

**INTEGRATING
EQUITY,
GENDER,
HUMAN RIGHTS
AND SOCIAL
DETERMINANTS INTO
THE WORK OF WHO**

**ROADMAP
FOR
ACTION**

(2014–2019)



**World Health
Organization**

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Summary

This document presents a Roadmap for Action, i.e., corporate integration of equity, human rights, gender and social determinants across the World Health Organization (WHO): all programmes, offices and key management processes. The Roadmap has three main directions:

1. provide guidance on the integration of sustainable approaches, which advance health equity, promote and protect human rights, are gender-responsive and address social determinants in WHO programmes and institutional mechanisms;
2. promote disaggregated data analysis and health inequality monitoring;
3. provide guidance on the integration of sustainable approaches, which advance health equity, promote and protect human rights, are gender-responsive and address social determinants, into WHO's support at country level.

The primary audiences of the document are WHO programmes and offices, required to integrate WHO core values and approaches, into the way they think, plan and operate. A secondary audience consists of Member States and other contributors of resources who are knowledgeable about the 2016–17 Programme budget and want to know how it links to roll-out of mainstreaming in practice.

The **Roadmap for Action** describes *how* the integration of equity, human rights, gender and social determinants will be rolled out, including strategic milestones. A companion document, the **Unifying Framework Guide** explains *what* integration of WHO core values and approaches means and provides illustrative examples. The Roadmap for Action is expected to be adjusted in synchrony with WHO's management cycle, i.e., the next adjustments will be in early 2016.

The Roadmap covers actions in four programme areas of the Twelfth General Programme of Work and the Programme budget, i.e.: programme area 3.31 in full, and programme areas 3.42, 4.43 and 6.14 in part¹. While the Roadmap is facilitated by the team, it is not the workplan or responsibility of a single organizational entity or level. It should be noted that headquarter units and regions may have additional actions depending on their specific mandates, circumstances and needs. Not all these actions are not captured by the Roadmap.

¹ 3.3 Gender, equity and human rights mainstreaming; 2 3.4 Social determinants of health; 3 4.4 Health systems, information and evidence; 4 6.1 Leadership and governance.

1. Introduction

Health outcomes are not equal for people throughout the world, or even within countries. The underlying reasons are complex. Those differences that are avoidable and unacceptable are inequities. For example, noncommunicable disease deaths occur at younger ages in low- and middle-income countries compared to high-income ones (1); blindness prevalence is two to three times higher in women than men in areas where trachoma infection is common (2); deaths among children under five years of age are notably higher in rural than in urban populations (3); and the risk of complications of childbirth among girls under 15 years old is much higher than for older women (4). While much work is already ongoing, WHO has increased its commitment to support countries in reducing health inequities through policies and programmes with which it is involved. In keeping with its constitutional commitment that the “highest attainable standard of health is one of the fundamental rights of every human being (5); and in response to a call from Member States to learn from and more effectively utilize earlier efforts, the Director-General Margaret Chan has prioritized the mainstreaming of equity, human rights, gender and social determinants across the Organization. The GER team, the Social Determinants of Health (SDH) unit, the Health Statistics and Information Systems (HSI) department, and the Country Cooperation and UN Collaboration (CCU) department share a focus on tools. They and their counterparts in the regional offices work together to reach out to programmes across WHO at all three levels: Headquarters (HQ), regional offices and country offices. The approach to implementation will promote cross-programme, cross-regional and cross-country collaboration and learning as well as support for regional leadership.

“Of all forms of inequality, injustice in health care is the most inhumane.”

Martin Luther King

This Roadmap aligns with the six leadership priorities of WHO’s Twelfth General Programme of Work (12th GPW):

1. universal health coverage;
2. the International Health Regulations (2005);
3. increasing access to medical products;
4. social, economic and environmental determinants;
5. noncommunicable diseases; and
6. health related Millennium Development Goals (MDG).

It also aligns as well as with WHO’s commitment to wider UN mandates, including the United Nations System-wide Action Plan for Implementation of the Chief Executives Board (CEB) Policy on Gender Equality and the Empowerment of Women (UN SWAP), the UN Common Understanding on the Human Rights-Based Approach to Development Cooperation and the post-2015 Sustainable Development Goals (SDGs) (6).

The proposed SDGs are formulated much more holistically and comprehensively than the MDGs, have a strong equity focus and suggest data disaggregation with a broad range of stratifiers: income, sex, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant to the national contexts. With this focus, SDG 3 “Ensure healthy lives and promote well-being for all at all ages” puts health at the centre-stage of sustainable development and confronts WHO with the challenge of providing global public health leadership.

“In a context of growing inequity, competition for scarce natural resources and a financial crisis threatening basic entitlements to health care, it would be hard to find a better expression of health as a fundamental right, as a prerequisite for peace and security, equity, social justice, popular participation and global solidarity...” (6).

Integrating equity, human rights, gender and social determinants into all WHO’s policies, programmes and institutional mechanisms will build on lessons learnt in previous efforts to enhance the organizational culture and ability to support Member States in making sustainable health and development gains.

2. Directions for Organization-wide integration of WHO core values and approaches

Integration of equity, human rights, gender and social determinants is expressed in the WHO 12th GPW, in the Gender, Equity and Human Rights Mainstreaming Programme Area, Outcome 3.3: *“Gender, equity and human rights integrated into the Secretariat’s and countries’ policies and programmes”*. Three main directions as described in the following pages will be pursued in order to guide roll-out to all programmes, offices and countries. The work is spearheaded by the GER team, in collaboration with the HSI department, the SDH unit, the Planning, Resource Coordination & Performance Monitoring (PRP) department, the CCU department, the Evaluation unit and the Office of the Director-General (DGO), and reaches out through networks in programmes and offices.

Direction 1: Provide guidance on the integration of sustainable approaches, which advance health equity, promote and protect human rights, are gender-responsive and address social determinants in WHO programmes and institutional mechanisms

This direction will contribute to the delivery of 2016–2017 Programme budget (PB) outputs 3.3.1 “*Gender, equity and human rights integrated in WHO’s programme areas*”; 3.4.2 “*A social determinants of health approach to improving health and reducing health inequities integrated in national, regional and global health programmes and strategies, as well as in WHO*”²; and 6.1.1 “*Effective WHO leadership and management in accordance with leadership priorities*”. Successful integration will begin with integration into key corporate processes and strengthening institutional capacity through technical guidance and information dissemination networks to promote organizational change and culture transformation. Cultivating dialogue and monitoring change will ensure commitment and accountability.

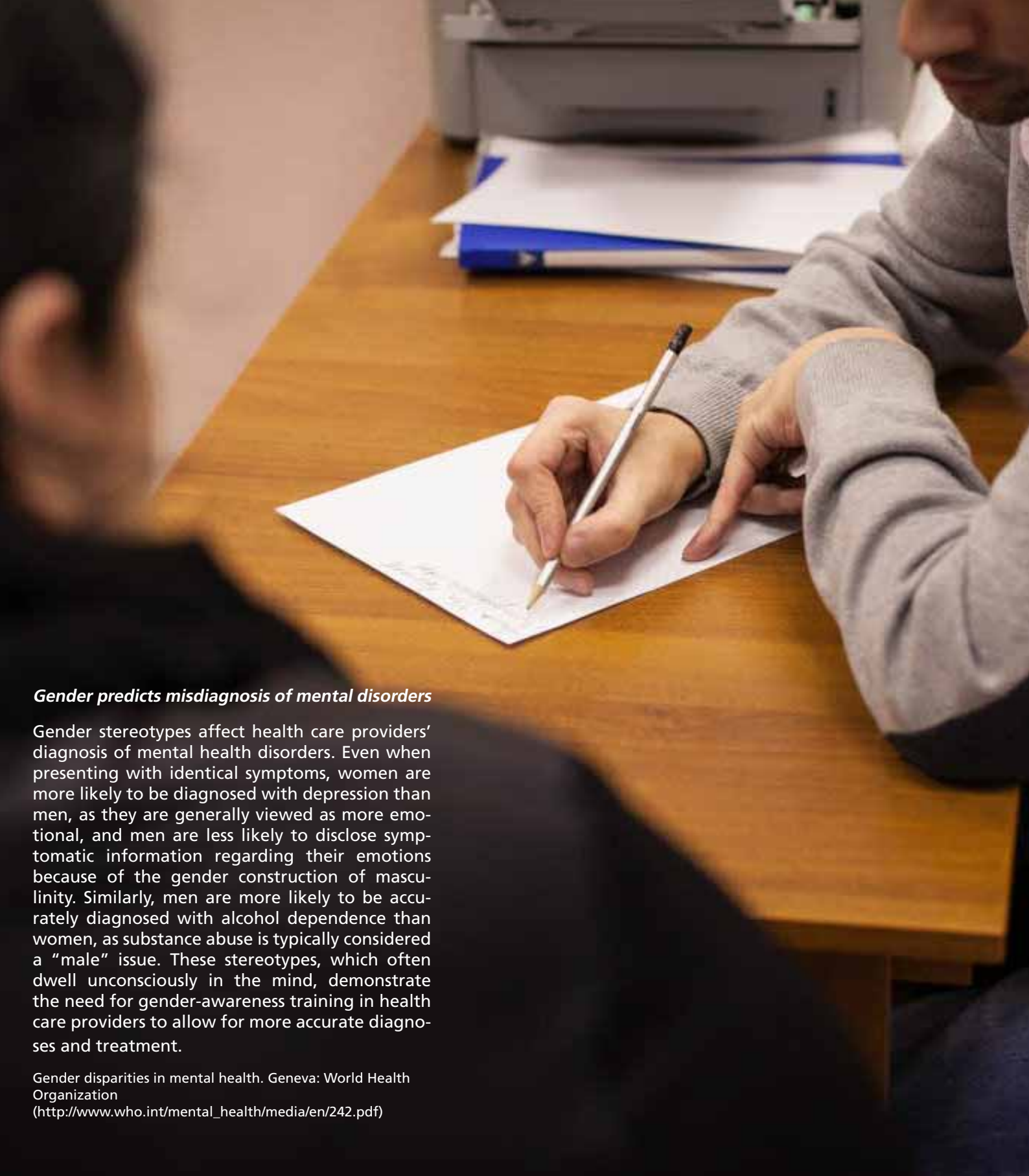
How (with examples of ongoing / planned action)	Examples of achievements
Facilitate integration in key WHO corporate processes - Essential mainstreaming criteria for operational planning and monitoring - Integration into end-of-biennium review guidelines for 2014–15 - Integration into guidance for PB 2018–19 preparation, including for outcome and output indicators and deliverables	- Now included in the WHO Country Cooperation Strategy guide - Now included in the WHO evaluation guide - Now included in the WHO Handbook for guideline development - The PB 2016–17 now includes GER in the category and programme area narratives
Provide technical and capacity - building support for integration in WHO programme areas and normative functions Unifying framework with examples and glossary Briefing package for programmes and country offices Seminars on how practically to integrate GER into guideline development	E-learning course - New HQ staff induction briefing Briefings and training conducted in some country offices - Now included in the WHO representative handbook (7).
Create WHO-wide focal point, collaborating centres and other external partner networks Develop a network guide Setting up and managing a comprehensive network	Regional and category focal points in place during the PB 2016–17 planning
Foster multilateral, intersectoral dialogue for commitment to integration and corresponding policy Policy panel discussions - Collaboration with other UN agencies, including using the informal UN Platform on social determinants of health	
Review and document best practices for integration - Commissioning of studies Publication of experiences	15 country and two cross-regional case studies on implementing human rights policies and actions commissioned

² Measured in indicator 3.3.1

Direction 1 milestones until the end of 2019:

- Number of WHO programme areas that have integrated (PB 2016–17 output 3.3.1 indicator)
 - by 2017: 15 out of 30 programme areas
 - by 2019: 30 out of 30 programme areas
- Progress towards meeting the targets in the United Nations System-wide Action Plan (UN SWAP) requirements (indicator for PB 2016–17 Outcome 6.1)
 - by 2017: 14 out of 15 performance indicators met or achieved. (Target 10 “gender architecture and parity” will not have been met.)³
 - by 2019: (provisionally) 15 out of 15 performance indicators met or achieved

³ WHO-UN SWAP performance indicators: accountability – (1) policy and plan; (2) gender-responsive performance management; (3) strategic planning; (4) results-based management – monitoring and reporting, oversight; (5) evaluation; (6) gender-responsive auditing; (7) programme review; human and financial; (8) resource tracking and (9) allocation; (10) gender architecture and parity; (11) organizational culture; capacity; (12) capacity assessment and (13) development, coherence, knowledge and information management; (14) knowledge generation and communication; (15) coherence.



Gender predicts misdiagnosis of mental disorders

Gender stereotypes affect health care providers' diagnosis of mental health disorders. Even when presenting with identical symptoms, women are more likely to be diagnosed with depression than men, as they are generally viewed as more emotional, and men are less likely to disclose symptomatic information regarding their emotions because of the gender construction of masculinity. Similarly, men are more likely to be accurately diagnosed with alcohol dependence than women, as substance abuse is typically considered a "male" issue. These stereotypes, which often dwell unconsciously in the mind, demonstrate the need for gender-awareness training in health care providers to allow for more accurate diagnoses and treatment.

Gender disparities in mental health. Geneva: World Health Organization
(http://www.who.int/mental_health/media/en/242.pdf)

Direction 2: Promote disaggregated data analysis and health inequality monitoring

This direction will contribute to delivery of PB 2016–17 outputs: 3.3.1 “Gender, equity and human rights integrated in WHO’s programme areas”; 3.3.2 “Countries enabled to integrate and monitor gender, equity and human rights in national health policies and programmes”; 3.4.3 “Trends in, and progress on, action on social determinants of health and health equity monitored, including under the universal health coverage framework and the proposed sustainable development goals”⁴; and 4.4.1 “Comprehensive monitoring of the global, regional and country health situation, trends, inequalities and determinants, using global standards, including data collection and analysis to address data gaps and system performance assessment”.

Only by disaggregating and analysing data can populations in need of health services be identified and included in informed policies and programmes. The global GER team together with the HSI department and SDH are developing instruments and interactive tools for monitoring health inequalities, and inequities, providing the foundation for further integration.

How (with examples of ongoing/planned action)	Examples of achievements
Develop materials to aid data disaggregation and integrated equity, human rights, gender and social determinants analysis across all levels of WHO – “Monitoring intersectoral factors influencing equity-oriented progress towards Universal Health Coverage (UHC) and health equity – Handbook on health inequality monitoring, in Spanish, Arabic and French – Advocacy booklet on monitoring health inequality, in Spanish – PowerPoint lectures based on the handbook, in Spanish	– WHO Health Equity Monitor – Handbook on health inequality monitoring in English – Advocacy booklet on monitoring health inequality and the accompanying video-clips – PowerPoint lectures based on the handbook – The e-Learning module on health inequality monitoring
Facilitate equity, human rights, gender and social determinants situation analysis of existing quantitative and qualitative national data – Case studies being finalized for four countries: Bangladesh, Brazil, South Africa and Viet Nam – Health equity assessment toolkit (HEAT)	– Interactive visualization report State of inequality – Extensive capacity -building through regional ‘training of trainers’ and HQ workshops on health equity analysis
Support capacity -building, including strengthening of health information systems, for country health inequality monitoring with data disaggregated by pertinent strata – Global network of institutes for capacity -building on health inequality monitoring among Member States – UHC PLoS equity paper in Spanish	– Training of trainers – Equity data analysis and interpretation capacity -building workshops – UHC PLoS equity paper (English)

⁴ Indicator/milestone to be determined.

Direction 2 milestones until the end of 2019

- Additional countries monitoring inequalities in reproductive, maternal, neonatal and child health indicators through data disaggregated at a minimum by age, sex, place of residence and wealth⁵
 - by **2017**: four additional countries
 - by **2019**: (*provisionally*) four additional countries
- Additional programmes⁶ monitoring inequalities through data disaggregated at a minimum by age, sex, place of residence and wealth
 - by **2017**: one additional programme
 - by **2019**: (*provisionally*) one additional programme

⁵ 93 countries are currently reporting reproductive, maternal, neonatal and child health indicators based on data from Demographic and Health Surveys/Multiple Indicator Cluster Surveys to the Global Health Observatory Health Equity Monitor http://www.who.int/gho/health_equity/about/en/ (accessed 18 Aug 2014)

⁶ This could, e.g., be tuberculosis, noncommunicable diseases, ageing and health. However, this would require new resources – something that might be feasible given the focus on equity in the SDGs, including capacity – building for data disaggregation (SDG17.18).



Direction 3: Provide guidance on the integration of sustainable approaches, which advance health equity, promote and protect human rights, are gender-responsive and address social determinants, into WHO’s support at country level

The third direction builds on the first two and contributes to delivering on PB 2016–17 outputs: 3.3.1 “Gender, equity and human rights integrated in WHO’s programme areas”; 3.3.2 “Countries enabled to integrate and monitor gender, equity and human rights in national health policies and programmes”; 3.4.2 “A social determinants of health approach to improving health and reducing health inequities integrated in national, regional and global health programmes and strategies, as well as in WHO”; 4.1.1 “Improved country governance capacity to formulate, implement and review comprehensive national health policies, strategies and plans (including multisectoral action, and ‘health in all policies’ and equity policies)”; 4.2.1 “Equitable integrated, people-centred service delivery systems in place in countries and public-health approaches strengthened”; and 6.1.1 “Effective WHO leadership and management in accordance with leadership priorities”.

Direction 3 requires working with disease- and condition-specific programmes as well as with health systems strengthening programmes at all three levels of WHO and aligned with the UHC goals. The global GER team together with SDH, HSI, and CCU among others will work with regional offices depending on the regional and country circumstances and requests, including facilitating multistakeholder review processes leading to programmatic changes that address avoidable health outcome and access differences.

How (with examples of ongoing/planned action)	Examples of achievements
Provide technical and capacity -building guidance for WHO regional and country office support for action in countries – Finalization of the methodology for reviewing how national health programmes can better address equity, human rights, gender and social determinants – Change in global treaty monitoring process to ensure health measures consistent with SDGs (provisionally SDG 3, 5, 10 and 17)	– The review methodology has been applied in six countries previously and the revised version – with human rights and gender strengthened – is now being piloted in an additional eight countries. – Regional and country focal points are systematically reviewing all draft Country Cooperation Strategies for integration of equity, human rights, gender and social determinants
Provide technical assistance to Member States on integrating equity, human rights, gender and social determinants into national health policies, strategies and plans – Materials and enhancing capacity for input across all three levels of the Organization	
Review and document best practices for rolling- out integration in countries – Operations and action research in pilot countries	

Direction 3 milestones up to the end of 2019:

- Number of countries implementing at least two WHO-supported activities to integrate into their health policies and programmes (PB 2016–17 output 3.3.2 indicator)
 - by **2017**: 32 countries (up from 6)
 - by **2019**: *(provisionally)* 56 countries
- Percentage of WHO Country Cooperation Strategies developed during the biennium that are explicitly guided by the Organization's core values and approaches based on equity, human rights, gender and social determinants
 - by **2017**: to be determined.
 - by **2019**: to be determined
- Number of countries improving planning, implementation and monitoring of health programmes by integrating social determinants of health and health equity in line with WHO-supported tools and guidance (PB 2016–17 output 3.4.2 indicator)⁷
 - by **2017**: 25 countries (up from 11)
 - by **2019**: to be determined

⁷ SDH Unit has confirmed that the 3.4.2 indicator double-counts the review tool, i.e., the numbers in the 3.3.2 indicator milestone. However, the indicators appear in the PB 2016–17 under two different Programme areas (3.3 and 3.4) in the version going to the World Health Assembly.



Ethnic minorities often excluded from health programmes

Countries need increased capacity to revise and reorient their health programmes to account for the shortcomings that exclude vulnerable populations from equitable access to care.

An equity study conducted in Macedonia showed that Roma women, who make up Europe's largest ethnic minority group, were more likely to be excluded from a government maternal health programme because of: lack of access due to inadequately distributed physicians; lack of appropriate documentation; and low levels of education which inhibited their ability to access care. They were also less likely to seek services because of fear of discrimination by health workers and fear of physical examinations for cultural reasons.

3. Architecture for Organization-wide integration

Effective integration becomes a responsibility for the whole Organization from top to bottom and across all programmes and offices. *“Organizational leadership and corporate services form the backbone of successful mainstreaming of values and approaches to equity, human rights, gender and intersecting social determinants in all areas of work”⁸*. Further, one of the proposed outcome indicators for the *“Leadership and governance”* programme area is *“Proportion of WHO country cooperation strategies developed during the biennium that are explicitly guided by the Organization’s core values and approaches based on equity, human rights, gender and social determinants”*.

Systematic integration requires a multipronged approach combining organizational leadership capacities, hierarchies and accountability mechanisms as well as formal and informal networks across the Organization. The facilitating centre for coordination is the global GER team. The Family, Women’s and Children’s Health Cluster collaborates closely with DGO and the General Management Cluster to support integration through their forums and processes, e.g., the Global Policy Group of Regional Directors (GPG), the meeting of Assistant Directors General, Organization-wide planning, reporting and accountability processes, Category Networks and Programme Area Networks. This will include equipping these with knowledge and instruments to exercise their leadership roles in integrating equity, human rights, gender and social determinants into their respective domains of responsibility.

The GER team will expand and facilitate an Organization-wide network building on the lessons learnt from the Priority Public Health Conditions Knowledge Network of the Commission on Social Determinants of Health and other documented Organization-wide network experiences. This network will include staff in key positions and functions as well as staff who have an interest in being champions of change for the integration of equity, human rights, gender and social determinants. As a key tenet of the network GER will encourage and foster cross-programme, cross-office and cross-country learning, experience sharing and support.

⁸ PB 2016–17 Category 6, “Corporate services/enabling functions”.

4. Assumptions and adjustments

A key assumption of the Roadmap and in particular its milestones is that the PBs 2014–15 and 2018–19 will be fully funded at the level of outputs and that there will be sufficient flexibility of the funding to allocate the resources to the activities, staffing and budget centres as required.

Integration of equity, human rights, gender and social determinants of health requires cooperation of a large and diverse group of actors across the Organization. Lessons from past experiences suggest that having the right tools and structures is not enough – continuous attention to the people's part and adjustments to the process are required.

Further, the SDGs will be finalized by the UN General Assembly starting in September 2015. These goals are likely to shape resource flows as well as demand from countries for the years to come.

Therefore, the Roadmap for Action will be adjusted at regular intervals according to WHO management cycles – with the first review scheduled to take place in early 2016.

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