed by critical realism, set out to ascertain "what works, where, for whom, why and how" (36) and to develop a granular understanding of the features that made gender mainstreaming successful in each case study. A realist approach was considered well-suited for this inquiry, given the limited understanding of the pathways leading to successful outcomes in gender mainstreaming and the complexity of social realities that encompass the cases (36,37).

Underpinning the realist approach is the underlying principle that particular mechanisms (M), actions, and associated changes lead to desired outcomes (O) within specific contexts (C) (36). This model demands that the relationship between contexts, mechanisms and outcomes be explored to understand how and why the outcome was achieved in some cases (but not in others), with a particular focus on the specific contextual conditions that activated or deactivated certain mechanisms to produce the observed outcome (36,38,39).

Figure 1. Framework for the realist approach – the context-mechanism-outcome configuration



Source: Adapted from Jagosh (2019) (36)

2.2 Methodology

UNU-IIGH collaborated with five UN agencies working in global health to co-produce practice-based evidence on what works in gender mainstreaming in health. The five agencies were the United Nations Joint Programme on HIV/AIDS (UNAIDS) Secretariat, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), and WHO. The diversity in global health and gender equality mandates across the partnering agencies provided further richness to the analyses and allowed for an exploration of how mechanisms operate across different organisational contexts.

Each agency identified a focal contact who served as the primary link between the research team at UNU-IIGH and the respective agency. Four sequential steps were then used to gather and analyse relevant data for the project.

Step 1. Background review

A detailed review of both publicly available and internal documents from 2001 onwards was undertaken to build an organisational profile of gender mainstreaming experiences for each agency. In some cases, gender strategies and documents predating 2001 related to specific gender and health programmes were also reviewed. More than 400 documents were included spanning the five agencies. This background review provided the broader contextual background necessary to position the cases and allowed for the identification of potential successes and evidence gaps in gender mainstreaming in health for each agency.

Documents included agency-specific gender policies, strategic plans, evaluation reports, annual reports, reports to executive or governing bodies, and knowledge products, tools and guidance related to gender and health.

Step 2. Identification and selection of successful case studies

Agency focal points identified potential personnel within their respective organisations, including those from headquarters, regional and country offices, to be interviewed. These key informants had a historical understanding of gender mainstreaming and/or experience supporting institutional gender work or implementing gender-responsive health programmes. The purpose of the interviews was to identify successes in programmatic and institutional gender mainstreaming in health within each agency. Interviews were informed and guided by the findings from the initial background review.

A total of 39 interviews were completed across the five agencies between June and September 2020 and included:

- gender experts with a long track record of gender mainstreaming in health and currently working in headquarters/secretariat or regional and country offices;[6]
- senior management currently working in headquarters/secretariat or regional and country offices; and
- current Heads of Agencies.

All invited participants agreed be interviewed, except for Heads of Agencies. Two retired UN officials, who had held senior management positions and have extensive expertise on gender equality and women's empowerment, carried out the interviews via Zoom, and these were recorded where participants consented. Ethical clearance for the study was obtained from Monash University (Project ID: 20317).

All interview material, audio, video, and transcripts were stored securely, adhering to our research and United Nations Evaluation Group ethical standards (40,41). Individual interview transcripts were deductively coded to create a list of successful cases with an accompanying brief description. Once all the interviews were completed and transcripts coded, a final list of successful cases was compiled for each agency and reviewed by the research team at UNU-IIGH.

Criteria for defining success were based on the principle that the ultimate goal of gender mainstreaming in health is to: (a) achieve improved health outcomes for all by addressing women's, men's and gender-diverse people's specific health needs; and (b) alter unequal power relations that are detrimental to health. Successful cases were included where:

- health programmes resulted in positive gender equality outcomes and positive health outcomes, sustained over at least five years (in cases of programmatic gender mainstreaming); or
- internal organisational changes demonstrated improvements in gender equality at the organisational level and/or significantly enabled programmatic gender mainstreaming in health (in cases of institutional gender mainstreaming).

The research team at UNU-IIGH then selected three successful case studies from each agency[7] on the basis that the range of programmatic and institutional successes were represented.[8]

Step 3. Construction of context-mechanisms-outcome configurations for each case study

Once case studies were selected, preliminary information was gathered on relevant contextual factors and mechanisms based on reviews of transcripts from key informant interviews, as well as detailed web searches. In addition, where necessary, further details relating to case-study outcomes were also sought. These searches included information about:

- global and UN system factors that may have contributed to putting the specific case-study issue on the UN agenda (e.g. international advocacy by civil society actors, a major crisis compelling action, a UN conference on the subject, a new policy by the UN system, UN Resolutions);
- organisational factors that may have precipitated attention to the specific case-study issue (e.g. an evaluation, support or pressure from governance structures, changes in leadership, adoption of a new policy or strategy, changes in the gender architecture);
- programmatic factors[9] relevant to the case study (e.g. programme objectives and design, milestones and achievements, and accountability mechanisms and processes, including routine evaluations); and
- country-level factors pertinent to the case study (e.g. country policies in support of the issue addressed by the programme, favourable political and economic situations, and support from civil society and women's movements).

[6] All key informants except three fulfilled these criteria. One of these was a senior manager from UNICEF who no longer works with the agency but was selected for her defining role in advancing the gender agenda in the agency. The other was the sole gender expert from the Gender, Equity and Human Rights team of WHO, who had worked with the agency for about two years, and the third was a programme specialist who had led some of UNDP's initial gender equality and preparatory work for the 1995 Fourth World Conference on Women in Beijing.

[7] Three case studies were selected for each agency, except for UNDP for which two case studies were selected. While UNDP had several success stories, these were in non-health areas and were thus excluded.

[8] One case study, which had been sustained for three years, was selected because it was identified by most of the key informants as an example of success.

[9] Relevant only for successful examples of programmatic gender mainstreaming in health.

Preliminary information relating to each case study's C-M-O configuration was compiled and sent to respective agency focal points with additional questions and requests for further clarification. One or more agency-specific virtual workshops were then organised to clarify, validate and refine emerging contextual factors and mechanisms, and answer outstanding questions. The virtual workshops involved more than 30 staff and were attended by key informants and other agency staff, including those from regional and country offices. In two instances, ex-staff members were also invited to provide additional details related to specific case studies. The proceedings of the workshop were recorded and transcribed, with transcripts used to refine and revise the C-M-O configurations of successful case studies. Informed consent was obtained from all workshop participants.

Step 4. Analysis and synthesis of findings

Once case study specific C-M-O configurations were finalised, analyses were conducted iteratively, evolving and building on new insights and patterns that emerged, including the following:

- **Grouping case studies according to their outcomes**. Initial analyses centred around looking for patterns across case outcomes. This analysis sought to understand the types of successful outcomes UN agencies were capable of achieving in programmatic and institutional gender mainstreaming in health. Case studies were then categorised according to outcome type. Preliminary results of C-M-O patterns based on this outcome categorisation were shared in an internal workshop with a reference group of gender experts. Critical input received from this meeting helped refine and further fine-tune the analysis.

- **Centrality of actors**. The second major analytical step involved understanding the specific actors through whom certain mechanisms (actions and associated changes) occurred. This representation of relevant actors within the broader C-M-O configuration provided a more comprehensive picture of who and how specific mechanisms were activated within particular contexts.

- **Identification of triggers, contextual enablers and sustaining mechanisms**. Case-study C-M-O configurations were analysed to understand what triggered a change to the status quo. In other words, what unlocked or catalysed a series of changes that then led to the successful outcomes observed? This analysis involved identifying: the combination of contextual factors and mechanisms, including actors, that triggered change; the contextual factors that created an enabling environment for triggers to spark change; and the mechanisms that helped sustain change over a period of time. Finally, within each outcome group, patterns across the triggers, contextual enablers and sustaining mechanisms were then explored to draw out the common factors that contributed to successful gender mainstreaming.

“This analysis involved identifying: the combination of contextual factors and mechanisms, including actors, that triggered change; the contextual factors that created an enabling environment for triggers to spark change; and the mechanisms that helped sustain change over a period of time.”

[9] Relevant only for successful examples of programmatic gender mainstreaming in health.

3

Backdrop to the case studies

3.1 Advances in gender equality and women's empowerment in health in the broader UN system

An overview of the broader context and history of advances in gender equality and women's empowerment in health within the UN system is presented here to set the stage for the case study analyses. Insights into the capabilities and constraints of the multilateral system showcase what it is equipped to do well but, in other cases, point out its limitations. The aim is to understand why certain cases were successful and whether findings are transferable beyond the UN system. Figure 2 illustrates that the UN has driven advances in gender equality and women's empowerment in health since its inception (27). These advances can broadly be thematised around four main functions:

1. **As an inter-governmental body, the UN has played a significant role in securing consensus on norms and standards related to gender equality in health in almost all countries**. For example, the 1995 Beijing Declaration and Programme of Action (PoA) was one of the first consensus documents through which Member States committed themselves to addressing gender-based barriers to women's health. The PoA identified inequalities between women and men by geographic location, social class, and ethnicity as major barriers to women's enjoyment of the highest attainable standard of health (42,43). Other examples include the various UN General Assembly Declarations between 2001 and 2019, which emphasised the centrality of gender equality and women's empowerment as a comprehensive approach to human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS), non-communicable disease prevention and control, and national universal health coverage plans (44–48). Human rights treaty monitoring bodies and the Committee on the Elimination of Discrimination against Women (CEDAW) general recommendations also called for a gender-sensitive response to HIV/AIDS (49). In December 2020, the UN General Assembly issued two resolutions that recognised the differential impact of the COVID-19 pandemic on women and girls (compared with men and boys) (50,51). The General Assembly recommended that Member States ensure access to essential health services, including mental health services, sexual and reproductive health services, HIV treatment and services for GBV (50,51). More recently, the Generation Equality Forum launched a five-year Global Acceleration Plan for gender equality, which included USD 40 billion in financial commitments from governments, philanthropy, civil society, youth organisations and the private sector (26).

2. **As a global convener, the UN has played a significant role in creating unparalleled opportunities for collective debate and dissemination of key evidence relating to the advancement of gender equality in health**. It has provided a platform for multi-stakeholder engagement, bringing together governments, feminist civil society actors, and other critical stakeholders. The 1994 International Conference on Population and Development Programme of Action was among the first to highlight the inextricable links between gender equality and women's reproductive health and rights (52). Subsequently, several human rights recommendations and concluding comments on Member State reports called upon countries to ensure access to affordable reproductive health services, including maternal health and contraceptive and abortion services (53). Universal access to SRH was one of the targets included under Sustainable Development Goal (SDG) 3 on health. Another landmark in gender mainstreaming in health was the 2005 Constitution of the Women and Gender Equity Knowledge Network (WGEKN) under the WHO Commission on Social Determinants of Health (CSDH). The WGEKN report submitted to the CSDH synthesised a wealth of information on the mechanisms and processes underlying gender-based inequities in health and proposed actions to address them (54).

Figure 2. Major UN milestones in gender equality and women's empowerment in health

1945	**UN constituted**. Its founding Charter outlines that its purpose is to promote and encourage "fundamental freedoms for all without distinction as to race, sex, language, or religion."
1946	**The Commission on the Status of Women constituted** as a functional commission of the Economic and Social Council.
1975	**International Women's Year** and launching of the **UN Decade for Women** (1976-85).
1979	The UN General Assembly adopts the **Convention on the Elimination of All Forms of Discrimination Against Women**.
1993	T**he World Conference on Human Rights** in Vienna recognises violence against women as a human rights violation; UN General Assembly adopts the Declaration on the Elimination of Violence Against Women.
1994	**The International Conference on Population and Development** in Cairo, Egypt, places women and couples' right to control their fertility at the heart of population policies and programmes.
1995	**The Fourth World Conference on Women** in Beijing, China, adopts a ground-breaking blueprint for advancing gender equality and women's empowerment and identified gender mainstreaming as the strategy to achieve this.
2000	**The UN Security Council passes the historic Resolution 1325**, recognising sexual violence as a tactic of war and calling for measures to prevent and address these. Since then, ten supporting UN Security Council resolutions are passed, the latest of these, Resolutions 2467 and 2493 in 2019.
2000 -2018	**The UN General Assembly passed Resolution 55/68**, entitled "Elimination of all forms of violence, including crimes against women." This was followed by numerous resolutions on various forms of violence against women (for example, domestic violence, Resolution 58/147 in 2004). Since 2006, there have been a series of resolutions on intensifying efforts to prevent and eliminate all forms of violence against women and girls. The most recent resolution, in 2018, focused on sexual harassment (Resolution 73/148).
2010	The UN General Assembly took the historic step of **creating the United Nations Entity for Gender Equality and the Empowerment of Women** (UN Women).
2012 -2018	**The UN General Assembly passes the landmark Resolution 67/146** to ban female genital mutilation (FGM) worldwide, which has been followed by a series of resolutions on intensifying global efforts for the elimination of FGM, the latest of these, Resolution 73/149 in 2018.
2015	**The Sustainable Development Goals** (SDGs) include SDG 5 as a stand-alone goal on gender equality and gender is also presented as a cross-cutting theme across all SDGs.
2019	**The Political Declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases** and the **Political Declaration of the high-level meeting on universal health coverage**, both acknowledge the need to mainstream a gender perspective.
2021	**The Generation Equality Forum** launched a five-year Global Acceleration Plan for Gender Equality, which included USD 40 billion in financial commitments.

Source: Adapted from UN Women (2015), UN Women (2021), UN (2018), UN (2019) (26, 27, 46, 48)

3. **As a global coordinator, the UN has a responsibility to ensure consistency in the implementation of commitments to gender equality across its own bodies, as well as among Member States**. The Inter-Agency Network on Women and Gender Equality (IANWGE), established in 2001, is a network of gender focal points in all UN system organisations and bodies. The network supports and monitors the Beijing PoA implementation and the many subsequent commitments for gender equality and women's empowerment made through UN General Assembly resolutions, conferences, and summits. IANWGE also oversees gender mainstreaming in organisational practices, normative work, policies, and the UN system's programmes (42,55).

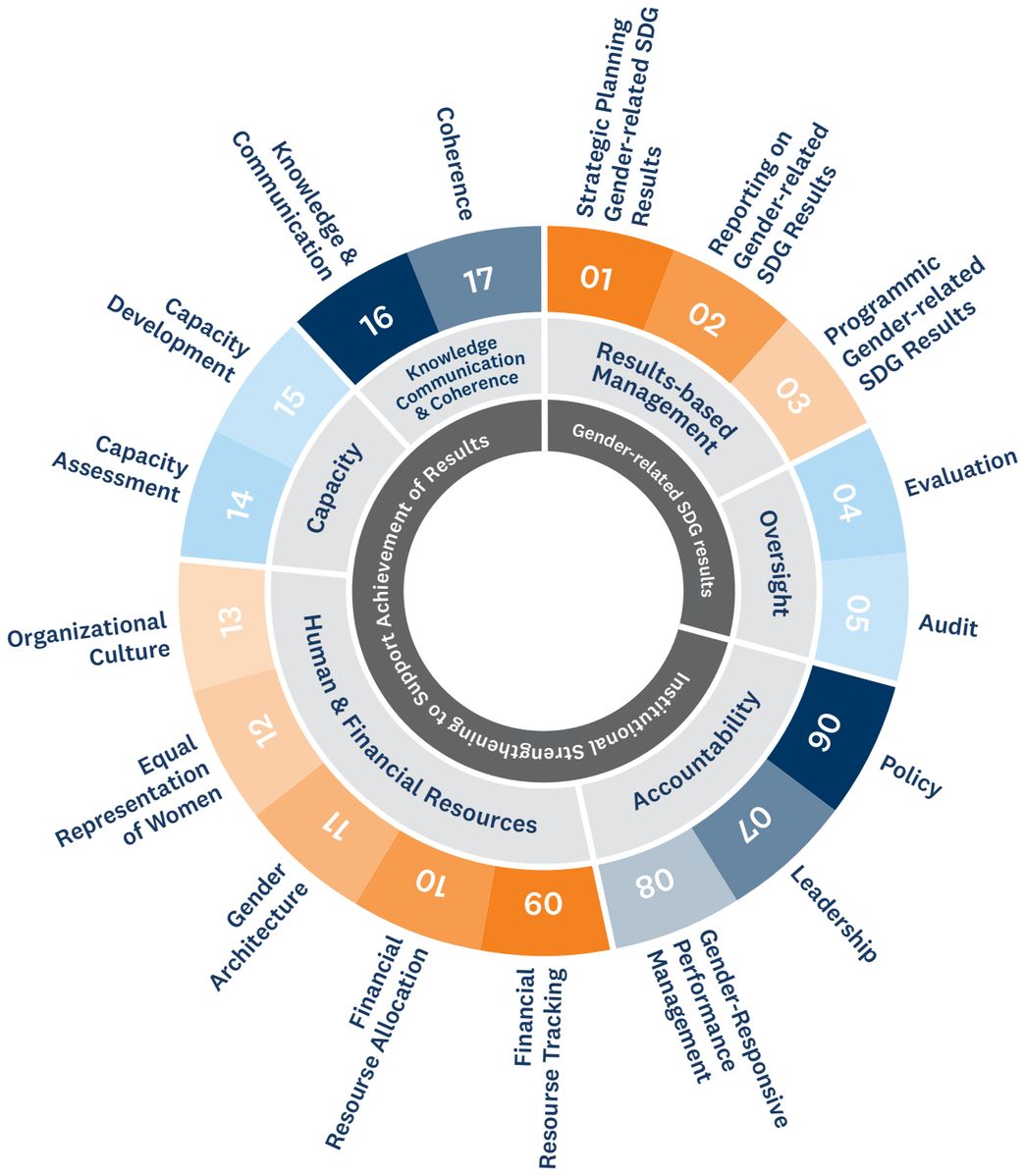
   One of the most far-reaching initiatives by the UN system spearheaded by UN Women is the UN system-wide Action Plan (UN-SWAP) – an accountability framework for gender equality and women's empowerment for UN agencies. The first phase of UN-SWAP (between 2012 and 2017) consisted of 15 performance indicators, based on intergovernmental mandates, on which each UN entity was to report (56). An evaluation of the first phase concluded that UN-SWAP had proven to be an effective framework for tracking system-wide progress and a useful benchmark and catalyst for gender mainstreaming in most participating entities (57). Building on lessons learned and recommendations from the evaluation, a second phase of the framework was developed, aligning with the 2030 Agenda for Sustainable Development. While the first phase of UN-SWAP implementation focused on institutional gender mainstreaming, the second phase expanded to include results (56, 58). It now includes monitoring activities and outcomes for gender-related SDG results (see Figure 3). In 2020, following the outbreak of COVID-19 and the UN Secretary General's Policy Brief on the impact of COVID-19 on women (5), additional COVID-related questions were included in UN entities' 2020 annual reporting (5) on performance indicators 1 and 3. [10]

4. **As a partner in delivering national and regional health programmes, UN agencies and funds have played important roles in implementing health programmes that directly empower women, girls, and other marginalised groups on the ground**. Summarising all these advances in the kinds of gender mainstreaming in health that are linked to the UN's operational function is beyond the capacity of this project. However, by focusing on specific case studies of success in programmatic gender mainstreaming among the five major agencies working in global health, this project aims to provide practice-based evidence of models of success that are linked to the UN's operational function (see Chapter 4 for further details).

The examples above showcase some of the UN system's profound impacts on advancing a progressive global agenda on gender equality in health. However, some of the same characteristics that have facilitated these advances have also been used to obstruct or erode these gains. Its inter-governmental nature, for example, leaves the system vulnerable to national agendas and geopolitics, which can change quickly and undermine existing commitments (59). Meaningful engagement with civil society groups, including feminist actors, within UN gatherings has fluctuated over time with a trend towards increasingly excluding their voices, despite their central role in advancing gender equality in health (60,61). In addition, applying and adhering to norms and standards, even within the UN system, has been inconsistent and, in some cases, clear violations of women's rights have occurred within the system's own practices (62–64). These examples testify to the ongoing and urgent challenges of building on the system's strengths while actively mitigating the risks of rights violations.

[10] The additional questions included on performance indicators 1 and 3 were whether the concerned UN agency had contributed to the Health Response, Safeguarding Lives and Livelihoods, and A Better Post-COVID 19 World (58).

Figure 3. Overview of UN-SWAP 2.0 performance indicators



Source: UN Women (2019) (56)

3.2 Gender mainstreaming efforts in health across the five UN agencies

3.2.1 Agency structures, mandates and involvement in global health

The five UN agencies covered by this study vary in their nature, structure, mandate and extent of involvement in global health issues. WHO is a specialised agency of the UN system, UNFPA and UNICEF are funds, and UNDP and UNAIDS are programmes. All the agencies have offices at three levels: headquarters, regional offices, and country offices, and some (like WHO and UNFPA) have liaison offices and offices responsible for specific activities.

The organisational structures and mandates influence the scope of each agency's gender mainstreaming work. For example, WHO is an intergovernmental organisation governed by the WHA, and has 194 Member States. Support for gender mainstreaming policies depends on Member States' positions (65), although its six regional offices are semi-autonomous and can define their own regional gender mainstreaming policies. A WHA resolution represents a commitment by governments –not just an agency decision – and gender-mainstreaming policies can respond to regional specificities. On the other hand, gender mainstreaming may not receive sufficient priority in the WHA unless championed by Member States, and the uptake of gender mainstreaming policies can vary considerably across regions.

The remaining four agencies have more centralised governance structures, with Executive Boards and greater scope for rolling out organisational decisions across regional and country offices. For example, the Executive Director, Regional and Country Directors within UNFPA have significant control over decisions. Consequently, leaders who champion gender mainstreaming can help move the gender agenda forward within the organisation and across programmes with a supportive Executive Board. A unique feature of UNAIDS' is formal civil society representation on its governing body, although they do not participate in the formal decision-making process and have no right to vote (66,67). The UNAIDS Programme Coordinating Board (PCB) comprises 22 governments from priority countries, UNAIDS Cosponsors, and five non-governmental organisations (NGOs), including associations of those living with or affected by HIV. This feature ensures that the voices of marginalised communities living with HIV, civil society engagement, and priorities surrounding gender and human rights are incorporated into the global response to HIV (66,67).

In terms of mandates, WHO engages mainly in normative work, such as standard-setting and providing technical support to Member States, with limited engagement in programme implementation. In contrast, the other agencies are engaged in normative work and programme implementation and/or coordination, the scale of which depends upon available resources. For instance, UNICEF has 190 country offices with unparalleled operational capacity to implement a cohesive and well-conceived roadmap for programmatic gender mainstreaming, leading to significant global impact on communities (68,69). An additional advantage of UNICEF is that, as a UN fund, it has a wide latitude to receive voluntary contributions from any source (70). Such non-earmarked funds can be used for anything in line with its financial accountability mechanisms (70). Given sufficient political backing, this would allow for sustained core funding for work on gender equality within the agency.

The range of gender and health issues with which agencies engage depends on the scope of their mandates. WHO is the lead agency for global health and has a mandate to engage with gender, equity, and rights in all aspects of health (71), while UNAIDS is focused on the global HIV response (72). UNFPA focuses on gender, and sexual and reproductive health rights, including HIV/AIDS, GBV, and harmful practices (73). UNICEF works on a broad range of issues in gender and health pertinent to childhood and adolescence, including nutrition, immunisation, water, sanitation and hygiene (WASH), GBV, and harmful practices (74). UNDP's work on gender and health focuses on inequalities and social exclusion, governance for health, and sustainable health systems, to which it brings a multi-sectoral perspective (75,76). UNDP's interagency partnerships, networks and coordination role at country level can serve as a critical entry point to the provision of technical assistance for gender mainstreaming, both institutionally and programmatically at country level.

3.2.2 What does success in gender equality in health look like for each agency?

Key informants from all five agencies shared their views on what they considered successes in programmatic and institutional gender mainstreaming. Generally, they emphasised the enormity of the challenge, noting that efforts were required to be sustained over periods of years to achieve even modest positive changes in gender equality. Responses to what constituted success in gender equality included an end goal, indicated by interim steps that showed that the organisation was on track to achieve that goal. In almost all cases, the end goal was related to programmatic gender mainstreaming, specifically the empowerment of women and girls. One key informant pointed out that the rationale for WHO's work on gender is both a means to an end (i.e. improving health outcomes within programmes or health systems), and an end in itself – advancing gender equality, reducing inequities and respecting, protecting, and fulfilling the right to health and other human rights.

However, across agencies, gender experts and senior managers expressed diverse perspectives on what constitutes the right approach to advancing gender equality within health programmes and organisations. For example, one senior leader believed that programmatic gender mainstreaming would be considered successful only once all programme managers accepted the need for integrating gender into their programmes. In another view, success in programmatic gender mainstreaming would be achieved when consultations and engagements with women's groups and feminist social movements became routine institutional practice rather than one-off events.

Another frequent theme that emerged from the interviews was the importance of taking an intersectional approach to gender equality. This means factoring in the kinds of gender-based discrimination or disadvantages faced by people who are simultaneously experiencing other social inequalities on the basis of their race, economic class, migration status, age, and so on. Recent strategies from some agencies explicitly mention the need to adopt an intersectional approach (75,77,78). Importantly, the influence of global movements and prominent activist campaigns for social and racial justice (e.g. #MeToo and Black Lives Matter) were highlighted as part of this shift.

Nonetheless, three areas of contention stood out, namely:

1. **Who is the target population for work on gender equality?**
2. **How useful is the terminology of "gender mainstreaming" and what alternative terminologies may be more appropriate?**
3. **When expertise on human rights and other social issues is combined with expertise on gender equality, is this more or less effective for gender equality?**

Target populations for work on gender equality

Across agencies, there was a shared understanding that, since women are at a disadvantage within institutions in terms of parity in recruitment and promotions, and a male-dominated "prioritisation culture" persists, institutional gender mainstreaming efforts should target women in order to create a level playing ground.

With respect to programmatic gender mainstreaming, interviewees from all agencies mentioned two parallel areas of focus: (1) integrating gender across all health-related programmes; and (2) specifically targeting women and girls in order to address health issues related to gender discrimination in society. However, perspectives differed regarding the prioritisation of men's health within programmatic gender mainstreaming efforts given the poorer health outcomes experienced generally by men and boys. One approach taken by WHO's Regional Office for Europe was to develop two separate and complementary health strategies for women and men. Each strategy lays out the roadmap for work on specific issues applicable to women and men from a gender perspective (e.g. the Strategy on the health and well-being of men in the WHO European Region focuses on masculinity-related health inequalities) (79,80). However, this approach is based on a binary conception of gender, which does not create space for people with gender-diverse identities.

Another area where opinions varied was the inclusion of lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) issues as part of agencies' work on gender

equality. Several experts reported that LGBTQI groups were excluded because of the prevailing binary focus on gender, which does not reflect advances in more inclusive conceptualisations of gender. Other participants argued that the inclusion of minority gender and sexual had sometimes disadvantaged women. One example given was where funding for gender and HIV had been previously channelled towards programmes targeting women and girls, but was then redirected to programmes aimed at men who have sex with men and gender-diverse minorities.

Gender mainstreaming terminology and alternatives

Despite "gender mainstreaming" being the most commonly used term for work on gender equality across the UN system, there was a clear impression among informants that "gender mainstreaming" was increasingly losing favour. The term had come to represent a box-ticking exercise whereby "women" and "gender" were simply added to documents without making any substantial changes that actually empowered women or addressed structural inequalities. There was also the sense that gender mainstreaming was an impossible task associated with minimal action, given that gender equality needed to be addressed in every policy, programme or action as captured by the Economic and Social Council definition (34).

Opinions diverged, however, on the appropriate language to use in its place. "Gender integration", "advancing gender equality and women's empowerment" and, more recently, "gender-transformative programming" were some of the emerging terms used in agency documentation, gender strategies, and by staff. Some respondents articulated that language around gender work is essentially a function of the leadership, whether at the executive or mid-management level. The leader's strategic vision, including programme priorities and approaches, appears to determine the language and framing around gender. For example, the current framing of cultural transformation exercises within UNAIDS through feminist principles or language[11] was enabled mainly by the appointment of a new Executive Director who supported this (81).

Implications for gender equality when approached alongside human rights and other social equity concerns

Mirroring a broader global movement towards rights-based approaches to gender equality and women's empowerment (82), there is an increasing trend across agencies to consider gender together with human rights and social equity concerns, both conceptually and in practice. For instance, informants highlighted that, within UNFPA, gender equality is viewed both conceptually and programmatically as located within a broader human rights framework and connected to the realisation of reproductive rights. This is showcased in UNFPA's Gender Equality Strategy, which clearly articulates the organisation's integrated perspective on gender and human rights (83).

One point of contention regarding the merging of gender equality work with other rights-based or social equity work relates to instances where the merger has resulted in the constriction of already limited resources and capacity to undertake gender equality work. For example, the Gender and Human Rights Units at the UNAIDS Secretariat were amalgamated in 2016–2017 following the global financial crisis. This weakened the architecture of both units and resulted in the loss of gender specialists and gender focal points at the Secretariat and regional offices. Similarly, within WHO, the Department of Gender, Women and Health was dissolved in 2011 and replaced with a much smaller Gender, Equity and Rights (GER) Team. In the case of WHO, this downsizing was later complemented by moving the Gender, Equity and Rights Team to the Director General's Office, signalling the importance of the GER Team within the organisation (84).

A second area where respondents voiced concerns around approaching gender equality alongside other social equity or rights-based concerns was the danger of gender equality being considered as interchangeable with rights-based work, especially since successful rights-based approaches do not always equate to outcomes that address gender inequalities in health. For example, programmes to decriminalise same-sex relationships or programmes to ensure access to healthcare for migrant populations are frequently grouped together as addressing human rights and gender equality, even though gender-responsive programming elements are not included.

[11] Feminist principles or language are those that confront and transform the values, practices and institutions that perpetuate gender stereotypes, discrimination, violence, and harassment.

4

Lessons in programmatic and institutional gender mainstreaming in health: An analysis of 14 cases

4.1 What types of successful outcomes did the agencies achieve?

Most of the reported successes focused on institutional gender mainstreaming.[12] Of those with a programmatic focus, very few applied to health programmes in which gender-specific inequalities were taken into account in their design, implementation, and evaluation to improve gender equality. Instead, health-related programmes were identified as successful when they tackled harmful social norms and empowered women and girls in communities. This illustrates the range of views with respect to what constitutes gender mainstreaming in health programmes.

Across the 14 cases selected from the initial list of successes, three overarching types of positive outcomes were identified that either:

1. **empowered women and girls to resist harmful gender norms and practices and advocate for their own health needs (four cases – see Box 1);**

2. **put gender and health issues on the global agenda (three cases – see Box 2); or**

3. **embedded gender equality issues in institutional processes and structures that supported gender equality in health programming (seven cases – see Box 3).**

These three types of outcomes reflect the different levels that UN agencies work on and showcase the capabilities and strengths of the UN system.

Box 1 illustrates that when gender mainstreaming is successfully integrated into operational functions, agencies can have a direct impact on empowering women, girls and other marginalised groups to resist oppressive gender norms affecting their health. UNICEF's menstrual health and hygiene (MHH) programme, for example, empowered adolescent girls to challenge harmful social norms that stigmatised menstruation (85–87). In the Middle East and North Africa (MENA), women and marginalised groups living with HIV were empowered to resist unequal gender norms and advocate for their needs and rights across a range of national, regional, and global platforms, through the work undertaken by the UNAIDS Secretariat, together with the MENA Rosa network (88,89).

> "Most of the reported successes focused on institutional gender mainstreaming. Of those with a programmatic focus, very few applied to health programmes in which gender-specific inequalities were taken into account in their design, implementation, and evaluation to improve gender equality."

[12] An overview of the range of efforts identified by key informants as successful examples of institutional and programmatic gender mainstreaming in health is provided in Annex 1.

Box 1. Cases that empowered women and girls to resist harmful gender norms

Case study 1: Empowering girls and women to challenge harmful gender norms to improve menstrual health and hygiene, implemented as part of a WASH programme (UNICEF)

Starting with a pilot programme in 14 low- and middle-income countries (LMICs) in 2014 as WASH in School for Girls, MHH activities were undertaken in 72 countries and, as of 2019, included in-school and out-of-school adolescents (90). Based on the pilot study, country programmes were developed in partnership with national and/or local governments and other partners to cater to local needs. Through working with municipal governments to engage children and their influencers, the programme helped change social norms around menstruation using innovative communication materials (86,87,90).

In a number of countries, UNICEF has used the principle of human-centred design in cooperation with adolescent girls. In this case, they produced mobile apps to track their periods and received information on menstruation through comic strips, stories, and booklets tailored to their local context and concerns (e.g. Oky in Indonesia, the Change Every Girl Needs in Pakistan). A series of guidance tools were produced to enable gender-responsive programming, which, among other things, outlined concrete "gender-transformative" actions, such as including women in WASH committees.

Reports from the field indicate that the programme has improved adolescent girls' access to menstrual hygiene products and facilities in many settings and encouraged them to challenge gender norms that stigmatise menstruation and participate actively in programme implementation locally (86,87,90).

Case study 2: Empowering women and girls to resist gender and social norms that encourage female genital mutilation (FGM), promote positive masculinities, and strive for more equal gender power relations (phase 3 (2018–2023) of UNFPA-UNICEF Joint Programme on the abandonment of FGM)

The Joint Programme, initiated in 2008, is funded by multiple donors and coordinated and administered by UNFPA while being jointly implemented with UNICEF. The first and second phases were implemented in 2008–2013 and 2014–2017. The programme is now in its third phase (2018–2023). Activities of the Joint Programme are implemented at three levels: global, regional, and national. At the country level, activities include advocacy for policies and laws to eliminate FGM, strengthening countries' capacity for delivering health services while opposing the medicalisation of FGM, and strategic community-level interventions to change social norms supporting FGM (91).

Implementing the first two phases of the Joint Programme achieved positive outcomes in adopting laws and policies against FGM in many countries and a clear reduction in the prevalence of the practice in some countries. However, according to an evaluation at the end of the second phase, changes in unequal gender norms were modest, indicating the possibility that the reduction in the prevalence of FGM may have been the result of patriarchal pressure (92). For example, the Joint Programme worked extensively with existing all-male power structures, such as cultural and religious leaders, to win their support for protecting women and girls from the harm caused by FGM, while the messaging on women's empowerment and agency was often not highlighted. Following the evaluation, the third phase of the Joint Programme prioritised the transformation of unequal power relations, structures and norms that sustain gender inequality and harmful practices. The FGM programme resulted not only in a decrease in the prevalence of FGM in many countries, but also in addressing the root causes of harmful practices and changing gender norms (93).

Case study 3: Empowering women and marginalised groups living with HIV in MENA (UNAIDS Secretariat, regional team)

The UNAIDS Secretariat, together with its partners, worked to strengthen the capacity of one of the first networks of women living with HIV (WLHIV) in the MENA region (88,94). The network was identified as a successful example of UNAIDS Secretariat's work with civil society organisations (CSOs) in the global HIV response. The Regional Office committed financial resources to support the capacities of the MENA Rosa network on gender vulnerabilities in the HIV response. The network leaders' capacity-building also focused on research and resource mobilisation. The UNAIDS Secretariat Regional Office provided technical input in developing the network's strategic plans over the period 2010–2021.

Outcomes included:

- empowering women leaders advocating for their rights and services across levels (e.g. policymakers, security services and health systems);
- visibility and engagement of WLHIV at national coordination mechanisms to prevent HIV (e.g. national strategic planning committees, Global Fund Country Coordinating Mechanisms);
- growing attention and prioritisation of sexual and gender-based violence by national governments through increased articulation and awareness of GBV that occurs in various settings – family, community, health facilities, police (95).

Case study 4: HIV reduction and the empowerment of adolescent girls and young women in decision-making through the adoption and implementation of comprehensive HIV programmes in South Africa (UNAIDS Secretariat country office)

Adolescent girls and young women (AGYW) have been a high-risk group for HIV infection in several countries, with generalised HIV epidemics in East and Southern Africa. Among countries in sub-Saharan Africa that are part of the Global HIV Prevention Coalition, many have adopted and implemented a combination of country-specific comprehensive prevention packages to address HIV in AGYW through the technical support of the UNAIDS Secretariat, including Cosponsors and partners (96). However, progress has been uneven.

This case study focuses on the primary outcomes from AGYW programming in South Africa, where there have been important gains achieved through comprehensive HIV programmes, including a 56% reduction in new HIV infections among AGYW, active participation oaf AGYW in HIV-related decision-making forums, including prevention programmes, and an increased prioritisation of GBV and its interlinkages with HIV (96).

Through sustained and extensive strategic leveraging and capacity support, the UNAIDS Secretariat country office contributed to advocacy, securing buy-in, and mobilising resources for scaling up combinations of HIV-prevention packages for AGYW.

Box 2 describes three successful cases where specific gender and health issues were put on the global agenda. Together, these cases illustrate what is possible when agencies successfully capitalise on their roles in global agenda-setting work, including convening, thought leadership, evidence generation, advocacy and technical support. The Women's Health Unit within WHO, working in collaboration with external feminist groups and academics for over two decades, managed to get violence against women and girls recognised as a global public health priority through a WHA resolution passed in 2016 (97). More recently, violence against women (VAW) was included as an outcome indicator included in WHO's 13th General Work Plan, with many Member States' health sectors implementing programmes responding to the health consequences of VAW (98). Similarly, through UNFPA's leadership and advocacy alongside coordinated work with other external stakeholders, including feminist civil society actors, GBV in humanitarian settings has been successfully positioned as a priority issue in the global health agenda (99). A further example is the work of UNDP's HIV, Health and Development Group, which has supported national governments and civil society partners to build capacities and strengthen legal and policy frameworks to tackle HIV stigmatisation and discrimination against women and key populations (76,100).

Box 2. Cases that put specific gender and health issues on the global agenda

Case study 5: GBV acknowledged as a global public health priority, and Member State health sectors have implemented programmes responding to the health consequences of VAW through sustained strategic leveraging of opportunities by WHO gender experts

While VAW has long received attention, mainly from women's movements, getting VAW to be framed as a health issue and eliciting a health sector response has been a long struggle. Dedicated and competent gender experts within WHO collaborated with external feminist groups and academics working on VAW to use every window of opportunity to advance work on VAW in accordance with WHO's mandate of evidence generation, standard-setting and capacity-building among Member States. A handful of gender experts and medical professionals (who established credibility within the predominantly biomedical organisation) framed VAW as an opportunity for WHO's leadership to build evidence, set standards, and build capacity among Member States.

Epidemiological data relating to prevalence was gathered and intervention effectiveness studies (clinical trials) showed how to reduce the incidence of VAW (159). The Women's Health Unit, presented research evidence and produced guidance material, including clinical guidelines for medical professionals to respond to VAW within hospital settings (160,161). Global events and declarations, such as the Beijing Platform for Action were used strategically to secure additional buy-in. The VAW programme moved to the Department of Sexual and Reproductive Health and Research (SRH) in 2011.

Following two decades of persistent and sustained work across networks of feminists internal and external to WHO, GBV is now recognised as a global health priority. In 2016 the WHA passed Resolution WHA67.15 on "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children" (97).

More recently, an outcome indicator has been included in WHO's 13th General Work Plan (GPW13), making it mandatory for WHO and Member States to report progress in reducing levels of violence against women and girls (98).

Case study 6: GBV in humanitarian settings prioritised in the global agenda through UNFPA's leadership and advocacy

UNFPA has strengthened its health sector response to GBV since the International Conference on Population and Development Programme of Action in 1994 and works both in humanitarian and developmental settings (101). The agency was among the early advocates for setting up a separate GBV Area of Responsibility (AoR) under the Global Protection Cluster of the Inter-Agency Standing Committee for Humanitarian Action, set up in 2007 (102,103). UNFPA supports interventions for the prevention of GBV and treatment and counselling services for GBV survivors, including clinical management of rape (99). It works with UN and NGO partners across sectors with staff involved in protection, security and community and health services. Gender-transformative programming in humanitarian settings includes carrying out gender and power analysis for context-specific prevention planning, addressing the immediate needs of GBV survivors before tackling inequality and discrimination, and engaging men and boys to change unequal gender norms (99).

In collaboration with other agencies in the humanitarian space, UNFPA has played a critical role in gaining acknowledgement for GBV as a priority issue in humanitarian settings. The first-ever World Humanitarian Summit, held in 2016, led to a consensus among stakeholders on a New Ways of Working Agenda among humanitarian, development, peacekeeping and peace-building partners (104). In the case of GBV, the emphasis was on addressing the root causes, namely gender inequality and discrimination (104). A series of UN Security Council Resolutions have reaffirmed the UN's commitment to preventing GBV in armed conflicts, following the landmark UN Security Council Resolution 1325 (105). The latest, Resolution 2467, passed in 2019, stresses the importance of addressing structural gender inequality and discrimination as the root causes of GBV (106,107).

Case study 7: Enabling the rights of women and girls through enhanced legal, policy and regulatory environments in the context of HIV (supported by the UNDP HIV, Health and Development group)

Through its HIV, Health and Development Group, UNDP has supported national governments and civil society partners to build capacities and strengthen legal and policy frameworks to tackle HIV stigmatisation and discrimination against women and key populations (76,100). Their work on removing and addressing legal barriers in HIV prevention was identified as a successful example of gender mainstreaming in a health area.

Decades of UNDP's investments have contributed to changes in national policies and laws addressing harmful social norms and practices that put women, girls and key populations at risk of HIV (100,108). Some of the encouraging outcomes include: enabling political spaces at community and government levels to discuss systemic issues and structural barriers around HIV prevention, gender norms and gender inequality in many LMICs; changing legal and judicial practices, with potential to enable women rights and rights of WLHIV, sex workers, LGBTQI and people who use drugs; and political commitment and policy changes at the intersection of HIV, rights of women and key populations, and health. These successes should be considered interim outcomes; the impacts of these laws and policy changes for women, girls, and key populations on the ground are beyond the scope of the case study.

A description of the seven cases that successfully embedded gender equality issues in institutional processes and structures is provided in Box 3. This group of outcomes related to successful institutional gender mainstreaming showcase the organisational-wide change that is possible when gender equality is embedded in institutional processes and structures and the positive impact this can have on gender mainstreaming at the organisational level and in health programmes. For example, PAHO's 2006 Gender Equality Policy successfully institutionalised an organisational mandate for gender mainstreaming and contributed to gender mainstreaming in health programmes in its Member States (109). UNICEF's first and second Gender Action Plans enabled the agency to systematically operationalise the integration of gender and include a set of targeted gender priorities in all its strategic plan outcomes across its various sectors, including health, since 2014 (110,111).

Box 3. Cases that embedded gender equality issues within institutional processes and structures

Case study 8: Institutional integration of gender across all technical programmes, Member State health programmes, and the Pan American Health Organization (PAHO)

In WHO, the most sustained gender mainstreaming success was PAHO's institutional mechanisms for integrating gender concerns across all technical programmes, backed by funding and monitoring and evaluation. PAHO's 2006 Gender Equality Policy successfully institutionalised an organisational mandate for gender mainstreaming, resulting in approaches to tackle gender inequalities being integrated within health programmes among its Member States. The outcome, sustained over at least ten years, was programmatic gender mainstreaming across all of PAHO's technical programmes (112–114). Drawing on its institutional mandate, integrating gender into its strategic plans was the "master switch" that led to other actions, including the creation of a series of formal structures within PAHO and its country offices, ultimately resulting in gender-responsive health programmes in Member States (112–114).

An acknowledged PAHO success, but no longer in operation, was a "Best Practices" initiative that encouraged Member States to be innovative in gender-responsive programming, showcase their results and inspire other countries to experiment. Best practices were defined as programmes that incorporated a gender-equality or ethnic-equity perspective, which led to concrete changes regarding inequality between men and women, and the attitudes of the people and health institutions involved (115).

Case study 9: Institutional integration of gender at global, regional and country levels, including in health (UNICEF)

UNICEF systematically operationalised the integration of gender into all its strategic plan outcomes across various sectors. Since 2014, there has been a set of targeted gender priorities across the Strategic Plan outcomes (74,116). UNICEF's two Gender Action Plans (GAP 2014–2017 and 2018–2021) sought to create an internal environment that would enable programmatic gender mainstreaming and integrate a gender perspective systematically in all its work and generate targeted priority gender programmes for adolescent girls (110,111). A theory of change was articulated in GAP 2018–2021, which envisaged a dialectic, two-way relationship between institutional and programmatic gender mainstreaming (110).

Notable and steady advances have been made in programmatic gender mainstreaming across all sectors, including health. In 2019, 107 country programmes out of 128 had one or more gender-integrated results in their programmes, compared with 92 country programmes in 2017. Some 90 UNICEF country programmes included results in one or more of the targeted gender priorities, compared with 73 in 2017 (117).

Case study 10: Member State implementation of gender-responsive programmes, including in the health sector, through the strategic use of Gender Programmatic Reviews (UNICEF regional and country offices, Europe and Central Asia)

The Gender Programmatic Review (GPR) is a broad-based consultative process aimed at developing gender-responsive country programme documents rolled out with the help of country partners (74). UNICEF strategically institutionalised the GPR process to develop gender-responsive programmes in Europe and Central Asia.

According to UNICEF's GAP 2018–2021, every country office must undertake a GPR at least once during its programme cycle (110). The GAP 2018–2021, and the GPR process outlined by it, provided an organisational mandate to country offices to advance gender equality goals, with much success in Europe and Central Asia. In 2018, 43% of country offices had undertaken a GPR. The GAP 2019 evaluation found that GPRs provided a key stimulus for increased attention to gender in-country programming (118).

Case study 11: Changes in institutional culture within UNAIDS Secretariat to support gender equality brought about by the Independent Expert Panel

The UNAIDS Secretariat set up an Independent Expert Panel (IEP) following critiques of a lack of transparency in internal and UN system-wide accountability mechanisms in response to allegations of sexual harassment and abuse of power within the organisation (64). The IEP was mandated to examine UNAIDS Secretariat's organisational culture, evaluate the effectiveness of existing policies and procedures around harassment, including sexual harassment, bullying and abuse of power, and outline recommendations for action (64). This action triggered a series of processes that transformed the organisational culture. Establishing the IEP resulted in positive outcomes and was identified as an example of a successful external accountability mechanism.

The IEP is perceived to have led (and be leading) to the following:

- recognition and growing personal awareness around rights, harmful behaviours, and (un)acceptable language or actions;
- shifting mindsets towards creating equal opportunities for more inclusive leadership (with a focus on women's leadership);
- a rebuilding of confidence, trust, and belief among staff that they will be backed and supported when reporting and disclosing sexual harassment, discrimination, and abuse;
- new initiatives on cultural transformation focused on empowering staff and enabling mechanisms to identify and report harmful behaviours at early stages, as well as addressing other critical inequalities (e.g. gender parity in staffing and consultancies, racial justice, and civil rights) (81).

Case study 12: Adequate financial allocations for programmes advancing gender equality and women's empowerment through effective use of the Gender Equality Marker (UNFPA)

The gender marker, or Gender Equality Marker system, used across many UN agencies, tracks and reports on allocations for gender equality and the empowerment of girls and women. The gender marker is one of the UN-SWAP indicators that UN agencies must report on (56). UNFPA has used the gender marker since 2014 and tracks the allocation of programme funds based on the extent to which gender equality and women's empowerment is considered and addressed throughout the design, implementation, and monitoring and evaluation process (119). All activities are classified into four categories:

1. activities with gender equality and women's empowerment as their primary objective;
2. activities that contribute substantially to gender equality and women's empowerment;
3. activities that make some contribution to gender equality and women's empowerment; and
4. activities that do not contribute to gender equality and women's empowerment.

The gender marker is now a mandatory component of UNFPA's work plans, and it is reported in UNFPA's annual reports (83). The classification is based on guidelines from the UN system's Finance and Budget (120).

Case study 13: Integration of gender into the Special Programme for Research and Training in Tropical Diseases (TDR) (WHO)

The TDR, while located within WHO, has a different governance structure and greater autonomy compared with other WHO departments (121). TDR has a long engagement with gender issues, and although setbacks were experienced, gender did not fall off the agenda as it was, to some extent, institutionalised. In 1995, for example, TDR established the Gender and Tropical Diseases Task Force and funded research that examined the gender aspects of tropical diseases. In the process, capacity for research with a gender perspective was built among many researchers from low- and lower-middle-income countries (122,123).

TDR formally adopted its intersectional gender research strategy in 2020, with precise mechanisms for performance accountability through monitoring and evaluation indicators and a clear pathway to mainstream gender dimensions throughout TDR's work (77). Part of TDR's commitment to equality, includes a gender balance on advisory committees, grantees, and authorship lists, as well as increasing the number and proportion of peer-reviewed publications that explicitly consider gender and women's issues (124).

Case study 14: Improved institutional and programmatic gender mainstreaming through increased participation in the Gender Equality Seal (UNDP)

The Gender Equality Seal was pioneered in Latin America in 2009 with UNDP's support and is a corporate certification programme that recognises the performance of institutions in delivering on gender equality and women's empowerment (125,126). The Gender Equality Seal certification is one of the main instruments to enhance country office synergies between institutional and programmatic gender mainstreaming to ensure collective action, including monitoring and performance accountability, for transforming gender equality. Country offices receive a bronze, silver or gold seal, which is a "quality guarantee" of good performance, according to the established standards for gender equality. Since 2011, 79 country offices have been awarded a seal (127–129).
The Gender Equality Seal is a successful example of institutional innovation towards gender equality and women's empowerment. Interim outcomes included:

- increased and prioritised programmes for gender equality and women's empowerment programmes;
- gender analyses that inform and contribute to gender-responsive programming;
- increased allocation of funds for gender equality programming;
- staff awareness, understanding and engagement on issues of gender equality and women's empowerment; and
- strengthened partnerships (127–129).

4.2 Explaining successful outcomes: What works, where, for whom, why, and how?

4.2.1 What were the contextual factors and mechanisms that triggered the change?

Across the 14 case studies, a similar pattern was observed with at least one contextual factor and one mechanism jointly acting as triggers to set off actions towards the reported outcomes (see Figure 4). In all cases, a specific change in the internal or external context opened up a window of opportunity for gender mainstreaming. However, these changes in contextual factors only served as triggers when key actors identified and reacted to these opportunities. Senior leadership or in-house gender experts, with technical expertise and political astuteness, played a critical role in recognising and leveraging opportunities. They, in turn, initiated a series of actions or sustaining mechanisms that were crucial to the outcomes observed in each case study.

Figure 5 provides an illustration of the triggers identified in each of the case studies.

Examples of successful triggers included the following:

- In the case of GBV in humanitarian settings, the combination of UNFPA's organisational mandate for humanitarian work through its Strategic Plans (130,131), and the change in the context when UNFPA became the leader of the GBV AoR under the Global Protection Cluster of the Inter-Agency Standing Committee (99), provided an opportunity for the agency to leverage gender expertise of the GBV AoR to mobilise support and buy-in from humanitarian actors across sectors to position GBV as a priority issue.

- In the MENA Rosa and AGYW in South Africa cases, changes in external contextual factors aligned with UNAIDS Secretariat's strategic priorities and provided the impetus for change. This was seized by respective UNAIDS Secretariat regional and country gender experts. In the MENA Rosa case, the regional gender expert recognised that the demand from regional networks of WLHIV aligned with the UNAIDS Secretariat's strategic approach of investing in CSOs, particularly building women's leadership in the HIV response. In the case of AGYW in South Africa, secretariat staff at the country office leveraged national commitments aligned with agency strategic plans, prioritising women and girls and key populations. Through this process, staff identified strategic entry points to secure buy-in for comprehensive HIV programmes for AGYW.

- In the UNICEF GPR example, UNICEF's Strategic Plan (2018–2021) and GAP 2018–2021 provided the mandate and roadmap for GPRs as UNICEF's country offices were required to carry out a GPR at least once during a programme cycle (74,110). Regional gender advisors seized this opportunity and used the GPR processes strategically to initiate dialogue with supportive country office leadership to leverage support from government, UN, and civil society partners for gender-responsive country programming.

- In the UNDP Gender Equality Seal case study, once again it was UNDP's Strategic Plans (2008–2013) and most recent Gender Equality Strategy (2018–2021) that provided the organisational mandate backing gender equality and women's empowerment in the agency's work (132–134). Successive Directors of the Gender and Development team at headquarters, committed to gender equality and women's empowerment, mobilised internal support and funding for the design, pilot, and roll-out of the Gender Equality Seal.

A common thread running through these triggers is the importance of strategic positioning of gender equality work in organisation-wide strategic plans. In many cases, this alignment signalled the priority accorded to the gender team, securing buy-in and commitment from technical departments – crucial aspects in effecting and sustaining successful gender mainstreaming (see section 4.2.3).

Another pattern worth noting is that in 11 cases, the changes in contextual factors were favourable – funding opportunities, the creation of supportive institutional structures, or national government prioritisation of specific health issues. However, in three cases, the opposite was true. In these instances, changes in contextual factors were associated with unfavourable evaluation reports, which identified significant areas for improvement in terms of gender mainstreaming, as follows:

- In the UNFPA-UNICEF FGM case, the change in the context was an evaluation towards the end of the second phase of the Joint Programme, which highlighted that gender equality and women's empowerment had not received adequate priority (135). Despite the programme's acknowledged success in achieving its objectives in the earlier phases of the programme – reducing the incidence of FGM – there was commitment from the programme lead at global level to push towards the twin objectives of eliminating FGM and addressing the root causes of harmful practices. As a result, the programme lead intervened to support changes to the third phase of the programme (2018–2023), which sought to expand the range of interventions aimed at women's and girls' empowerment, and to change unequal gender norms (93).

- In the UNAIDS Secretariat IEP case, a critical report by the IEP called for changes in leadership and governance at the Secretariat, including strengthening human resource management functions and reforming internal policies and procedures to prevent harassment and abuse within the organisation (64). The PCB reacted and put pressure on senior management to respond to the recommendations and fully implement the Management Action Plan (136).

- In the case of UNICEF's GAPs, an evaluation in 2008 identified that UNICEF was not living up to its potential for gender mainstreaming because of the limited allocation of resources, weak gender architecture, and gaps in leadership and accountability (137). The agency's Executive Board was committed to making changes in response to the evaluation. In particular, the Executive Director was committed to social and gender equity and, as a response, hired an internationally renowned gender expert as the new Deputy Executive Director of Programmes, supporting her initiatives for gender mainstreaming across the agency. In turn, the newly appointed Deputy Executive Director hired a senior gender expert who led the development and execution of a more ambitious gender agenda.

These three case studies show that robust performance accountability mechanisms driven by executive-level bodies, which ensured that action was taken in response to the evaluations. The limited number of successful cases that arose from changes following evaluations may indicate that internal performance accountability mechanisms within agencies need to be further strengthened. On the other hand, these examples also illustrate the real opportunities for change that can be leveraged through evaluations when accompanied by robust performance accountability mechanisms.

Figure 4. Summary of contextual factors and mechanisms that triggered change

Figure 5. Contextual factors and mechanisms that triggered change by case

Case study 1:

Empowering girls and women to challenge harmful gender norms to improve menstrual health and hygiene (MHH) (UNICEF).

Case study 2:

Third phase of the UNFPA-UNICEF Joint Programme on the abandonment of female genital mutilation (UNFPA).

Case study 3:

Empowering women and marginalised groups living with HIV in the Middle East and North Africa region (UNAIDS).

Case study 4:

Comprehensive HIV programmes that empower adolescent girls and young women (AGYW) in South Africa (UNAIDS).

Case study 5:

Violence against women (VAW) acknowledged as a global public health priority (WHO).

Case study 6:

Gender-based violence (GBV) in humanitarian settings made a priority issue (UNFPA).

Case study 7:

Enhanced legal environments that enable the rights of women and girls, including key populations, in the context of HIV (UNDP).

Case study 8:

Institutional integration of gender in the Pan American Health Organization (WHO/PAHO).

Case study 9:

Institutional integration of gender through UNICEF's Gender Action Plans.

Case study 10:

Use of the Gender Programmatic Review (GPR) with country offices (UNICEF).

Case study 11:

Changes in institutional culture within UNAIDS to support gender equality linked to the Independent Expert Panel (IEP) report.

Case study 12:

Effective use of the gender marker within UNFPA.

Case study 13:

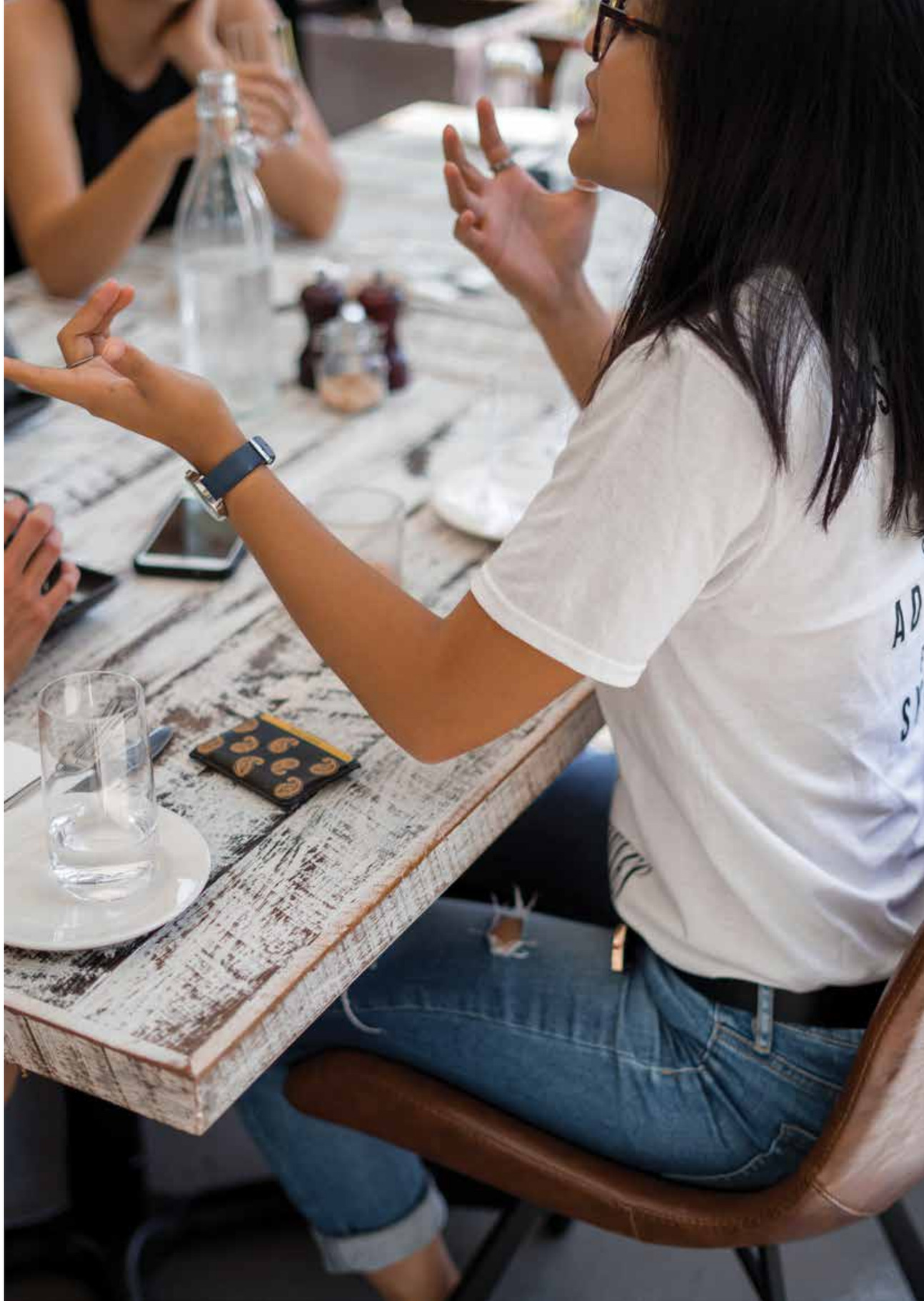
Effective integration of gender in Special Programme for Research and Training in Tropical Diseases (TDR) (WHO).

Case study 14:

Improved institutional and programmatic gender mainstreaming at country office level due to the Gender Equality Seal (UNDP).

LEGEND

External context	Internal agency context	Mechanism



4.2.2 What were the enabling contextual factors?

Although specific triggers precipitated successful outcomes, many contextual enablers needed to be in place to activate the triggers and facilitate the successful outcomes observed. These contextual enablers encompassed a range of conditions at multiple levels – global, UN system-wide, agency-specific, and national (see Annex 2 for infographics of the triggers, contextual enablers and sustaining mechanisms for each case study). Figure 6 summarises the main contextual enablers across cases and positions them in relation to triggers and common sustaining mechanisms, all of which collectively result in successful gender mainstreaming outcomes. Broadly, contextual enablers can be grouped into those external to individual agencies (e.g. global, UN system-wide, and national-level circumstances) and those internal or agency-specific (e.g. governance structures, processes, and staffing).

External contextual enablers

Feminist civil society movements and campaigns fuelled enabling political environments for tackling gender inequalities in health and contributed significantly to accelerating research and innovation around the differential impact of health programmes on women. CSOs also closed the gap between policymakers, implementers, and communities, advocating for increased attention to gender equality and the health needs of women and girls and other marginalised groups. For example, feminist movements were central in drawing significant attention to VAW as a health and women's rights issue (138). Currently, many feminist movements continue to fuel research on how development and health programmes differently impact women (139). Global acknowledgement of the harmful effects of FGM and active mobilisation by CSOs, and women's and human rights movements at the global level, have gained the attention of the UN, leading to the prioritising the tackling of harmful practices affecting women and girls and the launch of the Joint UNFPA-UNICEF Programme. More recently, the #MeToo movement catalysed a change in global attitudes and increased advocacy and momentum, strengthening awareness and calls for action against sexual harassment and abuse – an enabling circumstance related to the IEP case.

UN conventions, declarations and resolutions on gender equality, such as CEDAW in 1979, the 1995 Beijing Conference, the UN Economic and Social Council resolution on gender mainstreaming in 1997, the 2000 Millennium Development Goals, and most recently the 2015 Sustainable Development Goals, secured commitments from national governments to address gender inequalities, including those related to health, and provided agencies with supportive frameworks to underpin work on gender mainstreaming (27,34,43). In some of the case studies, sector-specific resolutions and political declarations were also found to serve as contextual enablers. For example, the UN General Assembly 2016 Political Declaration on Ending AIDS called on governments to reduce new HIV infections among AGYW, and promote access to tailored comprehensive HIV prevention services for women and adolescent girls, migrants, and key populations (140). This provided the political buy-in necessary to secure Member State support for tackling HIV among AGYW as a public health priority.

Member State support or pressure on particular health issues created conducive environments within which successful outcomes emerged, particularly in cases of programmatic gender mainstreaming. In the FGM case, national government commitments to eliminating FGM, and in some countries positioning FGM in a larger national agenda of gender equality, sexual and reproductive health and human rights, together with the presence of strong feminist civil society movements (141,142), created enabling environments within which the Joint Programme on the abandonment of FGM could evolve to tackle the unequal power relations, structures and norms that sustain harmful practices. A second example is the priority accorded to gender equality in PAHO, backed by the support for gender equality in the region's Member States, which creates pressure on the regional office to keep gender equality on the agenda. Widespread support from Member States for gender mainstreaming played a significant role in developing an organisational mandate for advancing gender equality in health in PAHO. Inextricably linked to Member State support was the conducive contextual environment created by strong feminist movements in many countries in the region.

Interagency collaboration leveraging complementary agency strengths stood out in several cases as a powerful contextual enabler for successful gender mainstreaming efforts. This was particularly the case for UNFPA programmes focusing on gender equality and women's empowerment, many of which are planned and implemented jointly with other UN agencies. For example, the UNFPA-UNICEF Joint Programme on the Abandonment of FGM is coordinated and administered by UNFPA but jointly implemented by UNFPA and UNICEF (93). The programme builds on the respective strengths of the two agencies, particularly UNICEF's extensive operational capacity, to work at global, regional and country levels, a well-resourced Communication for Development Unit within UNICEF, and gender expertise across both agencies. Another example is UNFPA's role as the lead of GBV AoR under the Global Protection Cluster. In this case UNFPA also effectively channelled the strengths of different agencies to support countries in addressing GBV in emergencies through field operations, capacity-building, setting norms and standards and advocating for increased action, research and accountability (99).

Donor interests and commitments towards particular issues were also identified as critical contextual enablers. For example, in the UNDP HIV and the law case, Global Fund and PEPFAR emphasised investments in human rights-based programmes for HIV prevention (143). In addition, there was funding from several other donors (UNAIDS, UNFPA, UNICEF, Health Canada, the Norwegian Agency for Development Cooperation, and the Swedish International Development Cooperation Agency) to scale up work on human rights and HIV programmes.[13]

Similarly, in the AGYW case study, South Africa was the recipient of the Global Fund's catalytic funding and PEPFAR's Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative, both of which were important funding sources that supported the implementation of comprehensive HIV programmes for AGYW (144,145).

UN system-wide performance and financial accountability framework on gender equality and women's empowerment (UN-SWAP), in some case studies, was mentioned as contributing to an enabling environment for gender mainstreaming, with its monitoring frameworks and gender indicators (58). In the case of UNFPA's successful institutionalisation of the gender marker (which is one of the UN-SWAP indicators), it provided a common set of standards that has helped maintain financial allocations for programmes that advance gender equality and women's empowerment (58). However, concern was expressed that the UN-SWAP indicators are heavily process-focused instead of outcome-focused. For example, although there is an indicator for how much is allocated or budgeted for gender mainstreaming, there is no indicator for how much is actually spent on gender mainstreaming.

Internal contextual enablers

Internal contextual features specific to each agency were also critical in creating an enabling environment. The following features allowed for the activation of triggers and enabled other sustaining mechanisms to occur, ultimately leading to successful gender mainstreaming outcomes.

Organisational structures that provided autonomy and supportive governance were crucial enablers in shaping and implementing strategies to strengthen programmatic and institutional gender work. In two of the WHO cases (VAW and TDR), the unique governance structures of the special programmes (the Special Programme of Research, Development and Research Training in

[13] Information derived from interviews.

Human Reproduction (HRP) and TDR) gave them greater autonomy than other WHO departments and allowed them to prioritise work on gender equality within their respective health areas of focus (121,146). Another example is UNICEF's streamlined governance structure. The Executive Board is responsible for major decisions with decision-making authority vested in the Executive Director and Regional and Country Directors. This feature, in combination with the agency's vast network of field offices, has meant that well-designed plans originating from headquarters have a high probability of positively drawing attention to gender equality at all levels of the organisation.

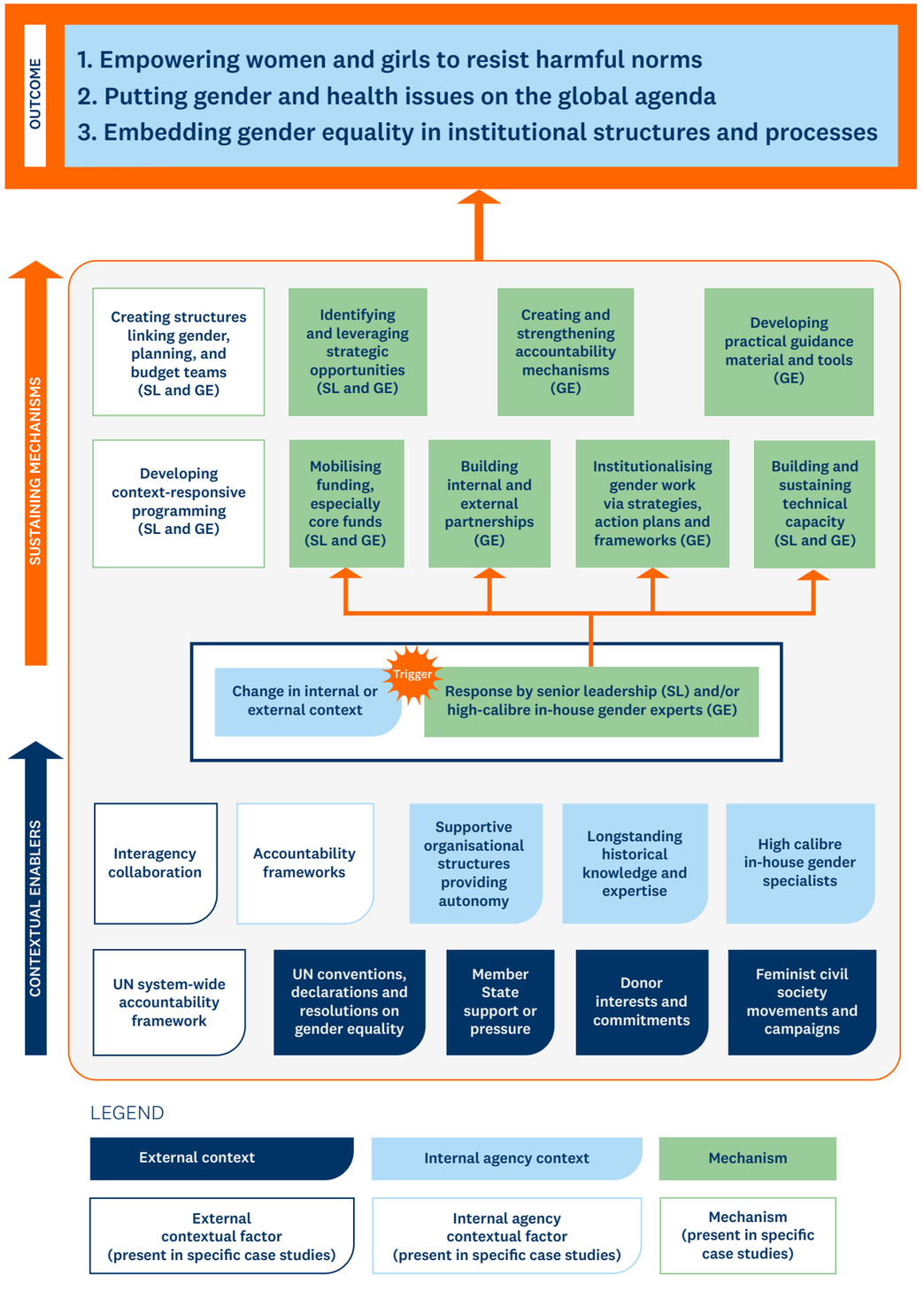
High calibre and committed in-house gender specialists, sufficiently and highly positioned at headquarters, regional and country offices, were critical for success across all cases. Having a stable and well-staffed gender team was essential to identifying and leveraging strategic opportunities, providing technical support and advice, and developing tools and guidance. For example, in the MHH case study, support from the leadership of the WASH programme and the presence of competent gender experts in headquarters and regional offices were crucial enablers that strengthened the MHH programme. Gender experts created an evidence base documenting how MHH programmes met other UNICEF priorities besides hygiene, sanitation and gender, such as education (keeping girls in school) and child protection (preventing exposure to the risk of GBV when defecating in open spaces) (110,147). The evidence base, in turn, strengthened buy-in for the programme across UNICEF. Furthermore, UNICEF's strengthened gender architecture meant that gender expertise was available to launch the programme successfully.

Longstanding historical knowledge and expertise working in specific health areas was an important contextual enabler across many of the cases, with respect to both successful programmatic and institutional gender mainstreaming. One example is UNFPA's long track record of promoting health sector responses to GBV in development settings and expertise in gender (148). UNFPA has been working on sexual and reproductive health and GBV in emergencies since 1994 and was among the early advocates for prioritising GBV in humanitarian settings (102). This historical knowledge and expertise created an enabling environment for UNFPA to advocate for the prioritisation of prevention services for GBV in emergencies. Another example is TDR, which has built up a body of knowledge on gender and tropical diseases since 1995 (149). This has led to the emergence of a core group of global experts working on gender and tropical diseases, an enabling contextual factor for the effective mainstreaming of gender dimensions throughout TDR's work (149,150).

Although not present in most of the cases, **strong performance accountability frameworks** were identified as essential contextual enablers in the three cases where triggers were associated with unfavourable evaluations. For example, in the FGM case study, the programme had strong performance accountability frameworks in place linked to a reflexive and responsive programme design, with regular evaluations and recommendations made for further improvement. In addition to leadership commitment to enacting the recommendations, an annual report makes them publicly accountable for its progress (93).

> "Having a stable and well-staffed gender team was essential to identifying and leveraging strategic opportunities."

Figure 6. Key triggers, contextual enablers and sustaining mechanisms for successful gender mainstreaming in health



4.2.3 What were the sustaining mechanisms?

In addition to the triggers and contextual enablers, several crucial actions led by key actors (e.g. senior leadership and in-house gender experts at headquarters, regional or country offices), created and sustained the changes that led to the successful outcomes documented (see Figure 6). Six main sustaining mechanisms were identified:

Institutionalising gender equality work through strategies, action plans and other frameworks. Across many cases, the development and implementation of action-oriented strategies, action plans, and other institutional frameworks that explicitly prioritised work on gender equality were critical to sustaining gains. The development and implementation of these institutional frameworks meant that success was less reliant on individual actors over time, allowing for gender mainstreaming work to be scaled up, which then resulted in organsational-wide impacts. In the PAHO case, the 2009–2014 and 2015–2019 Plan of Action supported the implementation of the Gender Equality Policy, which had been adopted as a resolution by the PAHO Directing Council in 2005 (109,151). The Gender Equality Policy and Plan of Action apply to PAHO and Member States, and include specific indicators with reporting mechanisms (152). The introduction of results-based management for the 2014–2019 Strategic Plan provided the Office of Equity, Gender and Cultural Diversity with the opportunity to introduce outcomes and outputs related to gender and other cross-cutting themes into the Programme of Work and Programme Budget (153). Similarly, the gender marker has been institutionalised within UNFPA's financial resources planning and disbursement systems (83). It is a mandated aspect of UNFPA's work plan creation and subsequent programme monitoring of all programme funds (119). The gender marker has been instituted in all the country offices and applied to all programmes.

> "Across the case studies robust performance accountability structures were identified as critical mechanisms to accelerate and sustain gender mainstreaming efforts."

Creating and strengthening internal and external performance accountability mechanisms. Across the case studies robust performance accountability structures were identified as critical mechanisms to accelerate and sustain gender mainstreaming efforts, linked to the institutionalisation of gender equality work. For example, UNICEF's GAP includes MHH indicators, which enforce regular reporting on progress from the MHH programme to the Executive Board and in the GAP annual report (110,154). In the VAW case study, the Gender and Rights Advisory Panel of HRP and SRH consists of external experts, which aims to facilitate the integration of gender concerns across work in HRP and SRH (155). This has served as an external performance accountability mechanism since its inception, monitoring and supporting the programme. In the VAW case study performance accountability is also enforced through the 2016 WHA Resolution on the Global Plan of Action and reporting to WHA against WHO's GPW13 (97,98). Within the UNAIDS Secretariat, the IEP investigation report triggered recognition by the PCB of the need to strengthen its oversight and accountability roles and responsibilities (64). Accountability around internal and external audits and ethics is now a stand-alone agenda item in PCB meetings. The Bureau of the PCB also directly engages with independent offices, supporting internal oversight at the Secretariat (156–158).

Developing practical guidance material and tools. This included the development of high-quality guidance materials to provide technical support to national stakeholders and to support internal capacity-building within agencies. Having competent in-house gender experts to provide area-specific technical support and guidance was key. In the MHH case study, the WASH programme lead, who had gender expertise, produced a series of guidance tools to enable gender-responsive programming. The tools outlined concrete gender-transformative actions, such as the inclusion of women on WASH committees, providing practical guidance on monitoring MHH interventions, and including a list of indicators to ensure that objectives were met (147).

In the HIV and the Law case, along with training manuals, capacity-building initiatives focused on human-rights based approaches to litigation, advocacy on HIV and TB, legal defence, and legal environmental assessments.[14] These resources enabled governments and civil society to design tailored country-specific capacity and advocacy activities to demonstrate how legal mechanisms can work for women, girls and key populations in the context of HIV. In the VAW case study, a whole host of normative work was produced by experienced gender experts, including: evidence-building on prevalence and health consequences, and effective interventions (159); standard-setting through clinical guidelines and handbooks for the care of survivors (160,161); guidelines for ethical research and strengthening health systems in response to VAW (162,163); and technical support and capacity-building among Member States to develop policies and programmes on health sector responses to VAW. The tools and guidance documents were developed into training materials in simple, operational and jargon-free language that made them user-friendly for partners, such as Ministries of Health, to implement (164).

Building and sustaining internal and external gender capacity. Within UNICEF in 2011, the Deputy Executive Director of programmes and the Principal Advisor on Gender both prioritised institutional funds for building a gender architecture at a time when it was lacking. With financial resources of USD 12 million, three senior P5-level positions were created at headquarters, and new P5-level senior regional advisors were added in each of the seven regional offices (110,118,165). These posts were funded from the core funds allocated for institutional strengthening to implement GAP 2014–2017 and GAP 2018–2021. A new standard was also issued as guidance to country offices by the Deputy Executive Director to build gender architectures. For country offices with budgets of more than USD 20 million, at least one dedicated Gender Specialist should be employed at P3 and P4 levels (118). For country offices below this budgetary threshold, a gender focal point with at least 20% dedicated time was required to meet the standard. Coupled with the GAP 2014–2017 and GAP 2018–2021, the strengthening of gender architecture contributed to important advancements in gender equality work across the agency.

In the UNDP Gender Equality Seal case, capacity-building and training initiatives with country office staff, facilitated by internal and external gender experts, were characterised by a constant reflective learning process and incorporating key learnings on gender equality into country office practices and processes. Such an action-oriented and co-learning approach enabled staff to identify best practices, implementation gaps, and potential alliances and opportunities for collaboration, including among staff at lower levels. Notably, UNDP's Gender Team also leveraged these capacity-strengthening activities to reinforce staff and country office buy-in and ownership of the Gender Equality Seal certification process.

[14] Examples of guidance materials and tools reported in interviews: In 2014, UNDP published a practical manual for conducting national dialogues on HIV and the Law; at the participating judges' request, UNDP maintains a judicial database that shares global good practice on judgements, as well as relevant laws and materials on HIV and TB prevention, treatment, and care; UNDP has developed an operation guide for governments, civil society and other key stakeholders to systematically assess national legal, regulatory and policy environments related to HIV.

The MENA Rosa case presents an example of external capacity-building. From the onset, regional gender experts and country office teams had committed to ensuring the independence and sustainability of MENA Rosa following the termination of financial support from the Secretariat. Accordingly, the regional office prioritised the building of MENA Rosa's capacity to mobilise resources, design and develop proposals, and build collaborations with other CSOs and donors (e.g. USAID and the Global Fund). The increase in capacity has enabled MENA Rosa to become autonomous and self-sufficient.

Mobilising dedicated and sustained funding, especially core funds. In PAHO, while there is no benchmark for budgetary allocation, there is a committed core budget for work on cross-cutting themes, including gender equality – approximately USD 12.6 million in 2018–2019 and USD 7 million in 2020–2021 for cross-cutting themes (166,167). Similarly, gender work in TDR receives support from core funding. Both case studies illustrate how long-term core funding has ensured that work on gender equality is sustained, although the recent significant reduction in committed core budgets on cross-cutting themes in PAHO is a cause for concern.

In the HIV and the Law case, beyond initial funding allocations to establish the Global Commission and its activities, technical staff within the HIV and Health Group made deliberate efforts to mobilise and leverage internal and external funding for the implementation of some of the critical recommendations. Technical and programme staff leveraged donor interests and commitments to mobilise resources from within the UN, such as the UNAIDS Secretariat, UNFPA, and UNICEF, and other funding agencies (e.g. the Global Fund, Health Canada, Norad, Sida) to scale up programmatic work.

Building internal and external partnerships. These were important mechanisms for generating buy-in and support and ensuring the sustainability of gender equality work within health programmes and at an institutional level. These partnerships included other interagency technical programmes, national governments, CSOs, and affected communities. In the UNICEF GPR case study, for instance, the gender advisor and gender specialist looked for opportunities to forge new partnerships via the GPR process. For example, a women's forum in the Kyrgyzstan Parliament and the National Women's Union in Kosovo became involved in the GPR process. Their involvement developed into long-term partnerships, enabling changes on the ground. Another example is the WHO VAW case, where soon after establishing the VAW programme, buy-in was sought from other internal technical programmes, such as maternal health and HIV. Alliances were forged with the HIV department, resulting in the prioritisation of VAW as part of the response to the HIV epidemic. In the UNFPA GBV in humanitarian settings case, building sustainability through country and community ownership, as well as partnerships with local organisations, was another mechanism that facilitated changes on the ground. The GBV programme recognises local organisations' strengths in terms of rapid responses in emergencies and knowledge of the specific contexts. The programme has worked in partnership with government agencies, women's organisations, and women's rights activists to establish a national system for responding to GBV in emergencies.

The case studies identified other important sustaining mechanisms, but these only applied to certain cases:

Creating structures that linked planning and budgeting functions with work on gender equality. In PAHO, the Office of Equity, Gender and Cultural Diversity is represented in the Strategic Planning Advisory Group with representatives from Member States and technical departments. This enabled direct input into strategic planning processes and the foregrounding of gender as a priority across technical programmes. Both the organisational mandate provided by PAHO's Gender Equality Policy, and the presence of the Office of Equity, Gender and Cultural Diversity in the Strategic Planning Advisory Group contributed to gender and other cross-cutting themes of equity, human rights and cultural diversity being prioritised in the strategic plans for 2014–2019 and 2020–2025 at the level of outcomes and outputs (152,153,168). An impact indicator is included at the Member State level. In addition, all technical departments and country offices must report to executive management on progress measured against the gender equity and ethnicity indicators. Importantly, Member States also report on specific indicators, disaggregated by sex and other demographic variables.

Identifying and leveraging strategic entry points includes shifting responsibility for gender equality priorities from gender experts to senior leadership. For instance, while the Gender Equality Seal provides a systematic roadmap to transform organisational settings, progress and success have only occurred when this has been regarded as a priority, rather than an add-on to daily tasks. In this regard, senior leaders were explicitly leveraged as champions and drivers of change, helping to shift the responsibility for gender prioritisation at the country office from gender experts to senior leadership.

Developing context-responsive programming and stakeholder involvement for the sustainability of gender-responsive country programming. In the MHH and FGM cases, considerable effort was made to develop programme activities that responded to specific local needs. The human-centred design process involved adolescent girls in the knowledge-building process within specific settings. Practice-based knowledge was valued, and the experiences shared by programme implementers became part of the evidence base on programme outcomes.

Although not an explicit mechanism, analyses illustrate the **importance of institutional gender integration in achieving successful programmatic integration**. For example, the successful integration of gender equality through UNICEF's GAPs provided the institutional mandate for change and became a trigger for successes initiated through the GPR processes at the country level, with support from regional teams. In turn, this successful gender-responsive country programming became an enabling contextual factor for implementing the MHH programme.

It is important to note that this pathway is not linear, such that once the crucial institutional mechanisms are in place, there is only forward movement on the programmatic front. Experience in most agencies has shown that an organisational mandate can lapse, strong gender departments can be dissolved, and core budgetary allocations can disappear. In this regard, social accountability mechanisms comprising external actors and alliances with the feminist movement and civil society actors can help defend the gains made and resist push-back.

5

Discussion and the way forward

5.1 Key ingredients of success

This project set out to identify the key factors necessary to leverage opportunities in order to produce substantial and sustained advances in gender equality in health within the UN system, as well as other multilateral and bilateral global health organisations. Five key elements of success consistently stood out among the 14 case studies (see Figure 7), each one described here in detail:

1. The power of leaders and gender experts

Leadership at the highest levels and gender experts at all levels (headquarters, regional and country-level) were key to the positive outcomes seen across all of the case studies. These individuals were pivotal in terms of catalysing, accelerating and sustaining positive changes that led to the successful outcomes observed. In particular, successes were sustained when leadership support was coupled with investment in gender architecture, especially through dedicated core funds. Health area-specific gender expertise was critical in the development of normative documents, tools and training manuals, which all contributed to considerable advancements in work on gender equality within specific fields.

For example, within UNICEF, a leading gender expert was appointed as Deputy Executive Director of Programmes. She, in turn, appointed and funded a Principal Gender Advisor at headquarters, who, in turn, mobilised funding and internal processes to hire senior regional gender advisors. As part of this process, large country offices were encouraged to hire their own gender specialists. The presence of these, often exceptional, gender leads/advisors/specialists with content expertise in health led to the implementation of gender-responsive health programmes at the country-level.

It is important to note that although gender parity in leadership was important, it was by no means sufficient. The skillsets, knowledge, and competence of those appointed individuals were the main factors of success. The case studies reinforce the point that gender expertise in health is a specific area of expertise in its own right, and investing in that expertise is necessary to successfully address gender inequalities in health programmes.

2. The power of institutional structures

To translate leadership commitments into concrete action, institutions required sufficient infrastructure to be able to advance the gender equality agenda. Internally, this institutional readiness involved: ensuring direct links between the gender team and the budget/planning teams, bringing the gender mainstreaming agenda directly into the decision-making arena; building strong performance and financial accountability mechanisms at headquarters, and in regional and country offices; and making gender equality in health part of the organisation's core business. The latter involved not just gender action plans, but a reflection of work on gender equality in all broader organisational strategy documents and programme budgets, with measurable outcome and output indicators. Other institutional features associated with successful examples included the autonomy of programmes with respect to decision-making and prioritising work on gender equality, complemented by adequate financial backing.

In PAHO, for example, in-house structures for participating in the organisation's strategic planning process and coordinating work across various technical areas greatly facilitated mainstreaming gender across different technical areas. The Office of Equity, Gender and Cultural Diversity is represented in the Strategic Planning Advisory Group with representatives from Member Countries and Technical Departments. This enabled direct input into strategic planning processes and the foregrounding of gender as a priority across technical programmes. Both the organisational mandate provided by PAHO's Gender Equality Policy, and the presence of Office of Equity, Gender and Cultural Diversity in Strategic Planning Advisory Group contributed to gender and other cross-cutting themes of equity, human rights and cultural diversity being prioritised in the Strategic Plans for 2014-19 and 2020-2025 at the level of outcomes and outputs; and the inclusion of an impact indicator at the level of Member States (152,153,168). In addition, all technical departments and country offices had to report to executive management on progress made against the gender equity and ethnicity indicators. Importantly, Member States also reported on specific indicators, disaggregated by sex and other stratifiers.

3. The power of feminist civil society

Forming effective partnerships with women's rights organisations was an essential component for implementing gender-responsive health programmes and ensuring that programmes were grounded in ethical principles and encouraged local ownership and sustainability. The significant contribution of feminist CSOs was particularly notable where agencies built meaningful partnerships whereby programmes and priorities were jointly defined and shaped. Partnerships with feminist CSOs also helped to strategically position work within national priorities. Agency investment in strong partnerships with women's movements involved building trust, creating processes for feedback, external social accountability, and sustained engagement. However, simply having civil society representation alone was not enough. Partnering with the right CSO was important to ensure that they provided genuine representation of specific groups and were grounded in feminist ethics.

For instance, UNAIDS is the only agency within the UN to have civil society representation in its governing body and has an ingrained culture of feminist civil society engagement in its HIV response. Among its successes has been the support of networks of women and marginalised groups living with HIV in the MENA region (88,94,95). Effective and meaningful partnerships that foster feminist civil society expertise has brought the constituency into global, regional and national planning and prioritising processes. In addition, this has enabled these groups to function as pressure points, creating mechanisms for external social accountability.

4. The power of evidence

Evidence and programmatic learning have proved central to driving action and change. The success cases illustrate how data and evidence have been used not only to showcase the problem, but also to demonstrate what works and how to be more effective. Evidence-based reflexive learning has pushed programme implementers to prioritise approaches that meet practical gender-specific needs as well as challenge harmful gender norms.

For example, UNDP is the Secretariat for the Global Commission on HIV and the Law and has played a leading role in articulating and advocating for the development of legal environments that transform global and national HIV responses. UNDP supported the production of the Global Commission's 2012 flagship report and the 2018 supplementary report (169,170). These reports provided a set of coherent and compelling evidence-based and actionable recommendations on removing punitive and discriminatory laws, policies and practices that impact women and fostering those which advance women's rights and empowerment in the context of the HIV response. Building on this work, technical staff within UNDP's HIV, Health and Development Group, have provided financial and technical support that focuses on evidence-building efforts related to policies, laws, regulations, and legislation that negatively impacts health and wellbeing, including those pertaining to the rights of women, girls, and marginalised groups. This evidence has built a consensus on the kinds of critical actionable steps that national stakeholders can take to generate supportive legal environments and policy at the intersection of HIV and human rights.

5. The power of the collective

As several cases highlighted, interagency efforts have had real impacts on the ground and offer important opportunities for advancing gender equality efforts in health. Successful interagency collaboration has occurred when the comparative advantages of each agency involved – their unique agendas, expertise and partnerships with government sectors and different feminist civil society movements – were fully leveraged.

The UNFPA cases demonstrate the potential power of successful interagency partnerships. For instance, the UNFPA-UNICEF Joint Programme on the abandonment of FGM has been able to draw on UNICEF's comparative advantages. This includes a large field presence, programme experience in the area of child protection, and a well-resourced Communication for Development Unit, which further amplified the message of FGM as an issue of gender inequality. The programme also benefited from UNICEF's expertise in programmatic gender mainstreaming. In addition, UNFPA as the leader of the GBV AoR under the global protection cluster, has also leveraged the strengths of different agencies (148).

Figure 7. Five ingredients for successful gender mainstreaming

The Power of Leaders and Gender Experts

Leaders can catalyse, accelerate and sustain success, by investing in gender architecture across the organisation with dedicated core funds.

- Leverage committed and responsive leadership
- Invest in highly qualified, strategically positioned, gender experts

The Power of Institutional Structures

Organisational strategies that include gender equality with measurable outcome and output indicators, links between gender teams and budget planning teams, and strong performance and financial accountability mechanisms were gamechangers.

- Create organisational strategies that include gender equality outcome indicators
- Build links between gender teams and budget planning teams
- Strengthen internal performance and financial accountability mechanisms

The Power of Feminist Civil Society

Feminist civil society expertise and pressure can ensure alignment with local priorities, grounding in ethical frameworks, external accountability and sustainability.

- Build meaningful partnerships in programme design, implementa on, M&E
- Embed feminist civil society groups in institutional governance structures

The Power of the Collective

Joint interagency collaboration can have real impacts on the ground when comparative advantages of the agencies involved are leveraged.

- Build the evidence base on health burden and solutions
- Design programmes to be reflexive and responsive to evidence

The Power of Evidence

Evidence, data and programmatic learning that shows what works (and what the problem is) can drive action and change.

- Leverage unique normative, operational and coordination roles
- Capitalise on agency-specific agendas and expertise

5.2 Areas for further attention

Although this project focused on distilling crucial ingredients for successful programmatic and institutional gender mainstreaming, it also brought to the fore several factors within the UN system that appear to work against advancements in gender equality in health.

A need to focus on outcomes and not primarily processes

Across the five agencies, there was widespread focus on processes rather than outcomes in gender mainstreaming. This feature tended to mask the slow progress made in the field and sometimes gave an inflated sense of achievement. For example, where agencies carried out normative and standard-setting work, the production of knowledge and guidance documents was often seen as a success, without any indication of the uptake, use or impact of these knowledge products on gender equality outcomes in health programmes. Similarly, the amount of time spent by staff reporting on UN-SWAP indicators (processes) raised the question of whether better value-for-money could be achieved by staff working on gender-equitable health programmes, given that in-house gender expertise is already limited in capacity. Linked to this point is the common notion that gender equality needs to be integrated into all programmes rather than prioritising specific areas of focus given the already limited resources and capacity for gender mainstreaming within many agencies. This was a recurrent theme that emerged from the case studies, which illustrated that successes like the FGM Joint Programme and MHH are possible when a targeted approach is adopted.

A need to prioritise other health areas and health systems

On the whole, across all agencies, programmatic gender mainstreaming efforts exhibited a narrow focus on limited health areas and insufficient prioritisation of key areas of health systems. Most gender mainstreaming efforts centred around GBV, harmful practices (e.g. FGM and child marriage), and HIV/AIDS. Some agencies had undertaken gender equality work in other health areas like immunisation, WASH, communicable diseases research, and ad hoc work on human resources and universal health coverage. However, these programmes were few and far between and constituted a small fraction of agencies' portfolios. Efforts to integrate gender into major programmes of work in areas with large burdens of disease (e.g., non-communicable diseases, emerging infectious diseases) or health system blocks (e.g. service delivery and the health workforce) have proven difficult and, so far, unsuccessful. A strategic approach that prioritises one of these major areas as an entry point for gender mainstreaming, backed by adequate financial resources and technical expertise, could have widespread impact and catalyse a snowball effect for successful programmatic gender mainstreaming in other areas.

Building better links between institutional and programmatic gender mainstreaming

The case studies identified the links between institutional and programmatic gender mainstreaming that are often integral for successful outcomes to be achieved. For instance, an organisational mandate, performance-based accountability mechanisms, strong gender architecture and budgetary allocations are all important for enabling programmatic gender mainstreaming. However, these findings also highlight the insufficient linkages and learning that occurs the other way around, namely programmatic gender mainstreaming lessons informing institutional efforts. For example, there is a disjuncture between evidence and normative work on sexual violence on the programmatic side, and a disregard for survivor-centred approaches in responding to sexual exploitation, abuse, and harassment on the institutional side. Another example is the evidence with respect to transforming gender norms and power structures at the community level through programmatic work, which is rarely used to inform institutional training on gender equality. More specifically, programming and practice-based conceptual frameworks have moved beyond the individual level to the couple/relationship level and the community level in the ecological model (171). UN gender training, however, continues to be based on individual behaviour change models. This unidirectional view of the relationship between institutional and programmatic gender mainstreaming misses ripe opportunities to improve gender equality within organisational structures, processes, and work culture. Ultimately, this negatively impacts on programmatic work, since internal organisational mainstreaming is often a pre-condition for successful gender mainstreaming in operational functions (172).

5.3 The way forward

This particular moment is an opportune time to rethink and improve work on gender equality in health, especially in the face of the current health, demographic, social, environmental and political changes. The silver lining of the COVID-19 pandemic is the unique opportunity it presents to do things differently, with political commitments to prioritise gender equality already emerging (3,26). The global nature of many of the challenges means that a response supported through an effective multilateral system is needed, with the UN and its agencies strategically well-placed to lead the agenda of gender equality in health. This project, which has supported agencies to learn from past experiences and build on outcomes where gender has been successfully integrated both institutionally and programmatically into core business, offers three important recommendations with respect to the way forward:

1. **Invest in high-quality, strategically positioned gender experts with decision-making power at headquarters, and regional and country offices. These positions should receive core funding to ensure their sustainability.**

   - For stand-alone gender teams within agencies to be effective, there is a need for gender experts to be strategically situated in major health programmes. Seeking out individuals (not just women) with gender expertise in health to fill these positions is critical.

   - To ensure that successes are built upon and erosion of hard-won gains is avoided, leadership in each agency should prioritise the maintenance of the organisation's gender architecture, even during financial downturns.

2. **Combine well-crafted organisational mandates with robust performance and financial accountability mechanisms to publicly track and report outcomes.** Support gender equality goals both institutionally and programmatically by moving beyond marker allocations with respect to funding and spending.

   - Commitments to gender equality need to be reflected in all organisational strategy documents, as well as programme budgets, with measurable outcome and output indicators. Gender strategies can then augment and support these commitments. A twin-track approach, whereby gender equality is integrated with programmatic results, as well as in targeted priorities, has shown promising results.

   - There is a need for performance and financial accountability mechanisms to ensure accountability to gender equality and health outcomes, rather than only gender mainstreaming processes, and to actual expenditures rather than simply budgets for work on gender equality. Linked to this is the need to go beyond self-reporting to include strict validation criteria in order for such tracking to be meaningful.

3. **Identify and seize expected and unexpected changes in contextual factors.** These could include, for example, exceptionally committed senior leadership, savvy gender expertise and leadership, strong donor interest, disruption due to crises, positive shifts in strategic advantage, and organisational restructuring. Changes present opportunities to create more gender-responsive programmes, put gender and health issues on the global agenda, or strengthen institutional practices such that gender equality in health and other programming is prioritised.

Meeting the challenge and opportunity of advancing gender equality in health programmes and institutional structures at this critical point in time requires collective action, building on existing evidence and knowledge.
This report makes an important contribution in this regard, identifying the elements that worked institutionally and programmatically to promote gender equality in health in the UN system. Looking forward, it is imperative that these practice-based lessons are used to inform work on gender equality in health within UN agencies, as well as other multilateral and bilateral health organisations.

References

1. World Health Organization. (2021). Coronavirus (COVID-19) Dashboard. https://covid19.who.int

2. United Nations (2021). Sustainable Development Goals Report 2021. https://unstats.un.org/sdgs/report/2021/The-Sustainable-Development-Goals-Report-2021.pdf

3. Fisseha S, Sen G, Ghebreyesus TA, Byanyima W, Diniz D, Fore HH, et al. (2021). COVID-19: the turning point for gender equality. The Lancet. 398(10299):471–4. https://doi.org/10.1016/S0140-6736(21)01651-2

4. Bambra C, Riordan R, Ford J, Matthews F. (2020). The COVID-19 pandemic and health inequalities. J Epidemiol Community Health. 74:964-968. http://orcid.org/0000-0002-1294-6851

5. United Nations. (2020). Policy Brief: The Impact of COVID-19 on Women. https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406

6. Bourgault S, Peterman A, O'Donnell M. (2021). Violence against women and children during COVID-19— One year on and 100 papers in: A fourth research round up. Center for Global Development. https://www.cgdev.org/sites/default/files/vawc-fourth-roundup.pdf

7. Mahapatro M, Prasad MM, Singh SP. (2021). Role of Social Support in Women facing Domestic Violence during Lockdown of Covid-19 while Cohabiting with the Abusers: Analysis of Cases Registered with the Family Counseling Centre, Alwar, India. J Fam Issues, 42(11):2609–24. https://doi.org/10.1177/0192513X20984496

8. UNFPA .(2021). Impact of COVID-19 on Family Planning: What we know one year into the pandemic. Technical Note. https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf

9. Hunie Asratie M. (2021). Unintended Pregnancy During COVID-19 Pandemic Among Women Attending Antenatal Care in Northwest Ethiopia: Magnitude and Associated Factors. Int J Womens Health. 18;13:461–6. https://doi.org/10.2147/IJWH.S304540

10. Boniol M, McIsaac M, Xu L, Wuliji T, Diallo K, Campbell J. (2019). Gender equity in the health workforce: Analysis of 104 countries. World Health Organization. https://apps.who.int/iris/handle/10665/311314.

11. Shaukat N, Ali DM, Razzak J. (2020). Physical and mental health impacts of COVID-19 on healthcare workers: a scoping review. Int J Emerg Med, 13(1):40. https://doi.org/10.1186/s12245-020-00299-5

12. Daalen KR van, Bajnoczki C, Chowdhury M, Dada S, Khorsand P, Socha A, et al. (2020). Symptoms of a broken system: the gender gaps in COVID-19 decision-making. BMJ Glob Health, 1;5(10):e003549. http://dx.doi.org/10.1136/bmjgh-2020-003549

13. Risberg G, Hamberg K, Johansson EE. (2006). Gender perspective in medicine: a vital part of medical scientific rationality. A useful model for comprehending structures and hierarchies within medical science. BMC Med, 4(1):20. https://doi.org/10.1186/1741-7015-4-20

14. Ravindran TKS, Kelkar-Khambete A. (2008). Gender mainstreaming in health: looking back, looking forward. Glob Public Health. 3(sup1):121–42.

15. Ravindran TS, Teerawattananon Y, Tannenbaum C, Vijayasingham L. (2020). Making pharmaceutical research and regulation work for women. BMJ, 3 Suppl 1, 121–142. https://doi.org/10.1080/17441690801900761

16. Goldstein RH, Walensky RP. (2019). Where Were the Women? Gender Parity in Clinical Trials. N Engl J Med. 26;381(26):2491–3. https://doi.org/ 10.1056/NEJMp1913547

17. Schiebinger L. (2003). Women's health and clinical trials. J Clin Invest, 1;112(7):973–7. https://doi.org/10.1172/JCI19993

18. Galdas PM, Cheater F, Marshall P. (2005). Men and health help-seeking behaviour: literature review. J Adv Nurs, 49(6):616–23. https://doi.org/10.1111/j.1365-2648.2004.03331.x

19. Bali S, Dhatt R, Lal A, Jama A, Van Daalen K, Sridhar D. (2020). Off the back burner: diverse and gender-inclusive decision-making for COVID-19 response and recovery. BMJ Glob Health, 5(5):e002595. http://dx.doi.org/10.1136/bmjgh-2020-002595

20. Cahill S, Grasso C, Keuroghlian A, Sciortino C, Mayer K. (2020). Sexual and Gender Minority Health in the COVID-19 Pandemic: Why Data Collection and Combatting Discrimination Matter Now More Than Ever. Am J Public Health, 110(9):1360–1. https://doi.org/10.2105/AJPH.2020.305829

21. Baker P, Shand T. (2017). Men's health: time for a new approach to policy and practice? J Glob Health, 7(1):010306. https://doi.org/10.2105/AJPH.2020.305829.

22. World Health Organization. (2020). Basic documents, 49th ed. World Health Organization. https://apps.who.int/iris/handle/10665/339554

23. van Daalen KR, Bajnoczki C, Chowdhury M, Dada S, Khorsand P, Socha A, et al. (2020). Symptoms of a broken system: the gender gaps in COVID-19 decision-making. BMJ Glob Health, 5(10):e003549. http://dx.doi.org/10.1136/bmjgh-2020-003549

24. Morrow, M., & Barraclough, S. (2010). Gender equity and tobacco control: bringing masculinity into focus. Global health promotion, 17(1 Suppl), 21–28. https://doi.org/10.1177/1757975909358349

25. Nawi Ng, L. Weinehall, A. Öhman. (2007). 'If I don't smoke, I'm not a real man'—Indonesian teenage boys' views about smoking. Health Education Research, 22 (6):794–804. https://doi.org/10.1093/her/cyl104

26. UN Women. (2021). Press release: Generation Equality Forum concludes in Paris with announcement of revolutionary commitments and Global Acceleration Plan to advance gender equality by 2026. https://www.unwomen.org/en/news/stories/2021/7/press-release-generation-equality-forum-concludes-with-commitments-and-global-acceleration-plan

27. UN Women. (2015). Timeline: The UN at 70 – Gender Equality Milestones & Memorable Moments https://www.unwomen.org/en/digital-library/multimedia/2015/9/timeline-un-at-70-gender-equality

28. United Nations Evaluation Group. (2017). Lessons Learned from 2016 Peer Learning Exchange. UN-SWAP Evaluation Performance Indicator. http://www.unevaluation.org/document/download/2686

29. United Nations Development Programme. (2015). Evaluation of UNDP contribution to gender equality and women empowerment. http://web.undp.org/evaluation/evaluations/thematic/gender.shtml

30. Payne S. (2011). Beijing fifteen years on: the persistence of barriers to gender mainstreaming in health policy. Social politics, 18(4), 515–542. https://doi.org/10.1093/sp/jxr019

31. Henry SK, Sandler J, Passerini L, Darmstadt GL. (2017). Taking on the gender challenge in organisations: what does it take? Glob Public Health, 12(7):846–57. https://doi.org/10.1080/17441692.2015.1094110

32. African Development Bank Group. (2011). Mainstreaming Gender Equality: A road to results or road to no where? An Evaluation Synthesis. https://www.oecd.org/derec/afdb/48294202.pdf

33. Hawkes S, Buse K. (2013). Gender and global health: evidence, policy, and inconvenient truths. Lancet, 18;381(9879):1783–7. https://doi.org/10.1016/S0140-6736(13)60253-6

34. United Nations. (1997). Economic and Social Council agreed conclusions on mainstreaming the gender perspective into all policies and programmes in the United Nations system. https://www.un.org/womenwatch/osagi/pdf/ECOSOCAC1997.2.PDF

35. United Nations Evaluation Group. (2018). Guidance on Evaluating Institutional Gender Mainstreaming. http://www.uneval.org/document/detail/2133

36. Jagosh J. (2019). Realist Synthesis for Public Health: Building an Ontologically Deep Understanding of How Programs Work, For Whom, and In Which Contexts. Annu Rev Public Health, 40(1):361–72. https://doi.org/10.1146/annurev-publhealth-031816-044451

37. Wong, G., Greenhalgh, T., Westhorp, G., & Pawson, R. (2012). Realist methods in medical education research: what are they and what can they contribute? Medical education, 46(1), 89–96. https://doi.org/10.1111/j.1365-2923.2011.04045.x

38. Flynn R, Rotter T, Hartfield D, Newton AS, Scott SD. (2019). A realist evaluation to identify contexts and mechanisms that enabled and hindered implementation and had an effect on sustainability of a lean intervention in pediatric healthcare. BMC Health Serv Res, 29;19(1):912. https://doi.org/10.1186/s12913-019-4744-3

39. Lacouture A, Breton E, Guichard A, Ridde V. (2015). The concept of mechanism from a realist approach: a scoping review to facilitate its operationalization in public health program evaluation. Implement Sci, 30;10(1):153. https://doi.org/10.1186/s13012-015-0345-7

40. United Nations Evaluation Group. (2020). Ethical Guidelines for Evaluation: http://www.unevaluation.org/document/detail/2866

41. United Nations Evaluation Group. (2008). Ethical Guidelines for Evaluation. http://www.uneval.org/document/guidance-documents

42. United Nations Inter-Agency Network on Women and Gender Equality. (2020). 25 Years After Beijing - A review of the UN system's support for the implementation of the Platform for Action, 2014-2019. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/IANWGE-Review-of-UN-system-support-for-implementation-of-Platform-for-Action-2014-2019-en.pdf

43. United Nations. (1996). Beijing Declaration and Platform for Action - The Fourth World Conference on Women. https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf

44. United Nations. (2011). Political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS. https://www.unodc.org/documents/southeastasiaandpacific/2012/02/hlm-hiv/20110610_UN_A-RES-65-277_en.pdf

45. United Nations. (2021). Political declaration on HIV and AIDS: Ending inequalities and getting on track to end AIDS by 2030. https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf

46. United Nations. (2018). Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. https://digitallibrary.un.org/record/1648984?ln=en

47. United Nations. (2011). Political declaration of the High-level Meeting of the General Assembly on the prevention and control of non-communicable diseases. https://undocs.org/pdf?symbol=en/A/66/L.1

48. United Nations. (2019). Political declaration of the High-level Meeting on Universal Health Coverage: "Universal health coverage: moving together to build a healthier world". https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

49. UN Women. (2020b). HIV and AIDS: Global norms and standards. https://www.unwomen.org/what-we-do/hiv-and-aids/global-norms-and-standards

50. United Nations. (2020). Resolution adopted by the General Assembly on 16 December 2020: Women and girls and the response to the coronavirus disease (COVID-19). https://undocs.org/pdf?symbol=en/A/RES/75/157

51. United Nations. (2020). Resolution adopted by the General Assembly on 16 December 2020: Strengthening national and international rapid response to the impact of the coronavirus disease (COVID-19) on women and girls. https://undocs.org/en/A/RES/75/156

52. United Nations. (1995). Report on the International Conference on Population and Development. Cairo 5-13 September 1994. https://www.unfpa.org/sites/default/files/event-pdf/icpd_eng_2.pdf

53. Center for Reproductive Rights. (2020). Breaking ground: Treaty Monitoring Bodies on reproductive rights. https://reproductiverights.org/breaking-ground-2020-treaty-monitoring-bodies-on-reproductive-rights/

54. Sen G, Östlin P, George A. Unequal, unfair, ineffective and inefficient. (2007). Gender inequity in health: why it exists and how we can change it. https://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

55. UN Women. (2020). Partnerships for gender mainstreaming within the UN System. https://www.unwomen.org/en/how-we-work/un-system-coordination/ gender-mainstreaming/partnerships-for-gender-mainstreaming-within-the-unsystem

56. UN Women. (2019). UN-SWAP 2.0 Accountability framework for mainstreaming gender equality and the empowerment of women in United Nations Entities. Framework and Technical guidance. https://archive.unescwa.org/sites/www.unescwa.org/files/page_attachments/technical_notes_un_swap_2019.pdf

57. United Nations. (2019). Review of the United Nation-Wide Action Plan on Gender Equality and the Empowerment of Women. https://www.unjiu.org/sites/www.unjiu.org/files/jiu_rep_2019_2_english_0.pdf

58. UN Women. (2020). UN-SWAP 2.0 Accountability framework for mainstreaming gender equality and the empowerment of women in United Nations Entities. UN-SWAP 2.0 Framework & Technical Guidance. https://www.unwomen.org/-/media/headquarters/attachments/sections/how%20we%20work/unsystemcoordination/un-swap/un-swap-2-tn-en.pdf?la=en&vs=2359

59. Sandler J, Goetz AM. (2020). Can the United Nations deliver a feminist future? Gend Dev, 3;28(2):239–63. https://doi.org/10.1080/13552074.2020.1753432

60. Buyse A. (2018). Squeezing civic space: restrictions on civil society organizations and the linkages with human rights. Int J Hum Rights, 22(8):966–88. https://doi.org/10.1080/13642987.2018.1492916

61. Smith J, Buse K, Gordon C. (2016). Civil society: the catalyst for ensuring health in the age of sustainable development. Glob Health, 12(1):40. https://doi.org/10.1186/s12992-016-0178-4

62. Felter M. (2011). Meeting Its immunity obligations: The United Nations and employee sexual harassment claims. B. C. Int & Comp Law Rev, 34(3):Supp 41. https://lawdigitalcommons.bc.edu/iclr/vol34/iss3/4

63. Mégret F, Hoffmann F. (2003). The UN as a Human Rights Violator? Some Reflections on the United Nations Changing Human Rights Responsibilities. Hum Rights Q, 25(2):314–342. http://www.jstor.org/stable/20069667

64. UNAIDS. (2013). Report of the Independent Expert Panel on prevention of and response to harassment, including sexual harassment, bullying and abuse of power at UNAIDS Secretariat. https://www.unaids.org/sites/default/files/media_asset/report-iep_en.pdf

65. Britannica. (2020). World Health Organization UN public health agency. https://www. britannica.com/topic/World-Health-Organization

66. UNAIDS. (2020). The UNAIDS governance handbook. https://www.unaids.org/ sites/default/files/media_asset/JC2984_Governance-Handbook-2020-EN.pdf.

67. UNAIDS. (2020). UNAIDS Programme Coordinating Board. https://www.unaids. org/en/whoweare/pcb.

68. United Nations Children's Fund. (2020). UNICEF executive team and experts. https://www.unicef.org/media/experts.

69. United Nations Children's Fund. (2020). How UNICEF works. https://www.unicef.org/about/structure/.

70. United Nations Children's Fund. (2020). Funding to UNICEF. https://www.unicef.org/partnerships/funding.

71. World Health Organization. (2019). Thirteenth General Programme of Work 2019-2023. Promote health, Keep the world save, Serve the vulnerable. https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf

72. UNAIDS. (2020). About UNAIDS. https://www.unaids.org/en/whoweare/about.

73. United Nations. (1994). ICPD Programme of Action. https://www.unfpa.org/ sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.

74. United Nations Children's Fund. (2018). UNICEF Strategic Plan 2018-2021. https://www.unicef.org/media/48126/file/UNICEF_Strategic_Plan_2018-2021-ENG.pdf.

75. United Nations Development Programme. (2018). UNDP Gender Equality Strategy 2018-2021. https://www.undp.org/publications/undp-gender-equality-strategy-2018-2021?utm_source=EN&utm_medium=GSR&utm_content=US_UNDP_PaidSearch_Brand_English&utm_campaign=CENTRAL&c_src=CENTRAL&c_src2=GSR&gclid=Cj0KCQjw5JSLBhCxARIsAHgO2SeYcBsWToz-CUcV62yK2JndqyJ2lY4cT1K78JCx3c4k7KJbSlXvI3iEaAlhYEALw_wcB

76. United Nations Development Programme. (2018). United Nations Development Programme HIV, Health and Development Annual Report 2017 - 2018. https://www.undp.org/publications/hiv-health-and-development-annual-report-2017-2018

77. World Health Organization. (2020). TDR Intersectional gender research strategy: Building the science of solutions for all. https://apps.who.int/iris/ bitstream/handle/10665/332288/9789240005068-eng.pdf?ua=1.

78. United Nations Development Programme. (2016). HIV, Health and Development Strategy 2016-2021. https://www.undp.org/publications/hivhealth- and-development-strategy-2016-2021.

79. World Health Organization Regional Office for Europe. (2018). Strategy on the health and well-being of men in the WHO European Region. https://www.euro.who.int/__data/assets/pdf_file/0010/394894/MHR_strategy_Eng_online.pdf

80. World Health Organization Regional Office for Europe. (2016). Strategy for women's health and well-being in the WHO European Region. http://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womenshealth- en.pdf?ua=1.

81. UNAIDS. (2020). UNAIDS Executive Director Report. https://www.unaids.org/sites/default/files/media_asset/47th-PCB_Speech_December_2020_En.pdf.

82. Carella A, Ackerly B. (2017). Ignoring rights is wrong: re-politicizing gender equality and development with the rights-based approach. Int Fem J Polit, 19(2):137–52. https://doi.org/10.1080/14616742.2016.1226640

83. United Nations Population Fund. (2017). UNFPA Gender Equality Strategy 2018-2021. https://www.unfpa.org/sites/default/files/pub-pdf/19-132_UNFPA_ GenderStrategy-EN.pdf.

84. World Health Organization. (2020). Gender, Equity and Human Rights - About Us. https://www.who.int/teams/gender-equity-and-human-rights/about.

85. United Nations Children's Fund. (2019). Gender equality. Global Annual Results Report 2019. https://www.unicef.org/reports/global-annual-results- 2019-gender-equality.

86. United Nations Children's Fund. (2021). Breaking the circle of silence: menstruation matters. https://www.unicef.org/jordan/stories/breaking-cyclesilence- menstruation-matters.

87. United Nations Children's Fund. (2021). How girls – and boys! – are busting period myths in 5 countries around the world. https://www.unicef.org/stories/ how-girls-boys-are-busting-period-myths-5-countries.

88. UNAIDS. (2012). Standing up and speaking out: Women and HIV in the Middle East and North Africa. https://unaids-test.unaids.org/sites/default/files/unaids/contentassets/documents/unaidspublication/2012/20120713_MENA_Women_and_AIDS_2012_en.pdf.

89. Robert Carr Fund. (n.d.). Case Study, MENA Rosa: Grassroots mobilization against HIV and Gender-based Violence. https://robertcarrfund.org/case-studies/grassroots-mobilization-gainst-hiv-and-gender-based-violence.

90. United Nations Children's Fund. (2019). Goal Area 4 Every child lives in a safe and clean environment. Global annual results report 2019. https://www.unicef.org/media/71336/file/Global-annual-results-report-2019-goal-area-4.pdf

91. United Nations Population Fund and United Nations Children's Fund. (2018). Performance analysis for Phase II - UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-UNICEF-Phase2Performance_2018_web_0.pdf

92. United Nations Population Fund and United Nations Children's Fund. (2018). Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change Phase I and II (2008–2017). https://www.unfpa.org/sites/default/files/admin-resource/FGM_Eval_Vol1_FINAL.pdf

93. United Nations Population Fund and United Nations Children's Fund (2020). Empowering girls and women to lead change. Annual Report 2019. https:// www.unfpa.org/publications/empowering-girls-and-women-lead-changeannual- report-2019.

94. MENA Rosa. (2019). We are MENA Rosa! http://menarosa.org/wp-content/uploads/2019/03/MENARosa_leaflet_en_1_print-1.pdf.

95. UNAIDS, MENA Rosa, & Frontline AIDS. (2020). Violence is everywhere: addressing the links between gender-based violence and HIV in the Middle East and North Africa. https://frontlineaids.org/wp-content/uploads/2021/03/FA_ViolenceIsEverywhere_AW_eng_Feb21_web.pdf

96. Global HIV Prevention Coalition. (2020). Implementation of the HIV Prevention 2020 Road Map. Fourth Progress Report, November 2020. https://www.unaids.org/sites/default/files/media_asset/fourth-annual-progress-report-global-hiv-prevention-coalition_en.pdf

97. World Health Assembly, 69. (2016). Sixty-ninth World Health Assembly, Geneva, 23-28 May 2016: resolutions and decisions, annexes. World Health Organization. https://apps.who.int/iris/handle/10665/259134

98. World Health Organization. (2019). The Thirteenth General Programme of Work, 2019–2023. https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf.

99. United Nations Population Fund. (2019). Evaluation of the UNFPA capacity in Humanitarian Action (2012-2019). UNFPA Evaluation Office. https://www. unfpa.org/sites/default/files/admin-resource/Final_Humanitarian_Evaluation_ Report_pages.pdf.

100. United Nations Population Fund. (2020). Making the Law Work for Women and Girls in the context of HIV. https://www.undp.org/publications/making-law-work-women-and-girls-context-hiv

101. United Nations Population Fund. (2018). Evaluation of UNFPA support to the prevention of, response to and elimination of gender-based violence and harmful practices (2012-2017). https://www.unfpa.org/sites/default/files/admin-resource/GBV_Report_FINAL_29_Nov.pdf.

102. Global Protection Cluster. (2021). Gender Based Violence Area of Responsibility. https://www.globalprotectioncluster.org/themes/gender-based-violence/#:~:text=As%20one%20of%20the%20Areas,gender%2Dbased%20violence%2C%20to%20ensure.

103. The Inter-Agency Standing Committee. (2021). IASC. https://interagencystandingcommittee.org/iasc.

104. World Humanitarian Summit. (2016). Women and girls: Catalyzing action to achieve gender equality. https://agendaforhumanity.org/sites/default/files/resources/2017/Jul/WOMEN_AND%20GIRLS-CATALYSING_ACTION_TO_ACHIEVE_GENDER_EQUALITY_0.pdf

105. United Nations Security Council. (2000). Resolution on Women, Peace and Security (S/RES/1325). https://daccess-ods.un.org/tmp/5855812.43038177.html.

106. Women's International League for Peace and Freedom. (2021). About women, peace and security in the security council. https://www.peacewomen.org/

107. United Nations Security Council. (2019). Resolution 2469. https://undocs.org/S/RES/2467(2019).

108. Institute on Inequalities in Global Health. (2021). Evaluation of the Global Commission on HIV and the Law. https://hivlawcommission.org/wp-content/uploads/2021/06/Final-Report-Independent-Evaluation-Global-Commission-HIV-and-the-Law.pdf

109. World Health Organization/Pan American Health Organization. (2006). Pan American Health Organization Gender Equality Policy. https://iris.paho.org/handle/10665.2/41278.

110. United Nations Children's Fund. (2018). UNICEF Gender Action Plan, 2018- 2021. UNICEF Executive Board Second Regular Session 2017. https://www.unicef.org/gender-equality/gender-action-plan-2018-2021

111. United Nations Children's Fund. (2014a). UNICEF Gender Action Plan, 2014- 2017. UNICEF Executive Board Annual Session 2014. https://digitallibrary.un.org/record/768401?ln=en

112. World Health Organization/Pan American Health Organization. (2015). Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action. https://iris.paho.org/handle/10665.2/28428.

113. World Health Organization/Pan American Health Organization. (2019). Gender mainstreaming in health: advances and challenges in the Region of the Americas. https://iris.paho.org/ handle/10665.2/51784.

114. World Health Organization/Pan American Health Organization. (2020). PAHO gender equality policy progress report: 58th Directing Council 72nd Session of the Regional Committee of WHO for the Americas. https://www.paho.org/en/documents/cd58inf14-progress-reportstechnical-matters-d-paho-gender-equality-policy-progress.

115. World Health Organization/Pan American Health Organization. (2013). VI Competition on Best Practices that Integrate Equality and Equity in Gender and Interculturalism in Health. https://www3.paho.org/hq/index.php?option=com_content&view=article&id=457:vi-competition-on-best-practices-that-equality-equity-gender-interculturalism-health&Itemid=820&lang=en

116. United Nations Children's Fund. (2013). The UNICEF Strategic Plan, 2014-2017: realizing the rights of every child, especially the most disadvantaged. https://digitallibrary.un.org/record/782052?ln=en.

117. UNICEF. (2020e). Annual report on the implementation of the UNICEF Gender Action Plan, 2018–2021. UNICEF Executive Board Annual Session. https://www.unicef.org/executiveboard/media/4631/file/2021-15-GAP_annual_report-EN-ODS.pdf

118. United Nations Children's Fund. (2019). Realizing Potential: Evaluation of UNICEF's Gender Action Plans. Evaluation Report. https://www.unicef.org/media/65591/file/Realizing%20potential:%20Evaluation%20of%20 UNICEF's%20Gender%20Action%20Plans,%20 December%202019.pdf

119. United Nations Population Fund. (2015). For people, planet and prosperity. Annual Report 2015. https://www. unfpa.org/sites/default/files/pub-pdf/UNFPA_2015_Annual_Report.pdf.

120. United Nations. (2018). Coding definitions for gender equality markers. Guidance Note. https://www.unsystem.org/ CEBPublicFiles/Guidance%20Note%20on%20 Coding%20Definitions%20 for%20GEMs%20-%20for%20 dissemination.pdf.

121. World Health Organization. (2021). Special Programme for Research and Training on Tropical Diseases: Our governance, our strength. ttps://www.who. int/tdr/about/governance/en/.

122. Vlassoff C. (1997). The gender and tropical diseases task force of TDR: achievements and challenges. Acta Tropp, 67(3):173–80. https://doi.org/10.1016/s0001-706x(97)00047-8

123. Vlassoff C. (1999). A Critical Appraisal of the IDRC-TDR Gender and Tropical Diseases Award. Parasitol Today, 15(1):7–8. https://doi.org/10.1016/s0169-4758(98)01356-8

124. World Health Organization. (2020). TDR Results Report 2020. https://tdr.who.int/publications/i/item/tdr-2020-results-report.

125. United Nations Development Programme. (2019). UNDP Gender equality seal comprehensive benchmarking matrix. https://erc.undp.org/evaluation/managementresponses/keyaction/documents/download/3635#:~:text=The%20 UNDP%20Gender%20Equality%20Seal,support%20 countries'%20gender%20equality%20goals.

126. United Nations Development Programme. (2021). The gender equality seal programme. https://www.genderequalityseal.org/programme/.

127. United Nations Development Programme. (2019). Annual report of the administrator on the implementation of the UNDP gender equality strategy in 2018. https://digitallibrary.un.org/record/3802139?ln=en.

128. United Nations Development Programme. (2020). Annual report of the administrator on the implementation of the UNDP gender equality strategy in 2019. https://digitallibrary.un.org/record/3861550?ln=en.

129. United Nations Development Programme. (2021). Annual report of the administrator on the implementation of the UNDP gender equality strategy in 2020. https://digitallibrary.un.org/record/3927398?ln=en.

130. United Nations Population Fund. (2017). UNFPA Strategic Plan 2018-2021: Accelerating progress and national ownership of the ICPD Programme of Action. Report of the Executive Director. https://www.unfpa.org/sites/default/ files/resource-pdf/DP.FPA_.2017.9_-_UNFPA_strategic_plan_2018-2021_-_ FINAL_-_25July2017_-_corrected_24Aug17.pdf.

131. United Nations Population Fund. (2013). The UNFPA Strategic Plan 2014- 2017. https://www.unfpa.org/sites/default/files/resource-pdf/Strategic%20 Plan%2C%202014-2017.pdf.

132. United Nations Development Programme. (2008). UNDP Strategic Plan, 2008-2011. Accelerating global progress on human development. https://digitallibrary.un.org/record/628899?ln=en

133. United Nations Development Programme. (2014). Changing with the World. UNDP Strategic Plan: 2014-2017. https://www.undp.org/publications/undp-strategic-plan-2014-17

134. United Nations Development Programme. (2018). Gender Equality Strategy, 2018-2021. https://www.undp.org/publications/undp-gender-equalitystrategy-2018-2021#modal-publication-download.

135. United Nations Population Fund & United Nations Children's Fund. (2018). Performance analysis for Phase II: UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change. https://www.unfpa.org/sites/ default/files/pub-pdf/UNFPA-UNICEF-Phase2Performance_2018_web_0.pdf.

136. UNAIDS Programme Coordinating Board. (2020). Update on the implementation of the management action plan. https://www.unaids.org/sites/ default/files/media_asset/PCB46_Management_Action_Plan_EN.pdf.

137. United Nations Children's Fund. (2008). Evaluation of Gender Policy Implementation in UNICEF. https://www.itad.com/wp-content/uploads/2008/03/2008_Gender_Evaluation_Report.pdf

138. Htun M, Weldon SL. (2012). The civic origins of progressive policy change: Combating violence against women in global perspective, 1975–2005. Am Polit Sci Rev, 106(3):548–69. https://doi.org. 10.1017/S0003055412000226

139. Turshen, M., & Berger, M. (2020). Feminist Health Movements. Companion to Feminist Studies, 393-410. https://onlinelibrary.wiley.com/doi/10.1002/9781119314967.ch22

140. United Nations. (2016). Political declaration on HIV and AIDS: On the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030. https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf.

141. El Dawla AS. (1999). The political and legal struggle over female genital mutilation in Egypt: Five years since the ICPD. Reproductive Health Matters 7(13): 128-136. https://www.jstor.org/stable/3775715

142. Muteshi J, Sass J. Female. (2005). Genital Mutilation in Africa: An Analysis of Current Abandonment Approaches. Nairobi. https://path.azureedge.net/media/documents/CP_fgm_combnd_rpt.pdf.

143. United Nations Development Programme. (2021). HIV, health and development annual report 2019-2020. https://www.undp.org/sites/g/files/zskgke326/files/publications/UNDP-HIVHealth- and-Development-Annual-Report-2019-2020.pdf.

144. Global Fund. (2019). Investing in the future: women and girls in all their diversity. https://www.theglobalfund.org/media8484/crg_investinginthefuturewomengirls_report_en.pdf.

145. USAID. (2021). Dreams: Partnership to reduce HIV/AIDS in adolescent girls and young women. https://www.usaid.gov/global-health/health-areas/hiv-andaids/ technical-areas/dreams#:~:text=Overview,the%20highest%20HIV%20burden%20countries.

146. HERA. (2019). External evaluation of the UNDP-UNFPA-UNICEF-WHOWorld Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) 2013-2017. https://www.who.int/ reproductivehealth/about_us/hrp/HRP-Evaluation-Report-Vol-2.pdf.

147. United Nations Children's Fund. (2017). Gender-responsive water, sanitation and hygiene: Key elements for WASH programming. https://www.unicef.org/ gender/files/Gender_Responsive_WASH.pdf.

148. United Nations Population Fund. (2019). Evaluation of the UNFPA capacity in Humanitarian Action (2012-2019). https://www. unfpa.org/sites/default/files/admin-resource/Final_Humanitarian_Evaluation_ Report_pages.pdf.

149. World Health Organization. (2015). TDR Annual Report 2014: Celebrating 40 years of research. https://www.who.int/tdr/publications/2014-annual-report/en/.

150. World Health Organization. (2021). TDR-Gender. https://www.who.int/tdr/ diseases-topics/gender/en/.

151. World Health Organization/Pan American Health Organization. (2010). Plan of action for Implementing the Gender Equality Policy of the Pan American Health Organization 2009–2014. https://iris.paho.org/handle/10665.2/6036.

152. World Health Organization/Pan American Health Organization. (2010). Plan of action for implementing the gender equality policy. https://iris. paho.org/handle/10665.2/41278.

153. World Health Organization/Pan American Health Organization. (2014). Strategic Plan of the Pan-American Health Organization 2014-2019. https://www.paho.org/hq/dmdocuments/2017/paho-strategic-planeng- 2014-2019.pdf.

154. United Nations Children's Fund. (2019). Gender equality: Global Annual Results Report 2019. https://www.unicef.org/reports/global-annual-results- 2019-gender-equality.

155. World Health Organization. (2014). External evaluation: Gender and Rights Advisory Panel (2002-2012). https://www.who.int/about/resources_planning/ HQPRP14.1_PBPA2012-2013.pdf?ua=1.

156. UNAIDS Programme Coordinating Board. (2019). Unified budget, results, and accountability framework (UBRAF): Performance monitoring report 2018 strategy result area and indicator report. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_PCB44_2018_PMR_SRA-indicator-report_EN.pdf.

157. UNAIDS Programme Coordinating Board. (2019). Unified budget, results and accountability framework (UBRAF) work plan and budget 2020-2021. https:// www.unaids.org/sites/default/files/media_asset/UNAIDS_PBC44_Workplan-Budget_EN.pdf.

158. UNAIDS Programme Coordinating Board. (2019). Unified budget, results, and accountability framework (UBRAF): Performance Monitoring Report 2018. Organization Report. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_PCB44_UBRAF_PMR_ORG_REPORT_EN.pdf.

159. World Health Organization. (2005). WHO Multi-country study on women's health and domestic violence against women. Summary report. http://apps. who.int/iris/bitstream/handle/10665/43310/9241593512_eng.pdf?sequence=1.

160. World Health Organization. (2014). Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. https://www. who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/.

161. World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf.

162. World Health Organization. (2016). Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication, Putting women first: ethical and safety recommendations for research on domestic violence against women. http://apps.who.int/iris/ bitstream/handle/10665/251759/9789241510189-eng.pdf?sequence=1.

163. World Health Organization. (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/.

164. World Health Organization. (2019). Caring for women subjected to violence: A WHO curriculum for training health-care providers. https://www.who.int/ reproductivehealth/publications/caring-for-women-subject-to-violence/en/.

165. United Nations Children's Fund. (2014). Report on the progress of work in gender equality and empowerment of women in UNICEF. https://digitallibrary.un.org/record/771019?ln=en.

166. World Health Organization/ Pan American Health Organization. (2017). PAHO Program and Budget 2018-19. https://iris.paho.org/bitstream/handle/10665.2/34467/CSP29-OD354-e.pdf?sequence=1&isAllowed=y.

167. World Health Organization/ Pan American Health Organization. (2019). PAHO Program and Budget 2020-2021. https://www.paho.org/en/documents/paho-program-and-budget-2020-2021.

168. World Health Organization, Pan American Health Organization. (2020). Strategic Plan of the Pan-American Health Organization 2020-2025. Equity at the heart of health. https://iris.paho.org/bitstream/handle/10665.2/52473/9789275173619_eng.pdf?sequence=5&isAllowed=y.

169. Global Commission on HIV and the Law. (2018). Risks, Rights and Health. Supplement. https://hivlawcommission.org/wp-content/uploads/2020/06/ Hiv-and-the-Law-supplement_EN_2020.pdf.

170. Global Commission on HIV and the Law. (2012). Risks, Rights and Health. https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport- RisksRightsHealth-EN.pdf.

171. Heise LL. (1998). Violence Against Women: An Integrated, Ecological Framework. Violence Against Women, 4(3):262–90. https://doi.org/ 10.1177/1077801298004003002.

172. Mehra R, Gupta GR. (2006). Gender Mainstreaming: Making It Happen. International Center for Research on Women. https://www.icrw.org/wp-content/uploads/2016/10/Gender-Mainstreaming-Making-It-Happen.p

Annex 1

Overview of the range of institutional and programmatic gender mainstreaming efforts reported by key informants

1. UNAIDS

Domain	Reported successes
1. Institutional structures and mechanisms for gender mainstreaming	The Action Framework (2009) and Country-action Operation Plan (2010) for women, girls, gender equality and HIV laid out the roadmap and created institutional structures for programmatic gender mainstreaming at country level. According to a senior staff member, the Action Framework also led to creating a fully-fledged gender team, a more focused investment in HIV, especially on the links between HIV and GBV. Importantly, it also enabled the systematic development of tools (e.g. the gender assessment tool) to operationalise the integration of gender with national HIV strategic plans. GAP-1 prioritised gender parity as an entry point to boost women's leadership. It enabled the focused leadership programmes for women and the prioritisation of women for appointment to senior-level position. In 2018, a cohort of women who participated in the women's leadership programme were promoted as country directors. UNAIDS instituted an external accountability mechanism to investigate allegations of sexual harassment and abuse of power. This process improved senior leadership accountability, and several institutional policies and processes were developed to create a safe and enabling workplace for all and protect human rights in the workplace.
2. Institutional processes for gender mainstreaming in Member States and funders	The gender assessment tool framework contributed to systematically operationalising the integration of gender into national HIV strategic plans. Between 2009 and 2011, over 100 countries undertook a gender analysis of the country HIV epidemic and developed Gender Action Plans for HIV based on findings of the assessment tool. There was an uptake of guidance and normative tools, such as gender assessment tools, by the Global Fund, leading to reprogramming and allocation of resources (USD 500,000) for cervical cancer screening and advocacy in 2019 in Tanzania.
3. Interagency collaboration on evidence generation	UNAIDS collaborative work with WHO in 2015 led to developing an advocacy brief that brought significant attention to cervical cancer in HIV. It resulted in the inclusion of a cervical cancer indicator in the Global AIDS Monitoring Framework in 2017, resulting in data collection and reporting on cervical cancer screening for women living with HIV.
4. HIV prevention programme	Many countries are adopting and implementing comprehensive programme packages to address the needs of AGYW. Fifteen out of 17 Member States have these. In South Africa, there is a strong and active engagement and participation of AGYW in decision-making, at forums and in HIV programmes.
5. Capacity-strengthening to foster women's leadership in HIV prevention	The UNAIDS Secretariat has worked to nurture and strengthen women's leadership, especially of HIV community groups. The Secretariat contributed significantly to the formation of the first HIV community-based network in the MENA region led by women (MENA Rosa). The network now has focal points across many MENA countries, championing the needs of women living with HIV and generating evidence that supports responsive decision-making on HIV.

2. UNDP

Domain	Reported successes
1. Institutional innovations for gender equality	The Gender Equality Seal is the most successful of institutional gender mainstreaming efforts. It tests the commitment of UNDP and country offices to organisational transformation towards gender equality. The Gender Equality Seal has worked across all five UNDP operational regions, with 79 country offices having been certified. The Gender Marker has been used successfully in UNDP programming and tracks financial commitment towards investments in gender equality.
2. Fostering enabling environment for gender equality	Progress in creating an enabling legal, policy and regulatory environment for women and girls, including key populations in the context of HIV. An intersectional approach focusing on vulnerabilities that lead to discrimination and stigmatisation, violation of human rights of key populations, GBV, and lack of access to health systems. Nurturing, building and empowering community leadership, networks and civil societies to advocate and advance legal and policy changes in the context of HIV (e.g. African Judges Forum, African Key Population Expert Group). Social protection, including financial, livelihoods and access to justice for older persons, widows and survivors of GBV. Facilitating an enabling governance environment resulting in cultural norms around women's roles in politics and increasing their access and involvement in decision-making structures, from national to local levels. This has led to programmes promoting empowering and promoting women for local council elections.
3. Capacity strengthening to stakeholders	Convening, promoting participation and engagement of key populations (LGBTQIA people, men who have sex with men, sex workers) in global, regional and national policy dialogues. Strengthening Member States' institutional capacities, such as parliaments and oversight committees, Ministries of Finance, Audit Offices, to integrate and develop gender-responsive budgeting in national policies, such as UNDP's support to the Rwandan Government.

3. UNFPA

Domain	Reported successes
1. Organisation-wide mandate for gender mainstreaming	The presence of gender as a stand-alone outcome in UNFPA's Strategic Plans provides an organisation-wide mandate and enforces accountability for gender mainstreaming. The Strategic Plan for 2018–2021 also includes UN-SWAP indicators, many of which pertain to institutional gender mainstreaming objectives. The organisation-wide mandate provides the policy framework for making institutional changes to support programmatic gender mainstreaming.
2. Gender-parity in staffing and an enabling environment for gender equality in the workplace	UNFPA has achieved gender-parity at the aggregate level for professional staff and continues to make efforts to ensure parity at each level. The organisation's policies on zero tolerance for sexual harassment and sexual exploitation, and abuse prevention, contribute to building a gender-equal workplace.
3. Tracking financial allocation for gender	The gender marker tracks financial allocations to programmes that include gender equality and women's empowerment. It is being implemented across several UN agencies. In UNFPA, the gender marker is reported to be a successful tool because: (a) all levels of the organisation, including most country offices, are implementing the gender marker; (b) it is being applied at the activity level, making the classification granular and accurate; and (c) it helps highlight UNFPA's commitment to gender equality in programming.
4. Prevention and services for GBV in development settings	UNFPA has worked on strengthening health sector responses to GBV since 1994. Key informants count the Essential Services Package developed for women and girls subject to GBV through a multi-agency global programme launched in 2013 as an important success. The Essential Services Package outlines internationally accepted standards and protocols for action by four sectors: health, police, judiciary, and social services. The Essential Services Package is being rolled out in many countries, and capacity-building is ongoing.
5. Preventing child marriage	UNFPA's work on ending child marriage started as a Joint UNICEF-UNFPA Programme in 2016 in 12 high prevalence countries. The first phase was from 2016–2019, and a second phase is currently underway for 2020–2023. The programme is considered a success because 24 countries had developed action plans backed by budgets to end child marriages. Many countries also introduced legislative changes that increased the legal minimum age for marriage. The programme is on track to being gender-transformative.
6. Promoting country accountability for sexual and reproductive health and rights	The regional office in the Arab States has worked with national human rights institutions in selected countries to include sexual and reproductive health and rights within the government's reporting to the UN Human Rights Council as part of the universal periodic review. The inclusion is a success because countries are held accountable for sexual and reproductive health and rights by the Human Rights Council by making recommendations for improvement.
7. Abandonment of FGM	In its third phase of implementation, this Joint Programme with UNICEF has resulted in policy and legislative changes supporting the abandonment of FGM and the reduction of FGM prevalence in many countries. Awareness among girls and key gatekeepers of the negative consequences of FGM has improved. Phase 3 of the Programme prioritises gender-transformative activities and indicators.
8. Prevention and services for GBV in humanitarian settings	UNFPA has been working in this area for more than 25 years, providing the dignity kit, services for GBV and advocating to make GBV a priority issue within humanitarian settings. UNFPA steers the sub-cluster on GBV in humanitarian situations in Inter-Agency Standing Committee for Humanitarian Actors. Key informants considered this a success because UNFPA has been present in every humanitarian crisis, including the current COVID-19 pandemic. It convened UN agencies and humanitarian actors and engaged in interventions to provide medical and psychosocial support to GBV survivors, rehabilitation, and clinical management of rape.

4. UNICEF

Domain	Reported successes
1. Institutional structures and mechanisms for gender mainstreaming	The gender action plans (GAP) 1 (2014–2017) and 2 (2018–2021) laid out the roadmap and created institutional structures for programmatic gender mainstreaming across all levels of the organisation. UNICEF has systematically operationalised the integration of gender in all its strategic plan outcomes across its various sectors and included a set of targeted gender priorities across the strategic plan outcomes since 2014. According to senior staff members, GAP 2014–2017 and GAP 2018–2021 owe their success to the processes through which they were developed and the pragmatic and strategic nature of their contents.
2. Institutional processes for gender mainstreaming at the country-office level	The GRP process at the country-level was strategically used in Europe and Central Asia to mobilise support for the integration of gender concerns in the country programme documents of Tajikistan, Kyrgyzstan and Azerbaijan.
3. Menstrual health and hygiene programme	The MHH programme for adolescent girls was implemented as part of the WASH programme. It is on track to be gender-transformative in challenging gender norms that disempower girls and women. MHH commenced with a pilot programme in 14 lower middle-income countries in 2014. In 2019, there were MHH activities in 72 countries. Reports from the field show that taboos and negative norms around menstruation are changing. Even male religious leaders were talking about the importance of ending the stigma surrounding the topic.
4. Preventing child marriage	UNICEF's work on ending child marriage started as a Joint UNICEF-UNFPA Global Programme in 2016 in 12 high prevalence countries. The first phase was 2016–2019. A second phase is currently underway for 2020–2023. By 2019, UNICEF had expanded its work on ending child marriage to 58 countries across all regions through rights-based interventions. The programme is considered one of the major successes of UNICEF's gender work because 24 countries have developed action plans to end child marriage backed by budgets. In addition, many countries have introduced legislative changes to increase the minimum legal age for marriage. The programme is seen as on track to being gender-transformative.
5. Gender-sensitisation of home visitors in the early childhood development programme in Europe and Central Asia Region	The evaluation of home visiting services (2014–2018) found that its implementation approach was rooted in a human rights approach, promoted gender equality and incorporated gender-sensitive and culturally tailored interventions. Home visitors have promoted gender-equal parenting practices, fathers' involvement in childcare, and encouraged equal treatment of male and female children in settings where a preference for male children is highly prevalent.
6. The professionalisation of community health workers, the majority of whom are women	Investment in community health workers – almost all of whom are women – by building knowledge and skills and paying appropriate remuneration. A cadre of women is being created, holding positions of influence within local communities. This is expected to alter the gender power dynamics within the frontline health workforce and improve access to healthcare for girls and women.
7. Immunisation programme	Gender equality in immunisation coverage and human papillomavirus vaccination for adolescent girls are objectives under the immunisation programme. A guidance document on how to carry out a gender analysis for immunisation programmes is available globally, and a guidance and gender tool kit has been produced for South Asia.
8. Nutrition programme	Gender equality in the coverage of treatment for children with severe acute malnutrition is an indicator of progress under mainstreaming. Coverage of adolescent girls with anaemia prophylaxis is one of the priority areas.

5. WHO

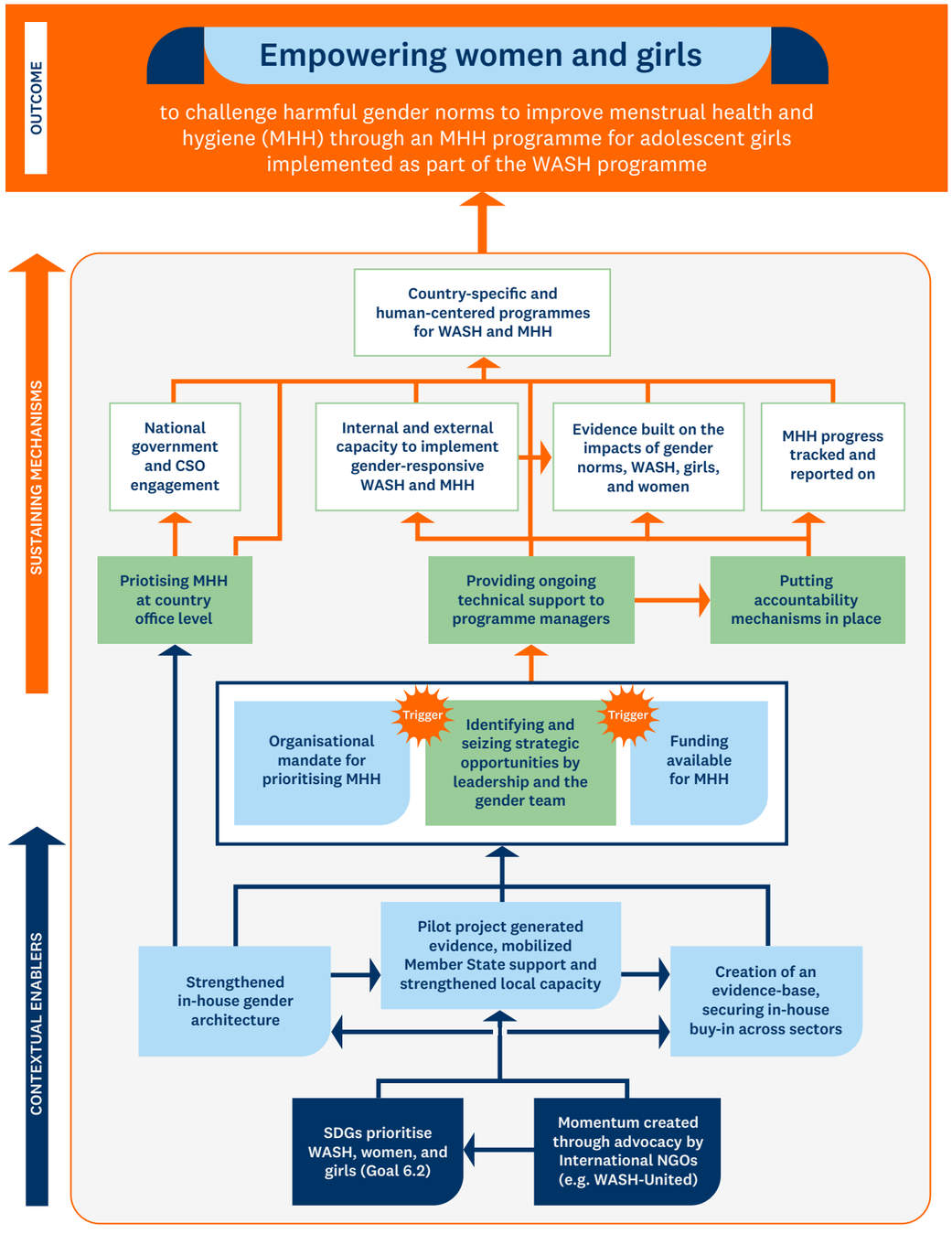
Successes in gender mainstreaming

Domain	Reported successes
1. Gender parity in staffing:	Headquarters: Although parity has not yet been achieved, steady progress is being made (45.8% of all professional and senior management are women in 2019, compared with 32.7% in 2002 and 39.8% in 2011). The current Director-General has appointed several women as Directors. WHO/EURO: Reached gender parity at P4 and P5 levels and above by 2017. Gender parity also among heads of country offices. WHO/AFRO: The Regional Director, in collaboration with UN Volunteers, launched the Africa young women health champions initiative to recruit mid-career professionals from 47 countries and expose them to the organisation at the entrance level, with the view of potentially recruiting them to various positions. Women at management level from regional and country offices are offered a leadership training programme, followed by mentorship.
2. Gender architecture	Headquarters (2018): A position in the Director-General's Office was created for a person to address issues of gender and young people. Currently, two P2-level staff, two consultants, and one intern are employed. Headquarters SRH/HRP (1997–present): A gender and rights advisory panel supports, as well as holds accountable, the gender work carried out by the department.
3. Capacity-building	GER: E-learning series on equity, gender, and human rights. Complemented by workshops to build gender, equity, and human rights capacity. PAHO: Virtual course on gender and health, awareness, analysis and action for in-house training, 2013–19. More than 8,000 participants for the Spanish version of the course and 4,500 for the English version have received certification (2016–2020). An enhanced course with intersectional analysis was initiated in 2020, and almost 4,000 participants have been certified.
4. Accountability	The 13th general programme of work (2020–2021) requires that all technical programmes report on how they have integrated gender, equity and rights.
5. Institutional mechanisms for programmatic gender mainstreaming	PAHO: For the past decade, organisational mechanisms have integrated gender issues into the strategic plan across a variety of technical areas. The Office of Equity, Gender and Cultural Diversity works with the planning unit to ensure that gender is integrated into the design of all regional programmes. These are financed, monitored, and reported periodically to executive management. The gender unit has developed a simple set of guidelines and training programme. A similar mechanism exists for country offices to work with Ministries of Health in Member States.
6. Strengthening the evidence base on gender, women and health	GWH/SRH department: Evidence on VAW is generated through multi-country studies on prevalence, health consequences, links between HIV and VAW, best practices for preventing VAW, the gender and rights dimensions of contraception, abortion, maternal health, adolescent health, and FGM. GWH prior to GER: Gender and health research uptake series includes: tuberculosis (TB), mental health, and lung cancer; knowledge products on gender and blindness, malaria, HIV and disasters; alcohol and tobacco use; and engaging men and boys in health programmes. GER: Knowledge products on gender-responsive and equitable health systems, women, migration and health, and gender, work and health. Health workforce department: Documents developed on gender equity in the health workforce. TDR: Gender dimensions of neglected tropical diseases – publishing and supporting research with an intersectional/gender perspective. PAHO: Knowledge products on gender and unpaid care work in health; social protection health schemes and health insurance in the context of universal health coverage. WHO/EURO: Gender analysis of non-communicable diseases though undertaking surveys in six countries.
7. Developing tools and guidelines and setting standards	GER/SRH: VAW – Clinical guidance, policy guidance and ethical guidance on research into intimate partner violence and sexual violence. Abortion, contraception, maternal health – technical and policy guidance from a gender and rights perspective. GER/GWH: Guidance and tools for integrating gender in HIV/AIDS, gender, equity and rights in country cooperation strategies and national health programmes. TDR: Toolkit on intersectional gender analysis in infectious diseases research. PAHO: Guidance documents on gender-responsive programming; monitoring gender equity in health policies; gender-based analysis of health data; developing a population-based gender and health profile; comprehensive care for transgender persons and their communities. WHO/WPRO: Guidance for gender analysis and gender-responsive programming in emerging infectious diseases programmes. WHO Polio Eradication Programme: Led the development of the Gender Equality Strategy 2019-2023 for the Global Polio Eradication Initiative.
8. Technical support to the Member States	SRH: Capacity-building and policy development for health sector responses to VAW; rights-based programming for SRH. GER: Conducted training workshops on applying a health equity assessment tool (HEAT) and the Innov8 tool to review and redesign national programmes in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand. TDR: Capacity-building on gender analysis in vector-borne disease programmes, institutionalised in Ghana and South Africa. PAHO: Capacity-building on gender and health with an intersectionality perspective; data disaggregation by sex, age and other relevant demographics; policy development for gender-sensitive approaches to health programming, including on GBV. "Best practices" initiative, helping to foster gender-responsive health programming in Member States through processes of competition, showcasing and cross-learning across countries.

Annex 2

Overview of the range of institutional and programmatic gender mainstreaming efforts reported by key informants

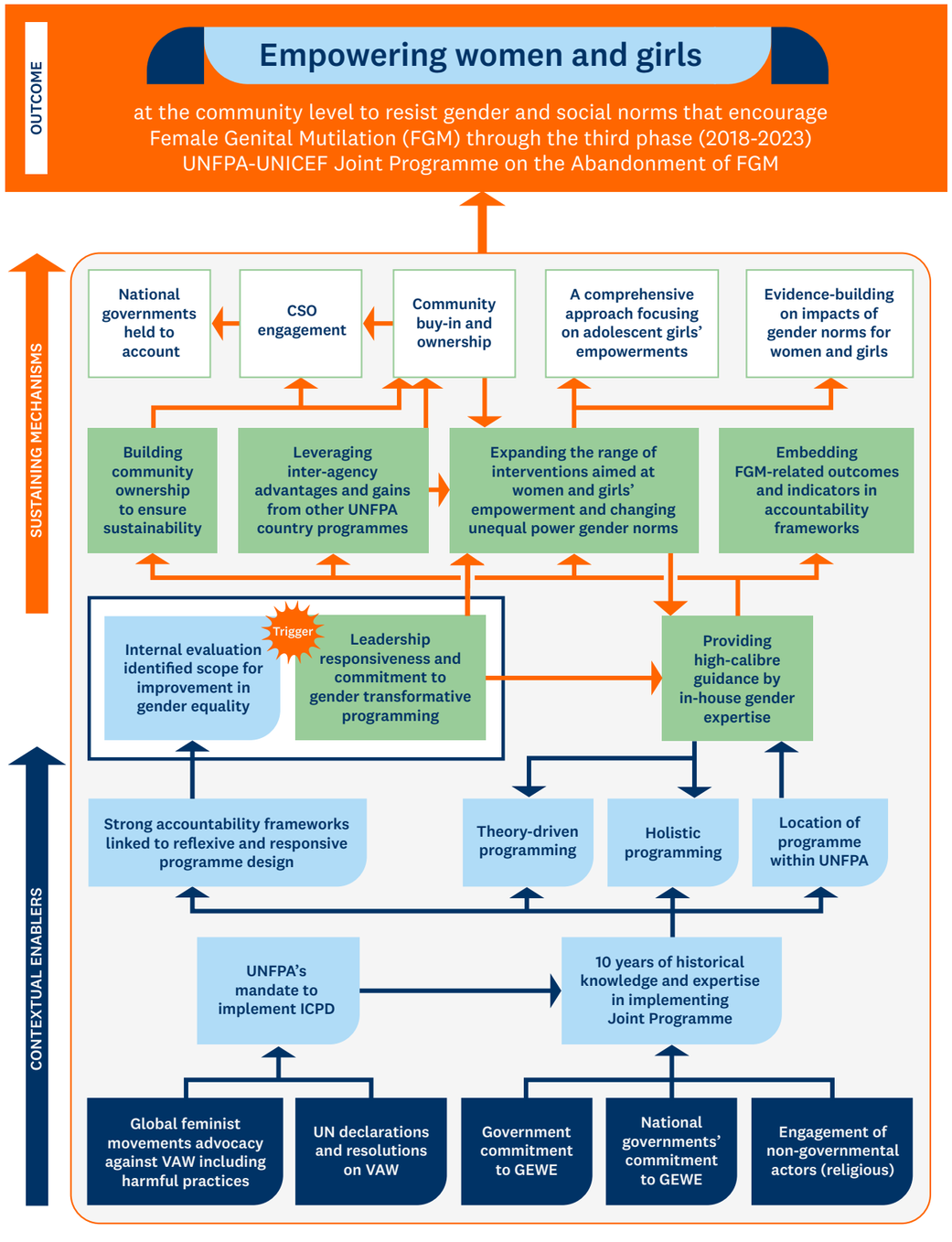
Case study 1: Empowering girls and women to challenge harmful gender norms to improve menstrual health and hygiene, implemented as part of a WASH programme (UNICEF)



LEGEND

External context | Internal context (UNICEF) | Mechanism (action) | Mechanism (change)

Case study 2: Empowering women and girls to resist gender and social norms that encourage FGM, promote positive masculinities, and strive for more equal gender power relations (phase 3 (2018–2023) of UNFPA-UNICEF Joint Programme on the abandonment of FGM)



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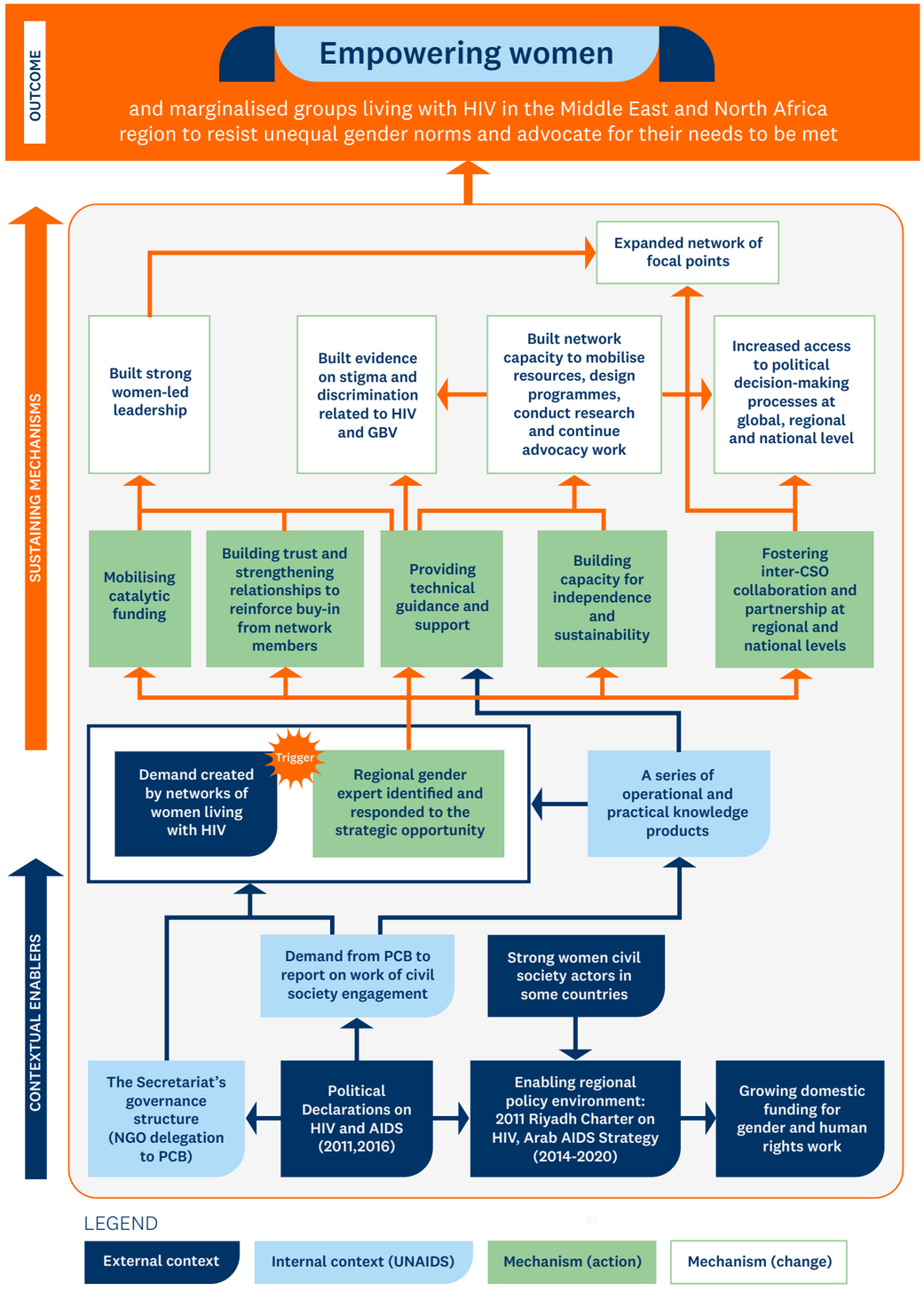
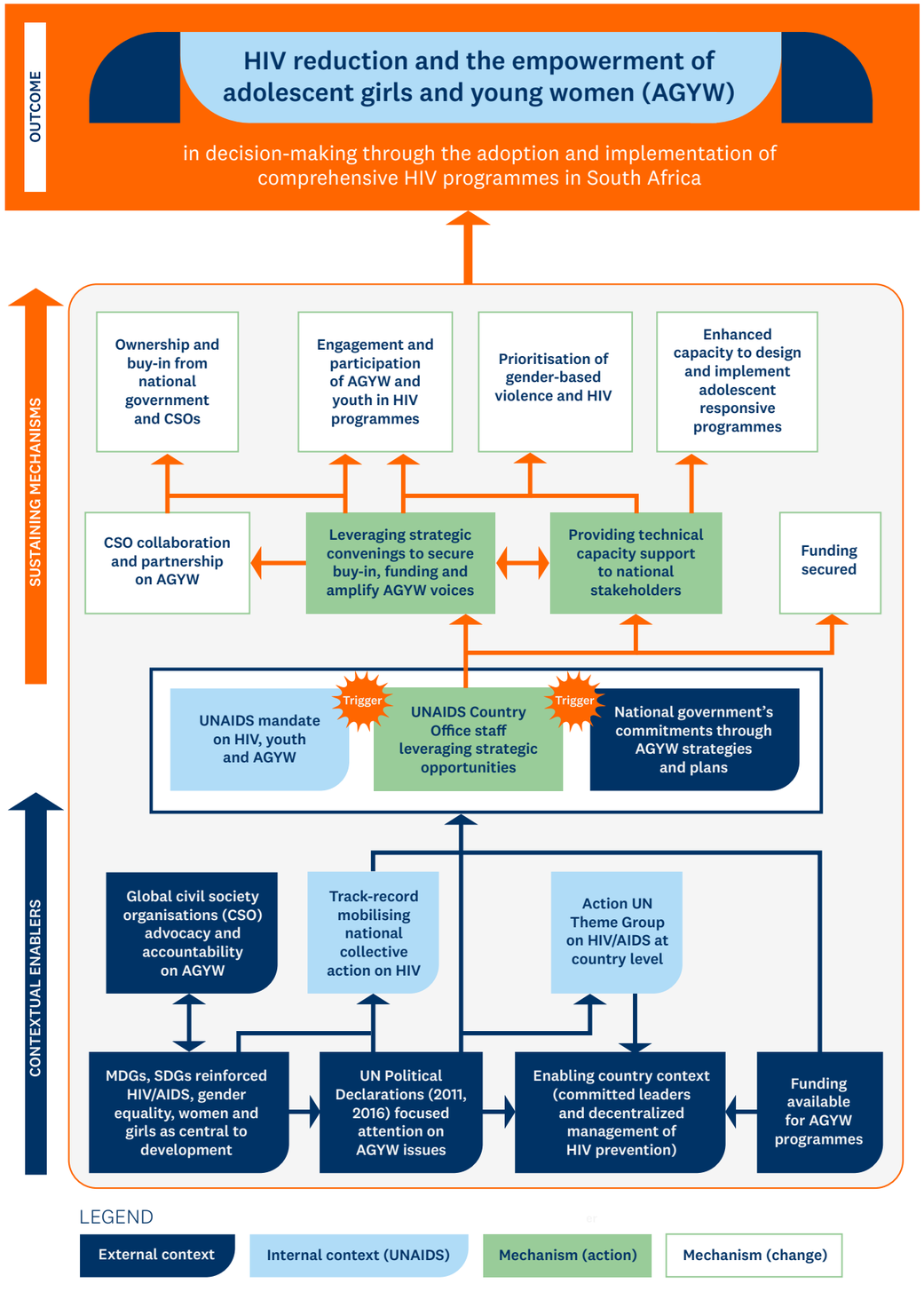
External context | Internal context (UNFPA-UNICEF Joint Programme) | Mechanism (action) | Mechanism (change)

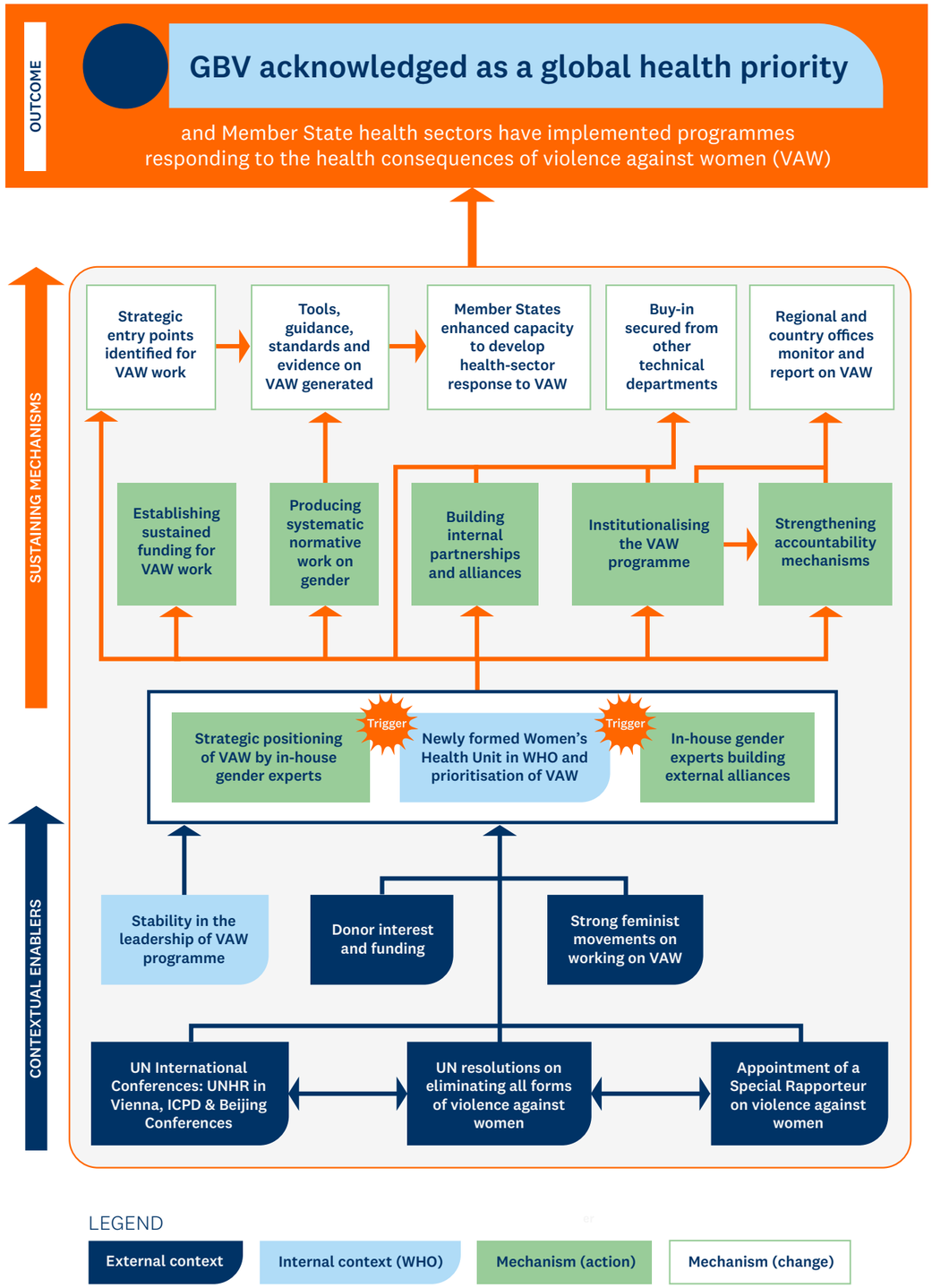
Case study 3: Empowering women and marginalised groups living with HIV in MENA (UNAIDS Secretariat, regional team)



Case study 4: HIV reduction and the empowerment of adolescent girls and young women in decision-making through the adoption and implementation of comprehensive HIV programmes in South Africa (UNAIDS Secretariat country office)



Case study 5: GBV acknowledged as a global public health priority, and Member State health sectors have implemented programmes responding to the health consequences of VAW through sustained strategic leveraging of opportunities by WHO gender experts



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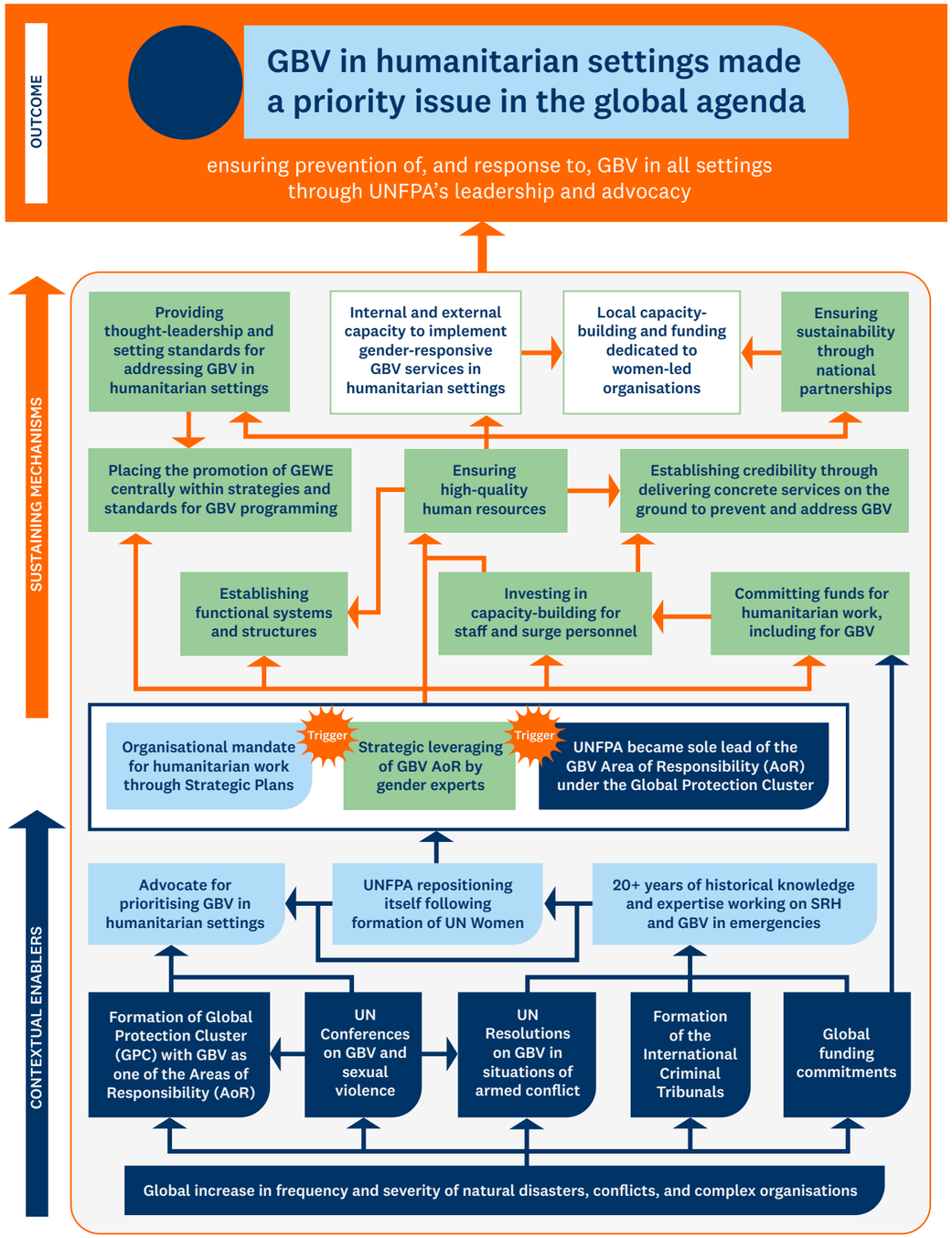
External context | Internal context (WHO) | Mechanism (action) | Mechanism (change)

Case study 6: GBV in humanitarian settings prioritised in the global agenda through UNFPA's leadership and advocacy



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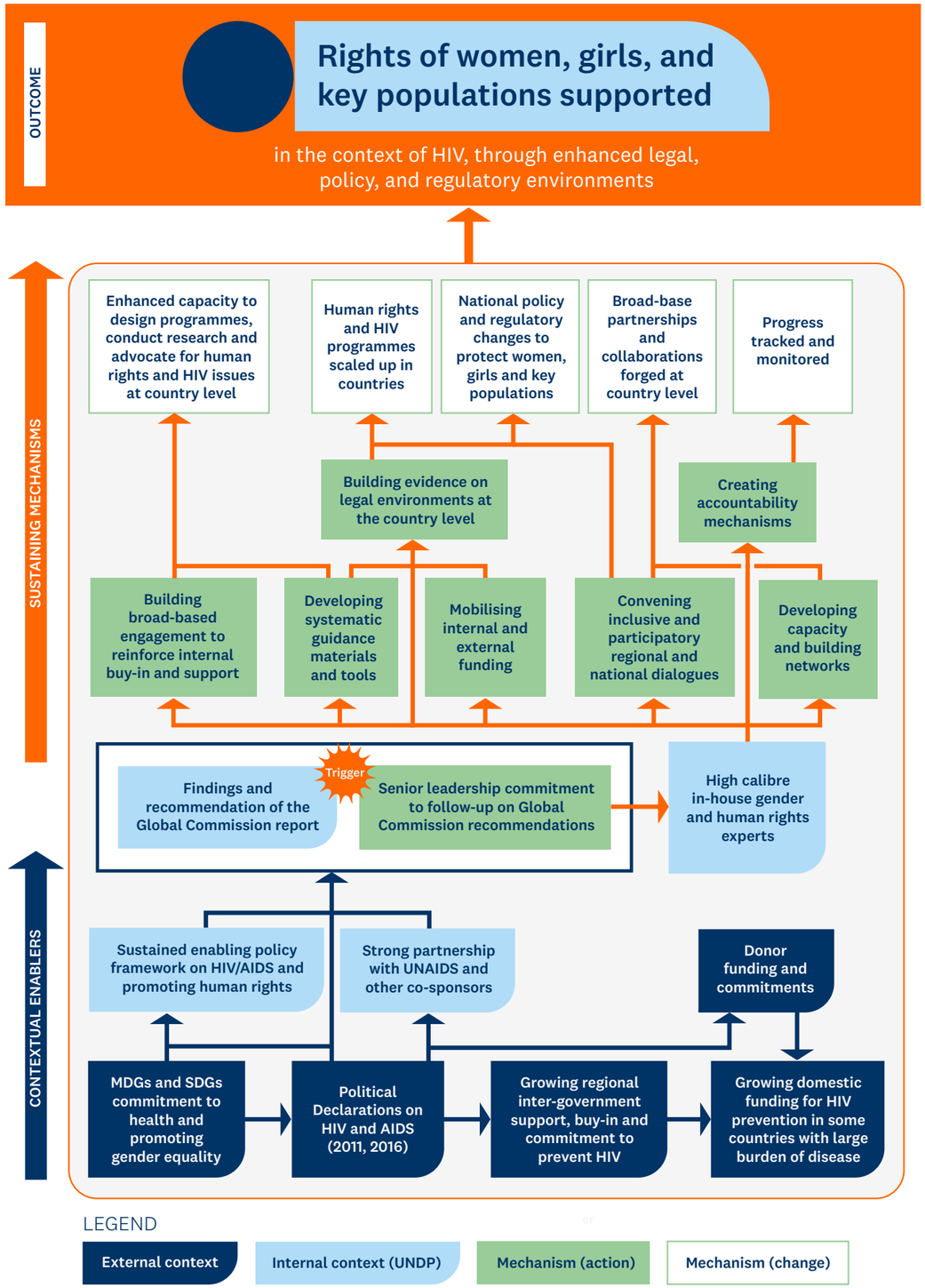
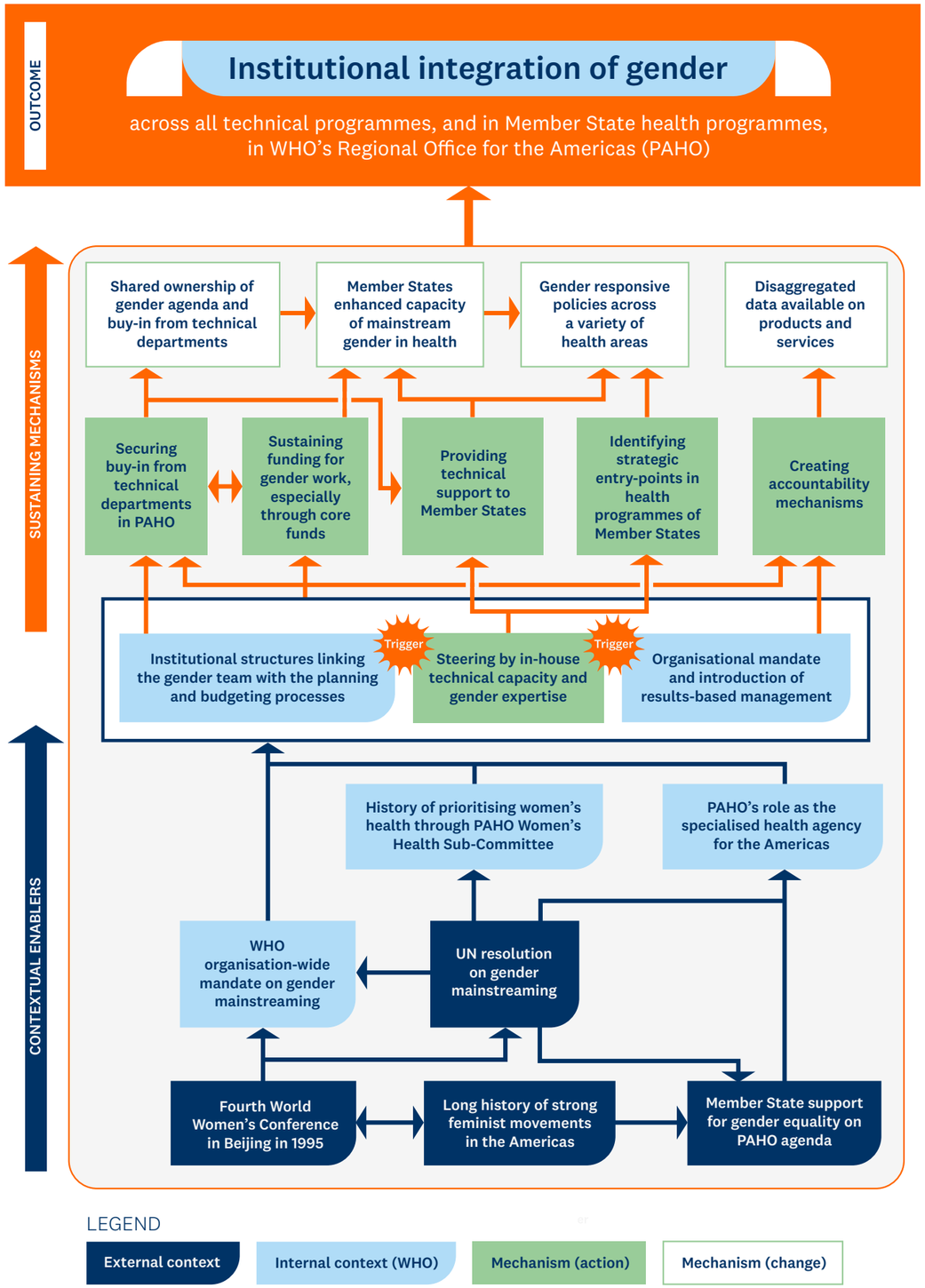
External context | Internacl context (UNFPA) | Mechanism (action) | Mechanism (change)

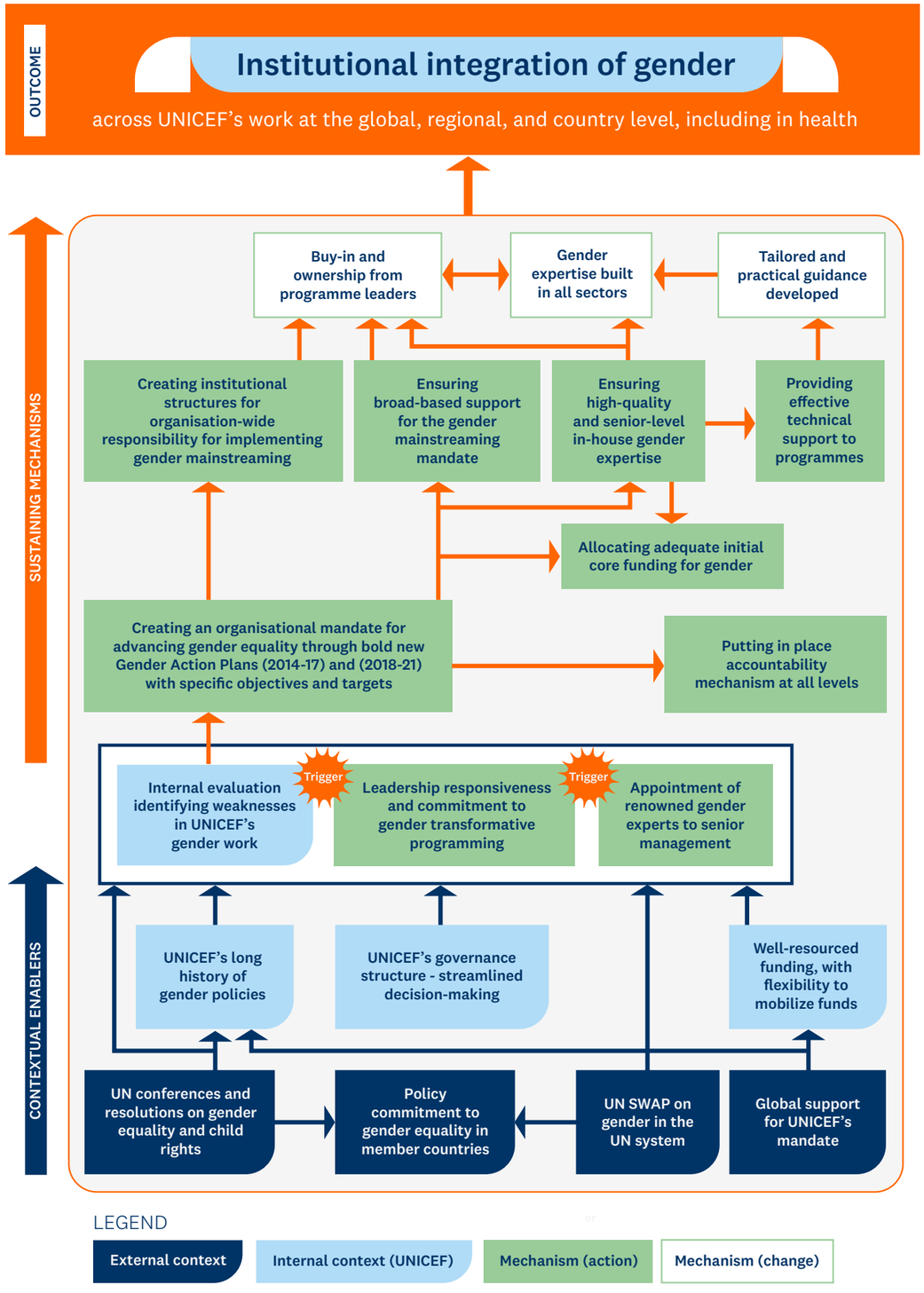
Case study 7: Enabling the rights of women and girls through enhanced legal, policy and regulatory environments in the context of HIV (supported by the UNDP HIV, Health and Development group)



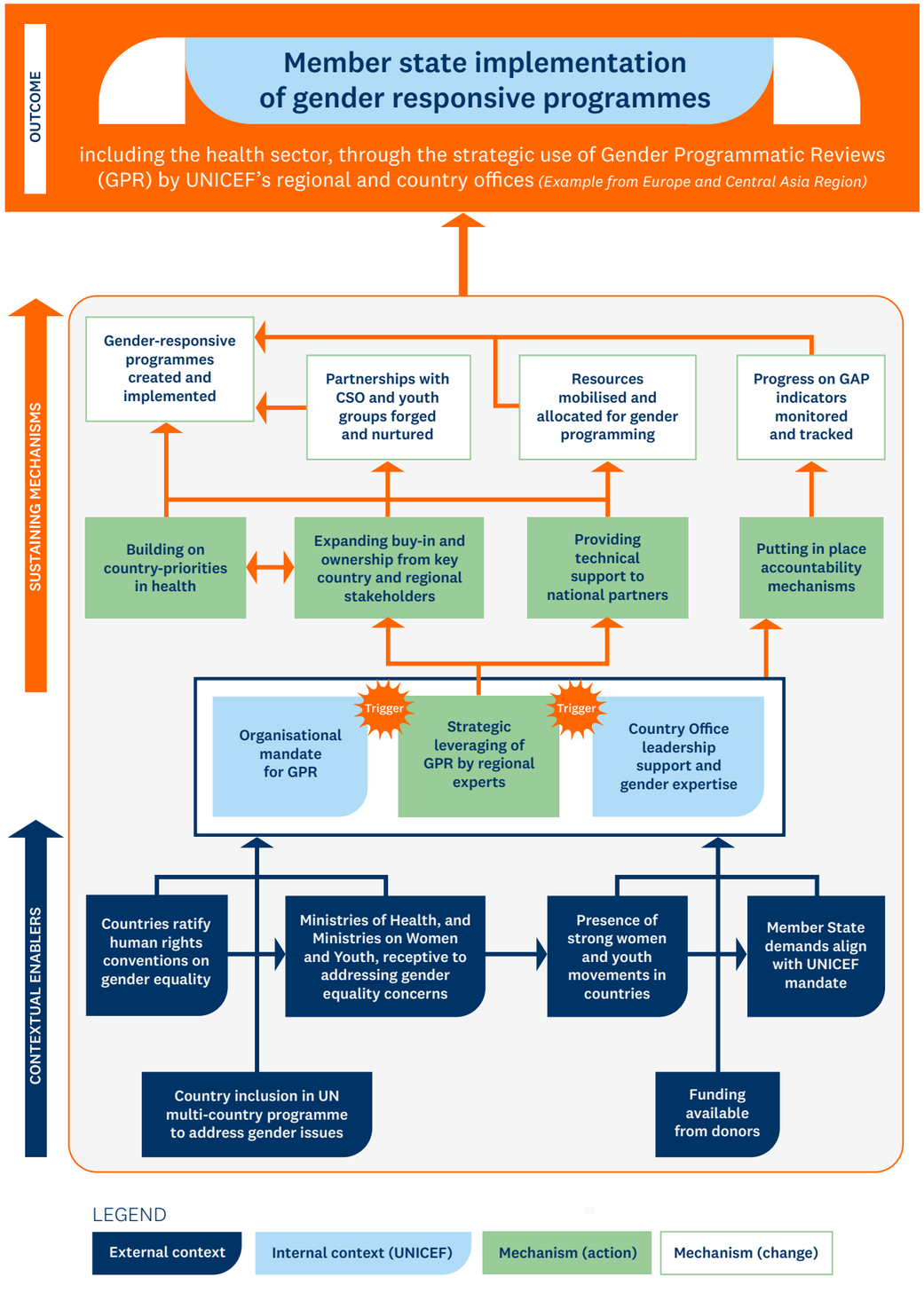
Case study 8: Institutional integration of gender across all technical programmes, Member State health programmes, and PAHO



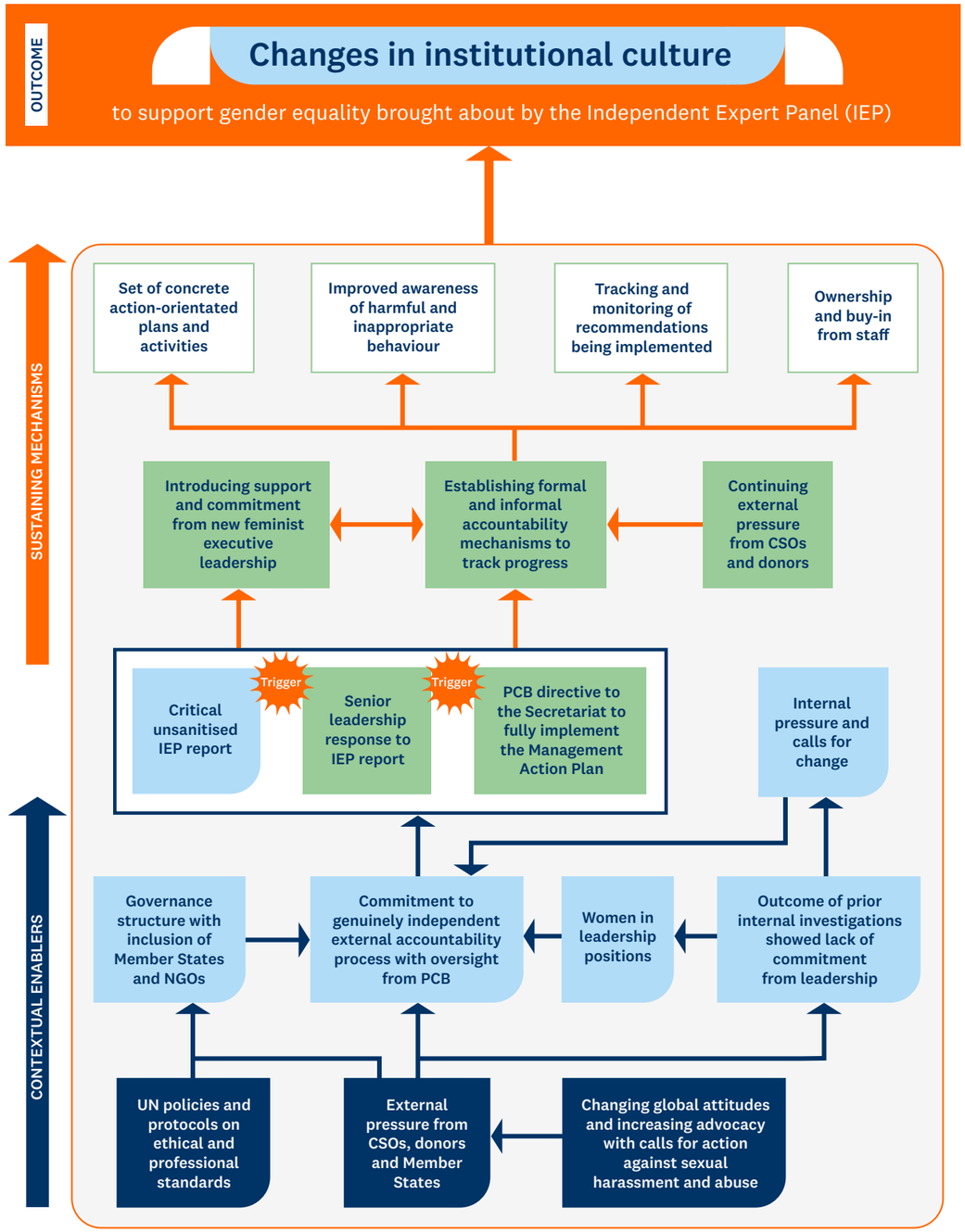
Case study 9: Institutional integration of gender at global, regional and country levels, including in health (UNICEF)



Case study 10: Member State implementation of gender-responsive programmes, including in the health sector, through the strategic use of Gender Programmatic Reviews (UNICEF regional and country offices, Europe and Central Asia)



Case study 11: Changes in institutional culture within UNAIDS Secretariat to support gender equality brought about by the Independent Expert Panel



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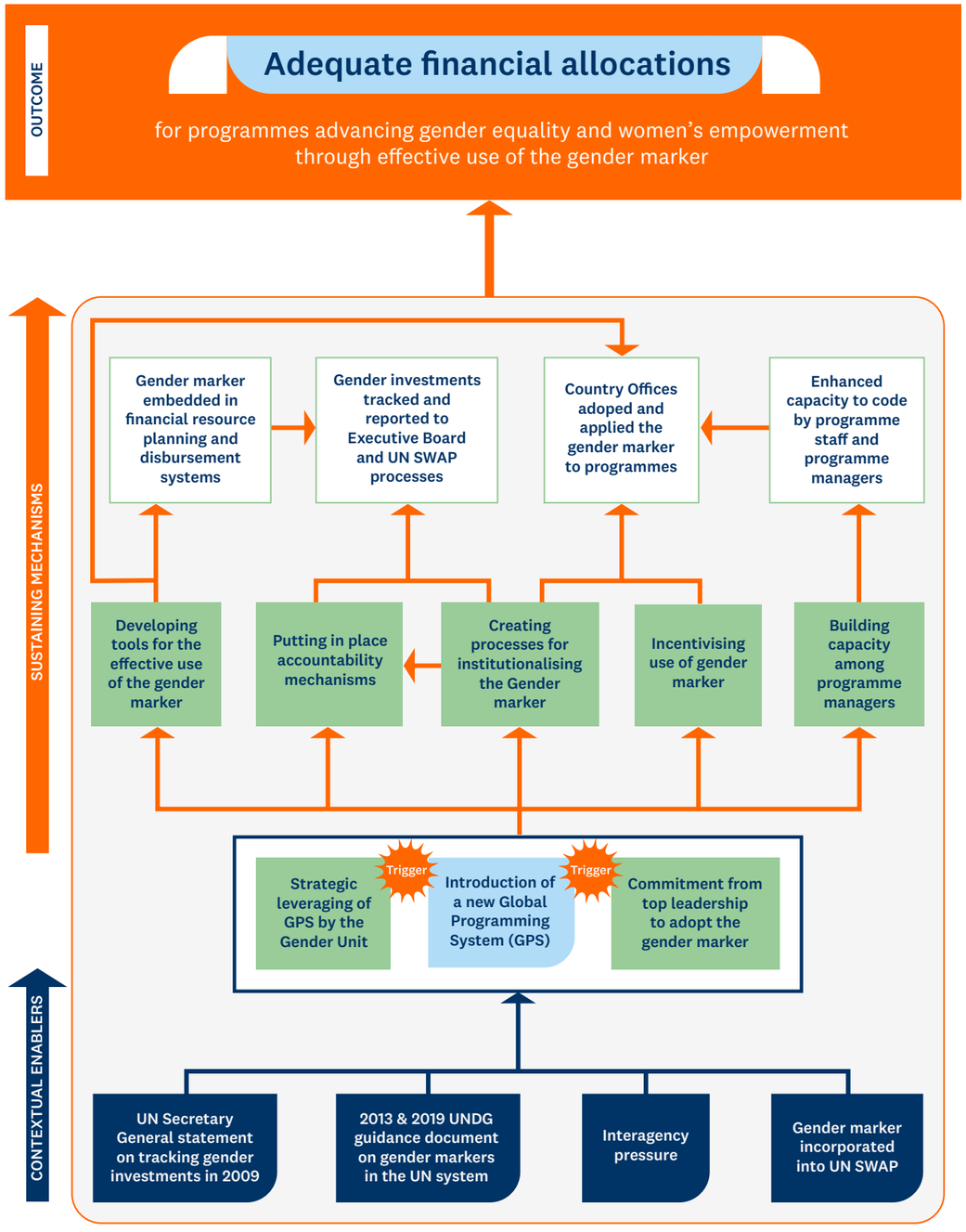
External context | Internal context (UNAIDS) | Mechanism (action) | Mechanism (change)

Case study 12: Adequate financial allocations for programmes advancing gender equality and women's empowerment through effective use of the Gender Equality Marker (UNFPA)



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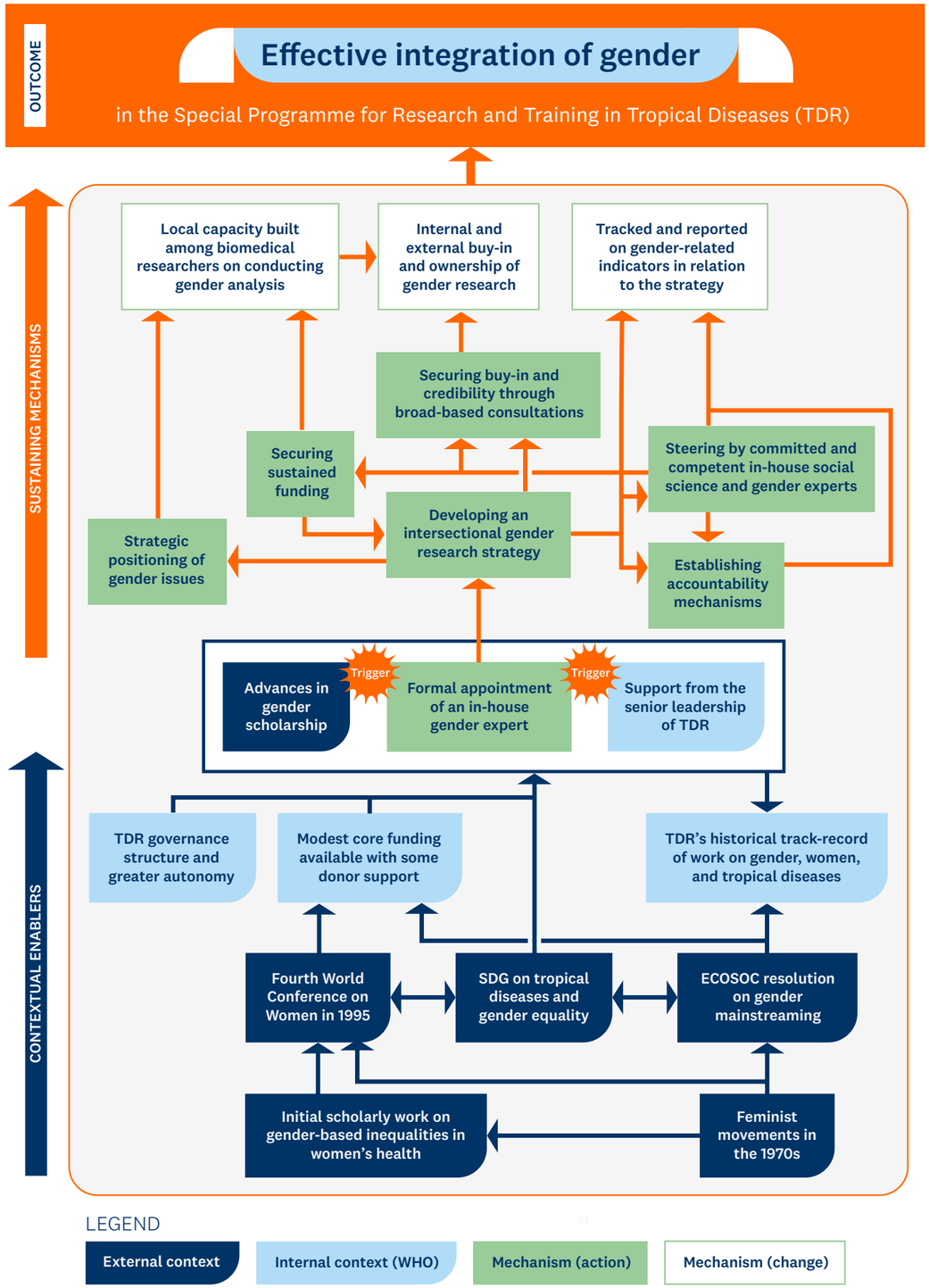
External context | Internacl context (UNFPA) | Mechanism (action) | Mechanism (change)

Case study 13: Integration of gender into the Special Programme for Research and Training in Tropical Diseases (TDR) (WHO)



Case study 14: Improved institutional and programmatic gender mainstreaming through increased participation in the Gender Equality Seal (UNDP country offices)