United Nations University
International Institute for Global Health

Gender Integration in Baguio General Hospital and Medical Center (Republic of the Philippines)

Advancing Gender Equality in Health Series
Section 2: Expanding evidence for change

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University of the Western Cape School of Public Health
Ramalingaswami Centre on Equity and Social Determinants of Health
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About the series:

This paper forms part of the 12 paper UNU-IIGH series: *Advancing Gender Equality in Health: Expanding voices, evidence, and time horizons for change* co-developed with civil society, academic, government, and funding experts. Recognising the pioneering work of decolonial and feminist researchers and activists spanning many decades, the series seeks to both challenge and strengthen the evidence-to-policy process by unsettling the status quo within knowledge production, drawing on practice-based evidence, and expanding space for crucial conversations.

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List of abbreviations

ANBEF	*L'Association Nigérienne pour le Bien-être Familial*
BGHMC	Baguio General Hospital and Medical Center
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CNSF	*Centre National de Santé Familiale*
CSI	*Centre de Santé Intégré* [integrated health centre]
DoH	Department of Health
EdM	*École des Maris* [School for Husbands}
FPIC	free, prior and informed consent
GAD	gender and development
GBV	gender-based violence
GFPS	gender and development focal point system
GPB	gender planning and budgeting
HDI	Human Development Index
LASDEL	*Laboratoire d'Etude et de Recherche sur les Dynamiques Sociales et le Développement Local*
MPFPE	Ministry for the Promotion of Women and the Protection of Children
MSP	Ministry of Public Health
MSPPAS	Ministry of Public Health, Population and Social Affairs
NCRFW	National Commission on the Role of Filipino Women
PCW	Philippine Commission on Women
PPGD	Philippine Plan for Gender-Responsive Development
RH	reproductive health
SRH	sexual and reproductive health
SWEDD	Saharan Africa Women's Empowerment and Demographic Dividend
TWG	Technical Working Group
WCPU	Women and Children Protection Unit

Overview of Section 2: Expanding Evidence for Change

In the current climate of multiple concurrent crises, national health systems are struggling to cope with cuts in funding, increasingly privatised healthcare and widening health inequities. In this regard, governments play an important role as critical actors in the provision of scaled and sustained health programmes. One important approach to strengthening health systems is through addressing gender inequalities within health programmes and policies. Gender integration involves identifying and addressing gender inequalities across the whole process of strategic planning, project design, implementation, and monitoring and evaluation. However, despite global commitments to gender integration, a substantial gap remains between intention and implementation. Current practices that seek to integrate gender largely focus on the technical aspects of "what to do", but lack practical insights on "how to do it" – particularly drawing from existing experiential evidence on promising approaches that have been scaled and sustained in diverse contexts and across different levels of the health system.

Recognizing this gap, the United Nations University International Institute for Global Health (UNU-IIGH), together with the School of Public Health (SoPH) at the University of Western Cape in South Africa, and the Public Health Foundation of India through its Ramalingaswami Centre on Equity and Social Determinants of Health (RCESDH-PHFI) have partnered to co-produce the Regional Promising Practices (RPP) project *What Works? Integrating Gender into Government Health Programmes in Africa, South Asia and Southeast Asia*. The RPP project aimed to deepen practice-based evidence on the kinds of policy-relevant factors that lead to successful gender integration in scaled and sustained government health programmes.

The project identified and analysed six promising cases at regional and national levels to understand the pre-existing contextual factors that enabled change, the factors that catalysed change, and the mechanisms that sustained changes over time. These cases are located in Niger, Ethiopia, India, Nepal and the Philippines, and included health policies and programmes at the system, institutional and community levels (table 1).

Table 1. List of Regional Promising Practices case studies

Case study	Country	Level of analysis
Integrating Men into Reproductive Health: The *École des Maris* Programme in the Republic of the Niger	Niger	Community
Meeting the Healthcare Needs of the Transgender Community: The Gender Guidance Clinics of Tamil Nadu (India)	India	Institutional
Gender Integration in Baguio General Hospital and Medical Center (Republic of the Philippines)	Philippines	Institutional
Gender Integration in Medical Education in Maharashtra and Other States (India)	India	System
Gender-Based Violence Service Provision in the Primary Healthcare System in Ethiopia	Ethiopia	System
Right to Safe Abortion in Nepal	Nepal	Policy

Section 2: Expanding Evidence for Change, consists of six stand-alone reports for each case study. Each report is structured in two parts. The first, presents an overview of the RPP project. The second focuses on a particular case study, beginning with a description of the programme or policy whereby gender was successfully integrated, explaining the approaches used to gather, analyse and validate data and then a presentation of the findings, namely the contextual factors that enabled the change, the factors that catalysed change, and the mechanisms that sustained the change over time.

This report focuses on gender integration at Baguio General Hospital and Medical Center (BGHMC) in the Philippines. Specifically, gender has been mainstreamed into the hospital's programs and services by institutionalizing the national Gender and Development Focal Point System (GFPS) to provide more gender-responsive and culturally sensitive healthcare. This report provides detailed insights into the factors that catalysed the institutionalization of the GFPS at BGHMC, what was achieved, and how it was sustained and expanded across hospital departments.

Vue d'Ensemble de la Partie 2 : Élargir les Preuves pour le Changement

Le monde actuel est atteint par des crises multiples et simultanées, les systèmes de santé nationaux avons de mal à faire face contre les coupes budgétaires, la privatisation croissante des soins de santé et l'accroissement des inégalités sanitaires. Dans ce cadre, les gouvernements jouent un rôle essentiel pour assurer la mise en œuvre et la pérennisation de programmes de santé. Une approche importante pour renforcer les systèmes de santé est de remédier les inégalités de genre par le biais de programmes et politiques de santé. Afin de bien intégrer la dimension du genre, il faut identifier et aborder ces inégalités à toutes les étapes d'un projet: y compris la planification stratégique, la conception des projets, la mise en œuvre, et le suivi et l'évaluation. Malgré les engagements globaux en faveur de l'intégration du genre, on constate encore à ce jour un écart considérable entre les intentions et les actions concrètes. Les pratiques actuelles se préoccupent souvent trop des aspects techniques, du « quoi faire », mais manquent de considérations pratiques sur le « comment ». Elles se basent rarement, par exemple, sur des approches prometteuses déployées à grande échelle, maintenues dans de divers contextes et à différents niveaux du système de santé. En réponse à cette lacune, un noyau d'organismes académiques s'est formé pour coproduire un projet de pratiques prometteuses régionales (RPP) intitulé « What Works ? Integrating Gender into Government Health Programmes in Africa, South Asia and Southeast Asia ». Ce projet est mené par l'école de santé publique de l'Université des Nations Unies (UNU-IIGH), en collaboration avec l'école de santé publique de l'Université de Western Cape en Afrique du Sud (SoPH), et le centre sur l'équité et les déterminants sociaux de la santé de la fondation indienne pour la santé publique (le « Ramalingaswami Centre on Equity and Social Determinants of Health » ou RCESDH-PHFI). L'objectif du projet RPP était de comprendre les facteurs qui conduisent à une véritable intégration du genre dans les programmes de santé à grande échelle, de manière durable, avec un accent sur la dimension pratique et politique. Le projet a identifié six études de cas représentant de bonnes pratiques au niveau régional et national. Il les a ensuite analysées pour comprendre les facteurs qui ont permis, catalysé et soutenu une meilleure intégration du genre. Les six cas exemples viennent du Niger, de l'Éthiopie, de l'Inde, du Népal et des Philippines et ils comprennent des politiques et des programmes de santé aux niveaux systémique, institutionnel et communautaire (voir le tableau 1).

Tableau 1. Études de cas RPP

Étude de cas	Pays	Niveau d'analyse
École des Maris – intégrer les hommes dans la santé reproductive	Niger	Communauté
Les « gender guidance clinics » du Tamil Nadu – répondre aux besoins sanitaires de la communauté transgenre	Inde	Institutionnel
Intégration du genre dans le centre médical « Baguio General Hospital and Medical Center »	Philippines	Institutionnel
Intégration du genre dans l'enseignement médical au Maharashtra et dans d'autres états de l'Inde	Inde	Système
La violence basée sur le genre dans les services de santé primaires	Éthiopie	Système
Droit à l'avortement sécurisé	Népal	Politique

La partie 2, intitulée « élargir les preuves pour le changement », comprend six rapports autonomes pour chaque étude de cas. Chaque rapport est structuré en deux parties. La première présente un aperçu du projet RPP. La seconde se concentre sur une étude de cas particulière, commençant par une description du programme ou de la politique ayant permis l'intégration efficace du genre, expliquant les approches utilisées pour collecter, analyser et valider les données, puis présentant les résultats: à savoir les facteurs contextuels qui ont permis le changement, les facteurs qui l'ont catalysé et les mécanismes qui l'ont pérennisé dans le temps.

Ce rapport se concentre sur l'intégration du genre au centre médical « Baguio General Hospital and Medical Center » (BGHMC) aux Philippines. Un système a été mis en place pour fournir des soins de santé plus sensibles au genre et aux différences culturelles ; ceci à travers l'inclusion formelle d'un système national de points focaux dédié au genre (Gender and Development Focal Point System - GFPS). Ce rapport fournit des informations détaillées sur comment le GFPS a été intégré dans les activités du BGHMC, les grandes avancées du projet, les éléments catalyseurs, et ce qui a permis de maintenir et d'étendre le programme à l'ensemble des services hospitaliers.

The Regional Promising Practices Project

What works?
Integrating gender into government health programmes in Africa, South Asia, and Southeast Asia

Introduction, rationale, and aims

The current convergence of simultaneous economic, environmental and geopolitical crises has led to a dramatic increase in the demand for health services, intensifying pressures on resource-constrained health systems [1]. The compound effect on health systems has been a drastic reduction of service provision, creating a ripple effect that has not only worsened overall health outcomes, but exacerbated entrenched gender-based and intersectional inequalities within and across health systems [1–4].

Gender refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women, affecting how women, men and gender-diverse people live, work and relate to one another at all levels – including within the health system [5, 6]. Gender power dynamics can manifest in ways that influence health outcomes through affecting health-seeking behaviours, access to health services and the composition and division of labour within the health workforce.

It also impacts the development and implementation of policies and programmes, the design and use of clinical treatment modalities, health financing and research priorities [5, 6]. For example, LGBTQIA+ populations often experience higher rates of mental health issues due to social stigma and discrimination, yet their mental health needs are often inadequately addressed or misunderstood by health professionals [7]. Although women comprise the majority of the health workforce, they are significantly underrepresented in leadership roles, and experience lower pay, fewer decision-making opportunities and a higher incidence of gender-based discrimination, violence and harassment, compared with their male counterparts [8, 9].

Furthermore, evidence shows that healthcare providers respond differently to men and women seeking care, often assuming that men are less likely than women to comply with treatment [9]. These differences are typically explained in terms of gender biases, in which men are seen as being in control and avoidant with respect to seeking healthcare, while women are seen as being more sensitive and willing to verbalize health concerns and engage in treatment. Differential responses from healthcare providers can reinforce gender norms around masculinity, resulting in individual needs being overlooked, leading to poorer health outcomes [10].

To advance gender equality in health and ensure that everyone has an equal opportunity to optimize their health, policies and interventions which consider and address gendered power relationships are needed to transform inequitable health systems and structures. Integrating gender into health programmes and policies is essential for achieving equality in terms of access to services and ensuring the provision of quality care while tackling harmful gender norms and challenging power dynamics [11, 12].

Gender integration involves identifying and addressing gender inequalities throughout the health management process, including strategic planning, programme and policy design, implementation, and monitoring and evaluation [11, 12]. However, despite the many commitments already made and the broad number of guidelines published on gender integration in health policies and programmes, there exist considerable gaps between intention, discourse and implementation [11, 12]. Specifically, evidence on gender integration largely focuses on the technical content of what must be done, but the practical

insights on how to integrate gender are lacking – particularly with respect to the drivers of change that can be leveraged politically to ensure health policies and programmes integrate gender in diverse contexts.

Programmes that have successfully integrated gender have been largely limited to a handful of health areas, namely sexual and reproductive health and rights (SRHR), maternal, newborn, child and adolescent health (MNCAH), HIV/AIDS, and gender-based violence (GBV) programming and service delivery. Major gaps persist in non-communicable diseases (NCDs), technological innovations, climate change and strengthening health systems [11, 12]. In addition, gender integration has typically been restricted to small-scale, community-based health interventions led by non-governmental organizations (NGOs). These are usually time-bound and limited in terms of their reach and resources, thus precluding delivery and sustainability at scale [11, 12].

To achieve scale and further advance gender equality, health programmes need to be implemented and owned by governments and sustained through national systems [12]. Governments can harness state power to drive transformative change, setting a precedent that compels other stakeholders (including the private sector) to follow suit and align their efforts with national goals for gender equality and improved health outcomes. Thus, strong political leadership is crucial to ensure gender integration in health remains priority, especially in the context of polycrises and growing anti-gender and women's rights movements.

Government ownership plays a key role in sustaining and scaling gender-integrated health programs through implementing supportive legislature, driving systemic reforms, providing necessary funding, infrastructure and resources to support the health workforce and programme needs. However, there is limited documentation and information sharing across diverse regional and national contexts on the key drivers of change that promoted successful gender integration in government health programmes and policies

To this effect, the UNU-IIGH has partnered with the SoPH at the University of Western Cape in South Africa and the Public Health Foundation of India through RCESDH-PHFI. Together we co-produced the RPP project, which aimed to establish an evidence base of the critical factors that have led to successful gender integration within government health programmes in Africa, Asia and Southeast Asia. Objectives included:

a. Documenting policy-relevant and contextual factors that facilitated change, the catalysts that initiated change and the mechanisms that sustained change over time;

b. Identifying the transferable lessons learned in order to inform current and future health programmes on how to integrate gender perspectives more effectively.

Conceptual framework and methodology

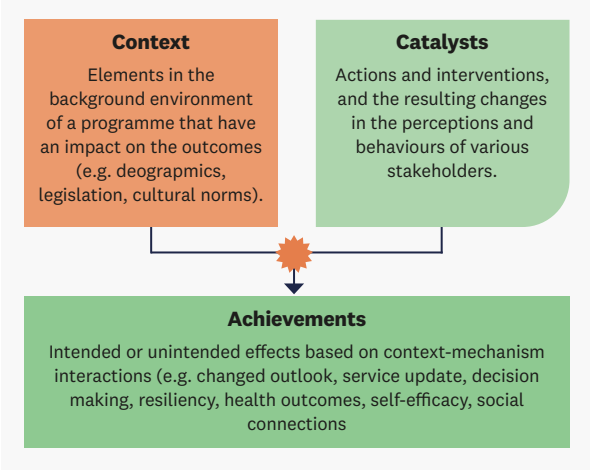
This project was informed by the approach and conceptual framework used in a previous UNU-IIGH study – What Works in Gender and Health in the United Nations – which sought to understand the drivers behind the successful integration of gender into health programmes and institutional structures within the multilateral system. It explored the pathways through which gender was successfully integrated by analysing: (1) the outcomes achieved; (2) the contextual enabling factors; (3) the factors that triggered change; and (4) the mechanisms that supported those changes to be sustained over time [13].

For the present series of studies, the conceptual framework was modified to align with the aims of the project. As the project was not designed to evaluate health programmes or policies, but rather understand the drivers of change, outcomes were not assessed. Instead, the project team focused on documenting the key achievements identified and reported. In addition, "triggers" were renamed as "catalysts", referring to catalytic moments whereby a change in the internal or external context opened a window of opportunity, which was subsequently seized by specific actors.

Thus, the framework was modified to include context, catalysts (instead of triggers), mechanisms and achievements (instead of outcomes) to describe the complex pathways of change that led to successful gender integration (figure 1).

Given the focus on regional, national and local levels, and the intention to leverage findings at the policy level, it was critical to form genuine partnerships with regional organizations to co-define and co-own the work. Each organization identified two or three experts to be part of the core team, and these members met online regularly. Together, this core group, through a

Figure 1. A modified CMO conceptual framework to analyse successful gender integration



shared decision-making process, collectively defined the scope, definitions, eligibility criteria and approaches used, and collectively examined each case study. This process of co-production enabled the core team to regularly review, reflect and respond to contextual realities from multiple perspectives as the project unfolded, allowing the findings to be iteratively developed and adapted. Ethical clearance for the study was obtained from the Joint Ethical Review Board of the United Nations University (Ref No. 202203/03).

Research process and strategy

Broadly, the project was carried out in four stages: (a) definition of eligibility criteria; (b) selection of cases; (c) data collection; and (d) cross-study comparisons.

Stage 1: Defining inclusion criteria for potential case studies

A set of eligibility criteria for potential case studies was developed following an initial review of the literature on gender integration in health programmes and policies (table 2).

A broad range of successful examples of gender integration in government health programmes and policies across the regions were crowdsourced using three approaches: (a) an open call; (b) a

Table 2. Eligibility criteria for potential case studies

Criterion	Description
Region	Health programmes implemented in one or more countries in either Africa, South Asia or Southeast Asia.
Government involvement	Health programmes that involved at least one governmental body, either at the national or subnational level, including health ministries, in programme design, implementation, or monitoring and evaluation.
Health focus	Health programmes that contributed to improved health outcomes implemented by health or other ministries. Such programmes may relate to (but not be limited to) community mobilization, water and sanitation, nutrition, regulation of food, tobacco and alcohol, as well as health service delivery, health information systems, access to essential medicines, health workforce, health financing, leadership and governance.
Gender focus	Health programmes that addressed the needs or situations of particular gender groups (women, men or non-binary people) with respect to power inequalities or harmful gender norms (e.g. transforming gender norms to end female genital mutilation, transforming power relations within the health workforce).
Duration	Health programmes that have been active for at least 3 years.

desk review; and (c) making direct contact with key stakeholders.

A month-long open call was launched via relevant social media platforms of UNU-IIGH, SoPH UWC and the PHFI, along with emails to institutional lists (Appendix 1). Stakeholders, including government, private, academic and other research institutions, NGOs and civil society organizations (CSOs), United Nations agencies, and others were invited to submit information regarding government health programmes or policies that met the inclusion criteria. Although the core team initially considered publicizing the call in languages other than English, because of potential translation costs it was decided that the call for submissions should be circulated in English with translations being available on request.

Table 3. Desk review search strategy

	Keyword searches
1	Gender mainstreaming OR gender transformation OR gender integration
2	Health programs OR health system OR community health program* OR health intervention AND
3	Government OR Government supported

Alongside the open call, an online desk review was completed by the team at UNU-IIGH. This involved searching online databases of published literature on PubMed and Google Scholar, relevant grey literature through Google searches and targeted searches of websites of government ministries, and bilateral and multilateral agencies. Table 3 shows the keywords used to guide the search strategy.

The search was limited to articles published between 2000 and 2022 to ensure that the most recent health programmes or policies were identified. Studies from the desk review were included in the long list if they matched the eligibility criteria.

The core team also directly emailed relevant stakeholders and key contacts, including gender focal points at regional WHO offices, regional and national CSOs, and contacts within government ministries (e.g. health, women's affairs), inviting them to share information regarding eligible programmes or policies, and to disseminate the open call across their networks.

Potential cases were sorted according to: (a) name of health programme; (b) country location; (c)

type of government involvement; (d) programme duration; (e) health area of focus; (f) programme aims; (g) gender impact; (h) health impact; and (i) contact details of relevant individuals.

Stage 2: Final selection of the case studies

Fifty-one potential case studies were submitted or sourced from the desk review, with 18 from Africa, 19 from Southeast Asia and 14 from South Asia [14]. These covered more than 26 countries across the three regions, including a multi-country programme on female genital mutilation and one on menstrual hygiene. Other health themes identified from the submitted case studies included the following:

- GBV (links with mental health, providers' training, health system responses through hospital-based clinics and outreach programmes, empowering survivors of violence)
- Male involvement (antenatal care, training for men to support women's sexual and reproductive health, positive fatherhood, boys' and men's attitudes to GBV through developing life skills, challenging hegemonic masculinities)
- Reforms to health services during COVID (mental health support for returned migrants, vaccines for Indigenous people and homeless women, reproductive, maternal, newborn and child health, gender-responsive HIV services)
- Water, sanitation and hygiene (menstrual health and hygiene, gender-separated toilets, women's participation and decision-making around water and sanitation)
- HIV services (targeted at drug users, sex workers, men who have sex with men, and adolescent girls)
- LGBTQIA+ issues (clinics for transgender men and women, impact of universal healthcare policies on LGBTQIA+ persons)
- Cross-cutting health systems issues (mainstreaming of gender data, gender-responsive planning and budgeting, community health workers, gender in medical education)
- Gender-responsive vertical programmes (gender-sensitive tuberculosis care, cervical cancer screening and gender-equitable malaria services)

The majority of submissions were made by CSOs working with government ministries, UN agencies and technical implementing partners, while a much smaller number were submitted by government ministries. Submissions concerning the African region were invariably from CSOs.

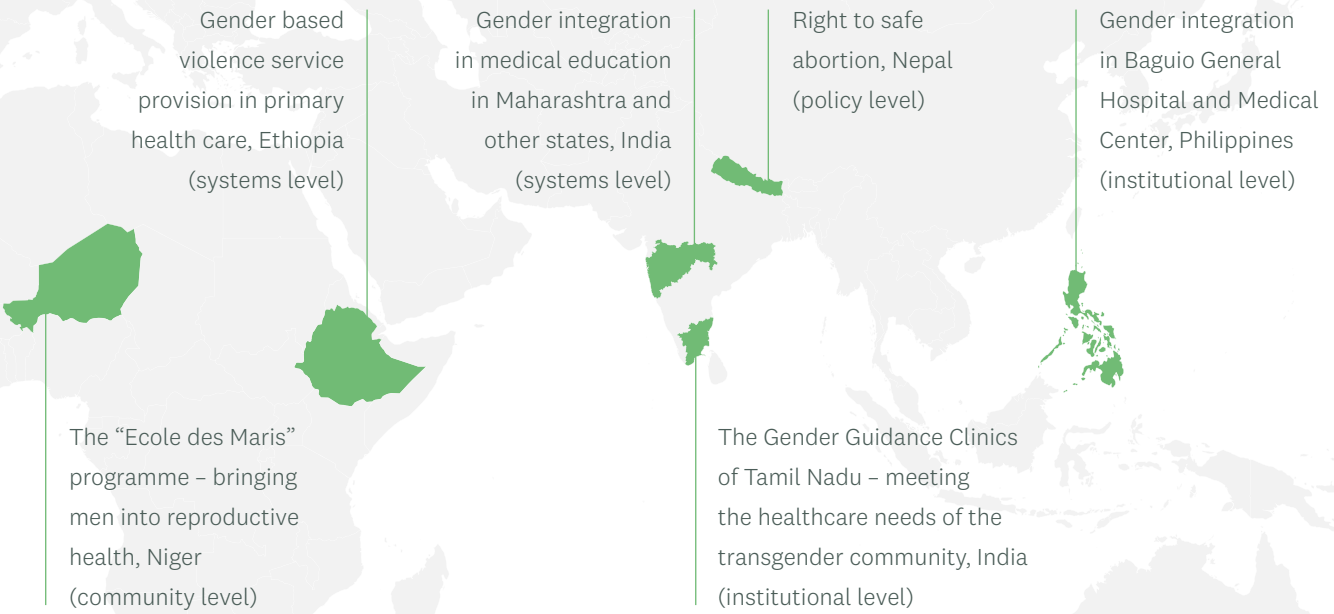
Initial screening of potential case studies revealed that:

- Many programmes showed minimal or unclear involvement from the government (i.e. government involvement was primarily advisory or consultative).
- Levels of donor funding often overshadowed government funding.
- Many programmes were of short duration, generally for 1 year or less.[1]
- Gender integration was limited and information on gender-relevant outcomes was largely absent.

Although the initial list of potential case studies spanned a broad assortment of health-related themes most programmes clustered around a narrow range of health areas, largely SRHR or GBV. There was also a large geographical skew,

1 In Africa, the duration of 17 programmes was unspecified, while two programmes were active for 1 year; in South Asia, the duration of seven programmes was unknown; and in Southeast Asia, five programmes operated for 1 year or less, with three programmes having an unspecified duration.

Figure 2. Map of the six case studies



with most programmes located in just a handful of countries and subregions. Overall, fewer than 20 potential case studies were associated with substantial government involvement, active for at least three years and went beyond addressing the health needs of any particular gender to address gender inequalities.

Input from 10 advisers with extensive expertise in gender and health across Africa, South Asia and Southeast Asia was sought to determine the final list of programmes. They made three broad recommendations, which guided the final selection of programmes:

a. Prioritize programmes in health areas beyond SRHR and GBV as these areas have been the mainstay of gender programming. They also recommended searching for cases of gender integration in disease-focused areas (NCDs or infectious diseases) and health systems (e.g. health workforce, sector-wide planning).

b. Choose programmes that capture regional diversity to balance the concentration of potential cases in a handful of countries (e.g. India, the Philippines, Ethiopia).

c. Given the difficulty in identifying programmes with definitive gender and health outcome measures, select those programmes where promising progress has been made and lessons can be drawn to address existing gaps.

Across the three regions, seven programmes were selected for in-depth data collection [15] on the basis of their regional representation, programme diversity, levels of gender integration and government involvement, and long-term sustainability. Programmes were located in the Philippines, Timor Leste, India, Nepal, Ethiopia and Niger. The focus ranged from gender mainstreaming in hospital systems, gender-responsive budgeting, male engagement and

mainstreaming gender in primary healthcare, to transgender health and sexual and reproductive health. The case study in Timor Leste, however, was eventually excluded because of the non-response from country partners, resulting in a total of six case studies (figure 2).

Stage 3: Case study data collection and policy dialogues

Once case studies were selected, each regional team collected data for their respective cases in cooperation with country partners. Both published and unpublished material was gathered and reviewed and in-depth interviews with key stakeholders were undertaken to broaden the data collected. For each case data were gathered on: (1) outcomes achieved; (2) contextual factors that enabled gender integration in the programme or policy; (3) factors that triggered change; and (4) mechanisms that supported the changes to be sustained over time.

Policy discussions were held with key government stakeholders and decision makers on the nature and implications of each study's findings, and opportunities for evidence-informed policy change were identified. The diversity of contexts meant that regional teams needed to use a number of different strategies to gather evidence, tailoring each policy dialogue to the case study in question.

Stage 4: Cross-case study analysis

In addition to the individual case study analyses by the regional teams, a 4-day in-person workshop was hosted by UNU-IIGH to produce cross-cutting analyses and consolidate the findings. Transferable lessons were identified on the key elements that drove the scale and sustainability of gender integration in government health programmes across policy, institutional, system and community levels, along with transferable tactics that can be used to broker change at various levels. In line with the co-creation model of the RPP project, partners discussed strategies to further promote the project's findings.

Gender Integration in Baguio General Hospital and Medical Center (Republic of the Philippines)

The need for gender integration and cultural competence in tertiary care

Responsive and equitable health systems are crucial for delivering effective and efficient healthcare in order to align with the Sustainable Development Goals and provide universal health coverage. Tertiary hospitals play a critical role in healthcare by providing specialized care and fostering medical research and education, as well as serving as referral centres for complex medical cases. However, persistent gender inequalities, which are rooted in unequal gender norms and biases, are often widespread across the health system, ultimately impacting the well-being of both healthcare providers and clients. These axes of discrimination often intersect with social dimensions, class, race and indigeneity, affecting access to quality healthcare, how patients are treated within the healthcare system, and the decision-making power they have over their own health and well-being. For example, LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual) populations in the Philippines face barriers in accessing services because of stigma, discrimination, gender-insensitive and gender-inappropriate treatment by healthcare providers, and lack of health programme and insurance coverage for gender-specific health services. Such experiences negatively affect the quality of care, engagement with care and self-medication, and pose a greater risk of medical complications. For instance, to meet their health needs, transgender individuals may resort to alternative methods, such as seeking unlicensed providers to perform gender-affirmative surgeries or searching for guidance from the Internet or other transgender persons on how to self-medicate [1].

While maternal health services and programmes have seen some improvements, maternal mortality remains high in the Philippines at 78 maternal deaths per 100,000 live births. Evidence suggests that maternal health service utilization in rural areas is affected by the lack of financial resources and unavailability of skilled health personnel. These in turn have negative effects on the lack of capacity of health facilities to provide services like evaluation of the progress of pregnancy, the provision of laboratory examinations, free medicines, immunizations, and other region-bound factors. Further, poor uneducated women are less likely to engage in post-partum services because of the lack of information on the importance of post-partum care, as well as limited access to health providers [2].

Gender integration[1] (or mainstreaming) in tertiary hospitals is an important strategy to address gender disparities and enhance access and quality of hospital healthcare services for all. To serve the needs of diverse populations and avoid reinforcing harmful stereotypes and norms, it is imperative that the healthcare system, including tertiary hospitals, takes measures towards improving gender integration and cultural competence.

The Baguio General Hospital and Medical Center in the Philippines

In the Philippines, the Department of Health (DoH) has reported that Indigenous groups, which account for approximately 13 per cent of the Filipino population, are among the most disadvantaged and marginalized, and are considerably vulnerable to health inequities [3]. These disparities are further compounded along gendered lines, with Indigenous women and LGBTQIA+ communities experiencing additional discrimination and stigmatization.

1 The terms “gender integration” and “gender mainstreaming” are often used interchangeably, referring to the process of incorporating gender considerations into all policies, programmes and practices to ensure gender equality.

The principles of health equity and inclusiveness are part of the universal healthcare strategy of the DoH, with the aim that all Filipinos, not just those financially and socially advantaged, have access to health services, especially in remote parts of the country. In line with this, BGHMC plays a critical role in providing services to communities in the northern Philippines, contributing to the broader national goal of accessible and inclusive healthcare.

BGHMC is in the City of Baguio, the largest city in the Cordillera region, with a large migrant community composed of various socioeconomic classes, ethnicities and religions. BGHMC is the largest tertiary hospital in the northern Philippines in terms of number of patients, staff and facilities, with a current capacity of 1,200 beds and over 15 different medical departments. It has been identified as the lone apex hospital in northern Philippines following the passing of the Apex Hospitals Act in 2022. The hospital caters to these diverse groups, including the LGBTQIA+ community, and Indigenous ethnolinguistic groups from the Cordillera Administrative Region and lowland communities in northern Luzon, particularly from Pangasinan and La Union Provinces. Many of these groups, to varying degrees, maintain Indigenous culture and practices. The hospital charges lower fees compared to services offered in Pangasinan and La Union, and most patients who access BGHMC are from lower socioeconomic groups.

In 2024 the hospital was undergoing major expansion, including a multi-specialty centre (heart, brain, kidney and lung) and a trauma centre, with the long-term goal of capacity to transplant organs so that patients do not have to go to Manila.

Since 2016, BGHMC has sought to provide healthcare that is both gender-responsive and culturally sensitive. Gender has been mainstreamed into the hospital's programmes and services through institutionalizing the national gender and development focal point system (GFPS). This case study documents what has been achieved so far and analyses the contextual factors that enabled the integration of gender, the actions that catalysed the expansion of the GFPS across all hospital departments and the actions that allowed changes to be sustained over time.

Overview of the GFPS

The gender and development programme

In 1995, President Fidel V. Ramos signed Executive Order 273, adopting the Philippine Plan for Gender-Responsive Development (PPGD) 1995–2025 [4]. The PPGD outlined policies, strategies, programmes and projects that the Government must adopt to enable women to participate in and benefit from national development. The Executive Order directed all government agencies, departments, bureaux, offices and instrumentalities, including corporations owned and controlled by the Government, to:

- Take appropriate steps to ensure the full implementation of the policies/strategies and programmes and projects outlined in the plan
- Institutionalize gender and development (GAD) principles in planning, programming and budgeting processes

In 2009, the Philippine Government enacted the Magna Carta of Women – a comprehensive law to advance women's rights, reduce health disparities and fulfil international commitments. All government institutions and agencies in the Philippines – from the national level down to the smallest political unit in villages – were mandated to adopt GAD mainstreaming (or integration) to promote women's rights and eliminate gender discrimination across all systems, structures, policies, programmes, processes and procedures. GAD represents a strategy for:

a. Making women's and men's concerns and experiences an integral dimension of the design, implementation, monitoring and

evaluation of policies, programmes and projects in all social, political, civil and economic spheres so that women and men benefit equally;

b. Assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels.

The GFPS is the main mechanism for implementing and strengthening gender mainstreaming and government agencies must allocate a minimum of 5 per cent of their budgets for this purpose [5]. Focal points are required to conduct regular gender-sensitivity training, gender analysis, gender audits and other GAD capacity development programmes that support the functions of the GFPS [6].

Governance and organizational structure of the GFPS at BGHMC

At a national level, monitoring and supervision of the GFPS is the responsibility of the Philippine Commission on Women (PCW), a policymaking, advisory and coordinating government body on women and gender equality [6], responsible for establishing GAD mechanisms at the regional and local levels. For instance, regional GAD committees have been established to implement gender-responsive policies and programmes across various regions [6]. These regional committees are responsible for communicating and consolidating the regional GAD plan and budget, preparing reports and ensuring the alignment of local GAD initiatives with the central office's priorities. At the local level, GAD is implemented through the GFPS, as in the case with the BGHMC.

At BGHMC, the GFPS is composed of 42 members, representing all medical units and departments across the medical centre (figure 3). Effective implementation and compliance with PCW monitoring, evaluation and reporting systems requires effective leadership and coordination across several departments, such that:

a. The GFPS is led by the medical centre Chief, who serves as the Chair and oversees implementation, issues policies and develops institutional structures to support GAD mainstreaming activities, as well as approving GAD plans and budgets.

b. The Chair is supported by the GFPS Management Committee, which includes five core members[2] and six guest members.[3] The Committee is responsible for implementation of the GFPS and reviewing all GAD plans and budgets. It identifies GAD mainstreaming programmes and activities based on BGHMC's priorities. Results from gender audits and analyses are drawn on to respond to gender issues raised by clients and staff.

The Technical Working Group (TWG) facilitates implementation through formulating GAD programmes, plans and budgets and provides technical assistance. It is composed of eight members, including a Chair appointed by the GFPS Chair, a Vice-Chair and six members from the most relevant departments.[4] The TWG is further supported by the GAD ward assistant. Aside from the TWG, 20 focal point persons implement the GFPS in their respective departments.[5]

2 These represent medical services, hospital operations and patient support services, nursing services, allied health professional services and finance services.

3 Guests include a quality assurance officer, the professional education and training office, the public health unit, the BGHMC employees' association, the legal office and the planning unit.

4 These include the Budget Office, the Human Resource Management Office, the Planning Unit, Nursing Services, the Engineering and Faculties Management Office and the Women and Children Protection Unit.

5 Anaesthesiology, Oncology, Dentistry, Emergency Room, Family and Community Medicine, Family Planning, HIV-AIDS Core Team, Internal Medicine, Medical Social Work, Obstetrics and Gynaecology, Otorhinolaryngology Head and Neck Surgery, Human Resource Management, Neurology, Nursing Services, Nutrition and Dietetics, Pathology, Paediatrics (2 representatives), Psychiatry, Radiology and Surgery.

Figure 3. Organizational structure of the GAD focal point system of BGHMC

Source: GAD Focal Point System [5].

Methodology

Research objectives

The study set out to document and analyse policy-relevant factors that led to the successful integration of gender into the delivery of health services at BGHMC. Specific objectives included the following:

a. Examine the contextual factors that contributed to the effective integration of GAD into BGHMC;

b. Analyse the catalysts and actors that helped establish and sustain GAD in BGHMC;

c. Identify promising practices that promoted effective GAD integration in government health programmes and health systems and which are transferrable to other geographic contexts;

d. Explore some of the achievements related to implementing the GFPS within BGHMC departments and their impact on the lives of patients and their families in terms of access to quality health services and addressing gender inequality issues.

Data collection

Data were collected from both primary (key informant interviews) and secondary sources (desk reviews and Internet research).

Primary data collection

All interviews were conducted by a local researcher. The interview guide and consent documents were translated into Ilokano, the lingua franca in the region. Interviews were conducted in both English and Ilokano, depending on the participant's preferences. Since BGHMC is located in the Cordillera Administrative Region, which is home to various Indigenous peoples, the free, prior and informed consent (FPIC) requirement of the Indigenous Peoples Rights Act was considered. However, the FPIC was not required by the medical centre as there were no interviews planned with clients of the hospital.

In-depth interviews with key informants included those involved in the development and implementation of the GFPS in BGHMC. Participants were selected based on their medical expertise, knowledge and experience with GAD implementation. A total of 10 interviews were conducted with BGHMC staff – four members of the TWG, four GAD focal point persons from different medical department, the chairperson of the GAD focal point system and TWG and the former Executive Director of the PCW. TWG members included:

- Vice-Chair
- GAD ward assistant
- Human Resource Management Office staff member
- Head of the Women and Children Protection Unit (WCPU)

GAD focal point persons were drawn from:

- Family and Community Medicine
- Obstetrics and Gynaecology
- Psychiatry
- Paediatrics

These interviews explored participants' views on factors that led to the creation of GAD within the BGHMC, their roles and responsibilities in implementing GAD, challenges and the perceived benefits of implementing GAD. Attempts were made to interview the Chief of BGHMC (or his proxy from the Management Committee), but conflicting schedules prevented this.

In addition, the former Executive Director of the PCW was interviewed and provided valuable insights on gender issues in the Philippines and PCW's role as the lead implementing agency for gender mainstreaming.

Secondary data collection

Desk and Internet research were undertaken to gather additional data on the following themes:

- Philippine gender equality laws, policies and ordinances and the experiences and struggles in enacting these laws
- Laws and policies on health reforms
- Documents on BGHMC
- The GAD focal point system

Relevant materials such as DoH Memo and Administrative Orders, as well as online materials and printed copies of BGHMC documents were analyzed include the following: BGHMC GAD Accomplishment Reports from 2015 to 2023; BGHMC GAD Plan and Budget 2017-2023; BGHMC Organizational Chart; DoH Administrative Orders e.g., DOH Administrative Order 2021-0026 Monitoring and Evaluation DoH Framework for Republic Act 11223 Universal Healthcare Act; DoH Administrative Order 2020-0024 Primary Care Policy Framework and Sectoral Strategies; BGHMC hospital orders GAD mainstreaming, e.g., Hospital Order 2023-0075 Reorganization of the Gender and Development Focal Point System.

Analysis

Interviews were audio-recorded, transcribed and translated to English where necessary. The transcripts were analysed line-by-line, with themes coded according to the contextual factors that enabled change, key catalysts, mechanisms that sustained changes and achievements. Notes were made of the key actors involved in driving and sustaining changes. Finally, findings were refined during the cross-case study analysis workshop in Kuala Lumpur.

Policy dialogue

On 23 June 2023, a policy dialogue on "Gender and Development Focal Point System (GFPS) as a Promising Mechanism in Integrating Gender in Government Health Programmes: The Case of the BGHMC" was convened. Some 25 participants (17 in-person and eight online) from government, academia, BGHMC and other health organizations met to discuss the case study findings, generate additional insights and propose policy recommendations on mainstreaming GAD in government health institutions in the Philippines.

Opening remarks were delivered by the Chancellor and a professor of the University of the Philippines Baguio. Following this, the case study was presented by the local research consultant, and participants engaged in an open forum to reflect on the findings and share insights from their own experiences.

The discussion highlighted several challenges related to GAD planning and budgeting evaluation processes and the institutional limitations of the PCW. Additionally, several areas for improvement were noted, including the need to integrate GAD into medical curricula, revise the hospital patient intake forms to improve data collection (sexual orientation, religion, ethnicity and other

relevant identity markers) and support GAD work through incentives, compensation and dedicated GAD positions in all government departments. Based on these discussion points, participants collectively drafted policy recommendations.

Overall, the policy dialogue was successful in engaging diverse stakeholders to appreciate and reiterate the importance of GAD work, and in mobilizing support and commitment to improve gender integration in tertiary care.

Ethics

In addition to ethical clearance from United Nations University, ethical approval was also granted by BGHMC (BGHMC-REC-2023-14).

Lessons on the politics of change

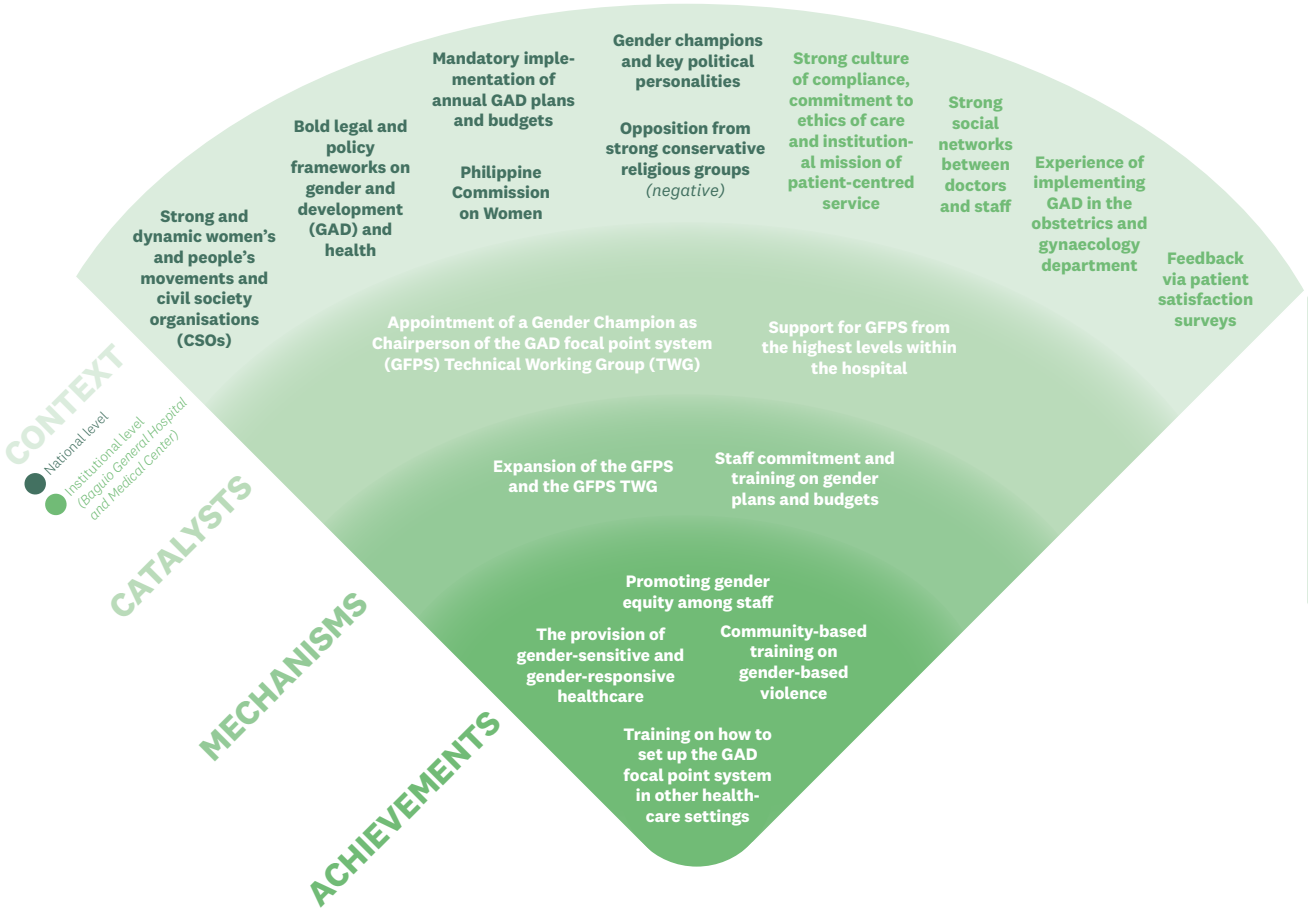
Figure 4 provides an overview of the contextual factors that facilitated the establishment of the GFPS at BGHMC, the factors that catalysed the expansion of the GFPS across all hospital departments and the mechanisms that sustained these changes over time. It also highlights some achievements. Each of these areas is discussed in more detail below.

What has been achieved?

BGHMC has implemented the GFPS in all its departments and regularly conducts gender analysis, gender planning and budgeting, as well as ongoing evaluation of GAD plans, which are mandated by law. While other government institutes find it difficult to meet the minimum 5 per cent budget requirement, in 2022, BGHMC attributed approximately 20 per cent of its budget to GAD.

Based on the patient satisfaction form administered in the hospital (discussed further below), BGHMC appears to enjoy high patient satisfaction scores and has a reputation for providing affordable, gender-responsive care and being sensitive to the needs of elderly persons and persons with a disability. Interviews and the document review showed that, across a range of departments, the GFPS has led to a number of promising gender- and health-related achievements.

Figure 4. Context, catalysts and sustaining mechanisms



Gender-sensitive and gender-responsive healthcare

A number of examples of gender-sensitive and gender-responsive healthcare at BGHMC were identified, including the following:

a. **The establishment of a WCPU.** This has improved the provision of health and psychosocial services to women and child survivors of abuse. Services include women- and child-friendly forensic interviews, physical examinations, specimen collections and diagnostic procedures, debriefing and counselling, referral to other departments and providing medico-legal certificates for testifying in courts [7]. The Cordillera Department of Health (DoH-CAR) is working to establish a WCPU in every hospital in the region. However, as of 2023 only four hospitals had established a functional WCPU, including at BGHMC.

b. **Improvements in the provision of sensitive and non-judgmental post-abortion care**, with an increase in patients over the years. This is yet to be achieved in some other hospitals, such as in the City of Manila and Quezon City. Reluctance to administer post-abortion care is attributed partly to conservative Catholic values and to the fact that abortion is a crime, with penalties of imprisonment ranging from 1 month to 20 years [8].

c. **Dedicated schedules, areas and personnel for teen parents** in the Paediatric Obstetrics-Gynaecology Department.

d. **Spousal consent is no longer required** for contraceptive drugs, devices and procedures, including bilateral tubal ligation.

e. **Psychosocial support sessions are available for caregivers** of admitted patients who are prone to stress as a result of their caregiving role.

Community-based training on gender-based violence

The WCPU at the BGHMC works to provide comprehensive medical and psychosocial services to women and children who have been victims of violence. With support from the TWG, the hospital has gone beyond their mandate to conduct GBV training of officials at village level. Members of the WCPU go to villages to conduct training sessions on identifying various forms of violence against women and children, as well as designing interventions for managing such cases. The TWG considers this one of the notable accomplishments of the WCPU and believes it should be replicated in other hospitals and regions.

Additionally, participants in the policy dialogue revealed that the WCPU had partnered with an international funding agency to provide tele-consultancy services at the village level. Computers have been set up in the local administrative office, allowing people to meet virtually or access services with WCPU staff.

Promoting gender equity among staff

A number of actions promoted gender equity among hospital staff, including:

a. Pro-active encouragement and recruitment of male medical residents in psychiatry (currently 80 per cent of department staff are female).

b. Pro-active encouragement and recruitment of female medical residents in the Surgical Department, which exhibits a large gender disparity. Two new female residents and fellows were recruited.

c. During the COVID-19 pandemic, the Family and Community Medicine Department was able to prioritize the medical needs of hospital employees. This included rolling out diagnostic tests, such as cervical cancer

screening and mammography, to masculine-presenting lesbians, with some tests diagnosing masculine-presenting lesbian hospital staff with health issues related to their reproductive systems.

d. Regular training on sexual harassment in the workplace.

GFPS training in other healthcare settings

In recent years, the TWG has trained management and staff of other hospitals on how to set up a GFPS. In early 2023, training was provided for the St. Louis Medical Center, a university hospital and the largest private hospital in Baguio City.

What contextual factors facilitated the establishment of the GFPS?

A range of national and organizational factors provided an enabling context, which facilitated initiation and scale-up of the GFPS in BGHMC.

National level

Strong and dynamic women's and people's movements and CSOs

The Philippines has a long history of a very strong and dynamic women's and people's movement, as well as civil society, all of which have been instrumental in policy reforms. For instance, during the 1960s, intense lobbying from NGOs – led by the Civic Assembly of Women[6] of the Philippines (now called the National Council of Women of the Philippines) – facilitated the creation of the National Commission on the Role of Filipino Women (NCRFW), the precursor of the PCW.

The NCRFW was created in January 1975 during a period of martial law, by virtue of Presidential Decree 633. The NCRFW was designed to "review, evaluate, and recommend measures, including priorities, to ensure the full integration of women for economic, social and cultural development at national, regional, and international levels and to ensure further equality between men and women". It was the first national women's organization in Asia that responded to the United Nations General Assembly's call for Member States to create government bodies focused on women's concerns [9].

The observed progressive stance on GAD is largely due to the advocacy work of key feminist personalities and "gender champions". For decades, many activists and feminist leaders joined the executive and legislative branches of government, advocating for sexual and reproductive health (SRHR) and helped to reform institutions, and draft and enact "women's laws".

Various women's coalitions included several NGOs and consortiums concerned with women's health, which conducted research, engaged a pool of writers to draft progressive health laws and mobilized lobby groups to push for these laws. For instance, WomanHealth Philippines Inc. is a nationwide organization of feminists and women's health advocates. Two of their long-time national officers, Maria Ana Ronquillo-Nemenzo[7] and Mercedes Lactao-Fabros,[8] as well as Sylvia Estrada-Claudio and Junice Demeterio Melgar of the Likhaan Center for Women's Health Inc., have been at the forefront of policy advocacy and the movement for SRHR nationally and globally. The passage of several women's laws in the Philippine Congress, on average, took 9 to 10 years of struggle.

6 A group of 210 affiliated women's organizations nationwide.

7 Maria Ana Ronquillo-Nemenzo is a feminist working on women's sexual and reproductive health rights. She served as Vice-Chair for the Basic Sector of the National Anti-poverty Commission in 1999 and Commissioner for the Women's Sector until March 2008. She is a pioneer in reproductive health rights advocacy and activism, and health policy expert on legislative concerns [10] .

8 Mercedes Lactao-Fabros was among the pioneering leaders of WomanHealth Philippines, Inc. She headed a team of feminist researchers for the IRRRAG seven-country research programme on reproductive health and rights. The research output was transformed into the chapter "From Sanas to Dapat: Negotiating Entitlement in Reproductive Decision Making in the Philippines", which analyses Filipino women's concept of sexual and reproductive rights from the aspirational ("sana") to rights ("dapat") [11].

Bold legal and policy frameworks on GAD and health

In 1981, during the martial law period, the Philippines signed the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). However, after the People Power Revolution in 1986, which ousted former dictator Ferdinand E. Marcos Sr. and ended martial law, the Government became more open and willing to engage in international agreements. This led the Philippines to sign key global frameworks such as the International Conference on Population and Development (1994) and the Beijing Platform for Action (1995). The Philippine Government ratified these international agreements and a number of United Nations treaties and other global commitments, reflecting a stronger commitment to international cooperation on human rights and development [12].

The Government then refocused its efforts towards improving women's empowerment and gender equality, and NCRFW officials decided to focus on mainstreaming women's concerns in policymaking, planning and programming of all government agencies [12]. These efforts are believed to have contributed to the integration of gender equality in the 1987 Constitution, which mandated that the State "recognize the role of women in nation-building and ensure the fundamental equality before the law of women and men" [12].

Gender equality laws in the Philippines are among the most progressive in the world. Some of the landmark laws that women's groups in the Philippines lobbied for are summarized in Table 4.

Philippine Commission on Women

The PCW is the national agency in charge of supervising the submission, evaluation and monitoring of annual GAD plans and budgets, as well as GAD accomplishment reports from all government agencies and units, including the GFPS. The PCW is a small office under the Office of the President, with limited budget and personnel. Supervision and evaluation of annual GAD plans and budgets were transferred to the central offices of government agencies to enhance and

Table 4. Summary of supportive legal frameworks and policies for gender equality in the Philippines

Date	Title	Description
1992	Women in Nation-building Act (RA 7192)	This national law aimed to promote the integration of women as full and equal partners with men in development and nation-building. Objectives included granting women, regardless of their marital status, the full legal capacity to act and to enter into contracts and equal access to membership in all social, civic and recreational clubs, as well as the right of admission into military schools.
1995	Anti-Sexual Harassment Law (RA 7877)	An act declaring sexual harassment unlawful in employment, education or training environments and other situations.
1995	Gender and Development Budget Policy in the General Appropriations Act	This was enacted to support, with real resources, programmes and projects focused on gender advocacy and committed to women's empowerment [13]. Under the General Appropriations Act, all government departments and agencies were mandated to allocate a minimum of 5 per cent of their total annual budgets for gender programmes, projects and activities. This important feature of the annual General Appropriations Act was further strengthened by the Magna Carta of Women (RA 9710).
1997	Anti-Rape law (RA 8353)	Expanded the definition of rape and reclassified it as a crime against persons. The law considers that any person may be victimized by rape.

Table 4 continues on next page

Table 4 continued from previous page

Date	Title	Description
2004	Anti-Violence Against Women and Their Children Act (Anti-VAWC Act) (RA 9262)	Covers all forms of domestic and intimate partnerships, and comprehensive forms of GBV. Also formed part of the basis for establishing the WCPU in hospitals, and the women's and children's desk in police precincts.
2009	The Magna Carta of Women (Republic Act No. 9710)	A comprehensive human rights law that seeks to eliminate discrimination against women by recognizing, protecting, fulfilling and promoting the rights of Filipino women, especially those from marginalized sectors. It defines the GAD programme as a development perspective and process that is participatory, empowering, equitable, sustainable, free from violence, respectful of human rights, supportive of self-determination and actualizing of human potential. It identifies GAD planning and budgeting as an essential mechanism to ensure the implementation of the law. It seeks to achieve gender equality as a fundamental value to be reflected in development choices and contends that women are active agents of development, not just passive recipients of development.
2012	Responsible Parenthood and Reproductive Health Act (RA 10354)	A national policy that mandates the Philippine Government to comprehensively address the needs of citizens when it comes to responsible parenthood and reproductive health. This law guarantees: (1) access to reproductive health and family planning services, with due regard to the informed choice of individuals and couples who use such services; (2) maternal healthcare, including skilled birth attendance and facility-based deliveries; (3) reproductive health and sexuality education for youth; and (4) regular funding for the law's full implementation [14].
2018	The Philippine HIV and AIDS Policy Act (Republic Act No. 11166)	Establishes the country's comprehensive policy for preventing, treating and supporting those affected by HIV and AIDS.
2018	The Universal Health Care Act (Republic Act No. 11223)	Institutes universal healthcare for all Filipinos, prescribing reforms to the healthcare system and appropriating funds. It is the policy of the State to protect and promote the right to health of all Filipinos and instil health consciousness among them. This Act seeks to progressively realize universal healthcare in the country through a systemic approach and clear delineation of roles of key agencies and stakeholders towards better performance in the health system and to ensure that all Filipinos are guaranteed equitable access to quality and affordable healthcare goods and services and protect them against financial risk.
2022	Safe Spaces Act (RA 11313)	Addresses all forms of sexual harassment, recognizing that both men and women must have equality, security and safety, not only in private, but also on the streets, in public spaces, online, in workplaces and educational institutions.
2019	Gender Equality and Women's Empowerment Plan (2019–2025)	A Government plan regarding the implementation of initiatives to achieve gender equality and women's empowerment. It serves as a guide and key reference in formulating GAD plans and budgets. The plan was updated in 2022 to support and align with the updated Philippine Development Plan (PDP) 2017–2022 and the remainder of the PPGD 1995–2025. It provides strategic actions to respond to the changing needs of women and girls following the COVID-19 pandemic [15].

streamline the process. For example, government hospitals, which used to submit directly to the PCW, are now required to submit their GAD plans and budgets to the central office of the DoH.

Mandatory submission of GAD plans and budgets began in 2014 when the PCW rolled out their Gender Mainstreaming Monitoring System to track annual plans, budgets and accomplishment reports. The approval of total annual budgets of government institutions and agencies is contingent on their GAD plans and budgets being approved by the PCW. However, institutional, administrative and fiscal limitations of the PCW hampers their monitoring of the proper implementation of the Magna Carta of Women.

Gender champions and key political personalities

The political culture of the Philippines is heavily personality-oriented and the passage of a bill depends on sponsorship from a popular politician. Unfortunately, many female politicians are not necessarily pro-women and such politicians usually act in accordance with their class interests. Thus, there are but a handful of genuine gender champions in Philippine Congress. One exemplary gender champion and ally to women's groups was former Senator Leticia Ramos-Shahani, who was the sister of former President Fidel V. Ramos.[9]

Opposition from strong conservative religious groups

The Philippines is considered one of the most gender-equal countries in the Western Pacific region [16]. However, full implementation of gender equality laws is often hampered by conservative patriarchal systems in Philippine society [16]. The strong hold and power of the Roman Catholic Church and Muslim organizations on politicians and the electorate have fettered laws promoting gender equality. This was evident in how conservatives attempted to block the Responsible Parenthood and Reproductive Health Act of 2012 by challenging its constitutionality in the Supreme Court. It is important to note that feminist leaders have made substantial contributions in advocating SRHR in the face of such religious and cultural barriers [17].

Institutional level (BGHMC)

"Culture of compliance" and patient-centred service

There is an apparent strong culture of compliance among government workers. For BGHMC, this can be attributed to a sense of fulfilment in "doing the job right" and the hospital's culture of providing patient-centred services. This is also linked to some criteria regarding tenure and promotion (e.g. individual performance and commitment ratings of the Civil Service Commission). On the other hand, attempts to foster a culture of critical thinking in order to institutionalize gender equality represents a challenge.

Patient satisfaction surveys

Patient satisfaction surveys are a prerequisite for certification by the International Organization for Standardization (ISO), which sets standards for ensuring the quality, safety and efficiency of products and services [18]. To maintain its ISO accreditation, BGHMC has improved its quality policy and hospital operations to conform to international standards [18]. As part of its efforts to improve the quality of health services, BGHMC has implemented a survey procedure to regularly assess patient satisfaction with a view to informing institutional action plans [19].

9 Leticia Ramos-Shahani was a former UN Assistant Secretary-General for Social and Humanitarian Affairs (1981–1986). She is credited with preparing the first draft of CEDAW, which was eventually adopted by the United Nations in 1979. The Philippines ratified CEDAW in 1981.

Doctors and staff are invested when patients are not total strangers

Many patients at BGHMC are kailyan or town-mates, kin, distant relatives, or acquaintances (unlike in megacities where the majority of patients are total strangers). Social networks, social capital and cultural sensitivity are very important. There is also the deeply rooted concept of inayan (from the Kankana-ey ethnolinguistic group), loosely translated as a principle of ethical conduct. Inayan is an important Indigenous principle related to the concept of taboo and avoidance of losing face in the community, manifested in the practice of doing right by others so as to avoid a negative reputation.

Experience of implementing GAD in Obstetrics and Gynaecology

As a government hospital, BGHMC must comply with all GAD laws and policies. In 2014, the GFPS was implemented not to address a felt need, but rather to comply with gender equity laws. At that time only one hospital department – Obstetrics and Gynaecology – was consistent in submitting GAD plans and budgets. We note that the Chair of the GFPS during this period was from Obstetrics and Gynaecology, which may have led to a stronger focus on accountability and greater involvement in the process.

Geographical, spatial and climatic conditions

The City of Baguio is a medium-sized city, with the cool weather contributing to a more laid-back lifestyle compared with the larger cities of the Philippines. Doctors face fewer socioeconomic pressures to match the financial status of others. This lower level of pressure may contribute to their ability to offer more affordable professional fees with respect to medical procedures at BGHMC, compared with hospitals in Metro Manila. There are also government mechanisms to access government subsidies.

Baguio's relatively lighter traffic conditions, with typical travel times of 15 to 20 minutes between home and hospitals—compared to the 2- to 3-hour commutes common in Metro Manila—contribute to a more favourable work-life balance. Research has shown that prolonged exposure to traffic congestion can negatively impact mental health, increasing stress, fatigue, and overall job dissatisfaction [20]. In contrast, shorter commutes in Baguio may reduce exhaustion among hospital staff, allowing them to be more focused and effective in their duties, including Gender and Development (GAD) work.

What catalysed the expansion of the GFPS across hospital departments?

Certain catalytic moments, whereby a change in the internal or external context opened a window of opportunity, which was seized by specific actors.

Appointment of a gender champion as Chair of the TWG

The current Chair of the GFPS TWG was appointed by the BGHMC Chief in December 2016. She strongly advocated for an institutionalized approach to the GFPS and recruited a licensed nurse to be Vice-Chair of the TWG, who subsequently assumed the position of Health Promotions Officer. The Chair took a very hands-on approach to institutionalizing the GFPS by recommending people to be appointed to the TWG from various medical departments and other units.

Support for the GFPS from the highest levels within the hospital

The BGHMC Chief supported all efforts of the TWG Chair in relation to institutionalizing the GFPS. This has been a critical factor in ensuring that all departments supported the system.

What actions allowed the changes to be sustained over time?

Expansion of the GFPS and the TWG

The highly personal character of Philippine culture has been an important factor in the recruitment of members of the GFPS. The TWG Chair personally recommends these medical consultants and staff members for appointment by the Chief. Generally, there are two members of the GFPS from every department – the department head and another member.

Those appointed are usually recruited for their potential to contribute positively to GAD and interest in GAD work. Often new hires and those perceived to be not overworked are selected because they cannot refuse the additional work. By including a broad range of perspectives and expertise, the TWG is in a good position to identify gender-related issues and develop comprehensive strategies to address them.

Staff commitment and training

Driven by their commitment to gender mainstreaming, the TWG has worked hard to comply with the national requirement to submit GAD plans and budgets, taking 2 years to achieve a higher level of compliance across hospital departments. Initially, the process was challenging because staff were trained in medical and allied services (i.e. bedside, nursing, and medical care), not planning and budgeting.

It took 3 months to learn the rudiments of GAD planning and budgeting. It was also difficult to determine which activities and line items could be assigned to the GAD budget.

GFPS members attended training on gender planning and budgeting (GPB) conducted by the PCW and other multi-agency formations in the region. However, the initial training did not equip the BGHMC staff on how to apply GAD plans and budgets in the hospital sector. In 2016, GFPS members conducted their own in-house 3-day intensive training on GPB. Trainers from PCW in Manila, as well as BGHMC staff and medical consultants, conducted training on: (a) gender sensitivity; (b) GFPS; (c) GAD planning and budgeting; and (d) training the trainer. These intensive internal training sessions were critical to the consistent and systematic submission of the annual gender plan and budget across all departments, as well as other gender mainstreaming efforts.

The intensive training on GPB helped equip several members of the GFPS TWG to more competently draft their GPB. Similar training is periodically conducted to assist new members of the TWG improve their planning and budgeting skills. There was no significant change in the number of training sessions during or after the COVID-19 pandemic. The TWG was able to conduct GAD-related training during COVID-19 using an online mode of delivery. The most recent training was conducted in 2024 to enhance the skills and capacity of staff on the GFPS, plans and budgets and annual reports [21].

Regular training on GPB helped the TWG optimize the inclusion and attribution of GAD mainstreaming programmes and activities in the hospitals budget. This has resulted in a sizeable increase in BGHMC's GAD budget. By 2016, all departments were consistently submitting their respective GAD plans and budgets.

Clarification on what kinds of expenses could be assigned to GAD helped BGHMC draw up their GAD plans and budgets. Since BGHMC is a medical service institution, attributing direct services, salaries and services associated with GAD, as well as material infrastructure (e.g. construction of physical facilities for gender-related services), enabled the TWG to surpass the 5 per cent GAD budget requirement. Under the current set-up, GAD plans and budgets of BGHMC are submitted to the central office of the DoH, which then

submits them to the PCW. GAD plans and budgets for the coming year are submitted before the end of the current fiscal year. For both PCW and DoH (central office), the usual turnaround time for giving feedback and approving the GAD plans and budgets is 2 months.

What were the missed opportunities and challenges?

While the GFPS in BGHMC has shown promising achievements related to gender and culturally sensitive services, and sustained implementation across all hospital departments, a number of challenges remain.

More systematic recruitment processes for GFPS are required

Currently, all hospital staff are being trained in preparation for the next generation of GFPS members. However, there is no systematic recruitment process for prospective second-line GAD staff and advocates. There is a need to improve the process of appointing staff to the GFPS, and change their terms of office and the method of succession and development of second-line staff.

Foster greater appreciation and remuneration of GAD work

While the 2011 guidelines released by the PCW notes that efforts should be made to recognize good performance and establish incentives and award systems [6], findings from the interviews and policy dialogue indicate that GAD work is under-appreciated. Across government institutions, GAD work is often added to existing workloads of staff who are already overworked. Appropriate valuation of GAD work should be institutionalized. Mechanisms should be put in place to properly acknowledge the value and importance of GAD work through dedicated GAD positions. This has been a long-standing issue within the central offices, the Department of Budget and Management and the Office of the President. Despite efforts between 2017 and 2019 to push for at least one GAD position in all government offices, there has been no positive development. The issue was sidelined during the COVID-19 pandemic and the proposal still needs to be revived and lobbied at various levels of government. Meanwhile, other incentives for GFPS members should be explored and institutionalized, such as individual performance commitment ratings, performance-based bonuses and other means to acknowledge accomplishments.

Data on gender and other identity markers

There is an urgent need to revise the patient information form to improve data collection. Analysis should disaggregate such variables as sex assigned at birth, gender, sexual identity, religion, ethnolinguistic group and other relevant identity dimensions that impact patient services. Culture and religion, for example, are important factors in determining health interventions, as well as whether proposed medical interventions are accepted or rejected by the patient.

BGHMC faces challenges in treating patients whose religious beliefs conflict with certain medical procedures, such as contraception and blood transfusions. When patients refuse consent for medical treatments because of religious or cultural beliefs, doctors must offer alternatives that are more compatible with patients' beliefs. For example, many doctors and staff are from Cordillera ethnolinguistic groups and are familiar with Indigenous knowledge systems and practices, such as Indigenous birthing positions. Consequently, doctors are open to incorporating scientifically supported Indigenous practices if a patient requests them.

Revising the patient information form could help inform strategies to better accommodate diverse patient needs. For transgender patients, especially those who are victims of physical or psychological abuse or violence, data on sexual identity is

important. This could be simultaneously pursued at both the medical centre and the DoH. Gender-sensitive and progressive politicians, government officials and advocacy groups should be enlisted to push for this simple, yet impactful reform.

Maximize local resources and collaboration

Strategies and mechanisms should be implemented to develop and strengthen inter-agency structures and mechanisms, such as the Regional GAD Committee, to maximize resources and share lessons and benefits. Local experts and the PCW mechanism of accreditation and referral of the GAD pool of trainers should be tapped for the training needs of the various GFPSs in the region.

Integrate GAD into the curricula of medical and allied health professions

The Commission on Higher Education and the Association of Medical Schools should be lobbied to integrate GAD into medical curricula and into the medical education of allied health professionals. This would help improve GFPS implementation across more medical establishments, with graduates already sensitized to the importance of GAD and related processes.

Increase the number of services for men and LGBTQIA+ groups

There has been a steady increase in the practice of do-it-yourself or non-prescribed cross-sex hormone therapy, especially in medically restrictive contexts [22]. This indicates a growing demand for professional medical services related to gender transition, including referrals to psychiatrists and endocrinologists willing to provide these services. However, the Philippines remains very conservative with respect to gender and sexuality, especially gender-affirming interventions such as cross-sex hormone therapy and surgery. These are highly controversial themes for the Roman Catholic Church, as well as fundamentalist Christians and Islamic groups in the country. The Philippines should learn from the experiences of countries that have successfully implemented gender clinics for LGBTQIA+ communities, taking into consideration the unique context of Philippine culture and society.

However, to strengthen gender integration within BGHMC, gaps in service provision for LGBTQIA+ groups and men need to be addressed. Interviews revealed that, while services offered by the WCPU are commendable, they are limited to women and children under the age of 18. However, cisgender, gay, non-binary, and queer men, as well as trans women, who experience violence, abuse, or sexual assault can only seek treatment at the Emergency Department. Unlike the WCPU, the Emergency Department may not provide the same level of care nor connect victims to appropriate referral services.

The absence of gender- and sex-disaggregated data on current patient intake forms hinders efforts to analyze the extent of the problem, understand the barriers faced by adult male victims and individuals of diverse identities (including cisgender, transgender, non-binary, heterosexual, gay, bisexual, and queer), and identify their needs or provide appropriate support services.

An economic climate of austerity

The Philippines continues to incur huge foreign debts from international financial institutions. Despite the huge amount of loans, the DoH will suffer from a 10 billion pesos (US$176.93 million) budget cut in 2024. The reduction in the budget of social services, including health, is blamed on “big payroll and overhead in maintaining a large bureaucracy, plus rising debt service” [23]. The Philippines has a top-heavy bureaucracy with several undersecretaries, assistant secretaries and their deputies, in government bureaucracies, and numerous deputy speakers and deputy committee chairs in Congress.

Further, pandemic-related debt amounted to US$22.55 billion, mainly from the Asian Development Bank and the World Bank, and an additional $3.25 billion in grants and loans. According to the Finance Secretary of former President Duterte, these loans had favourable rates with 40-year terms [24]. After Duterte's term, the Philippine national government debt was at PhP13.52 trillion in September 2022 [23]. In June 2024, President Marcos Jr. signed four new loan agreements with the World Bank totalling $1.14 billion [24]. Total external debt (EDT) stood at US$130.18 billion as of end-June 2024, up by US$1.49 billion (or 1.2 percent) from the US$128.69 billion level as of end-March 2024 [25].

Despite these huge amounts in external and domestic loans, substantial cuts were made to the 2025 budgets of the Department of Health in the amount of PhP25.80 billion [26], which will have negative impact on the delivery of vital health services. Philhealth or the Philippine Health Insurance Corporation mandated "to provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines" [27] was given a zero budget in the 2025 national budget passed by the Congress of the Philippines [28].

Moreover, beginning in May 2024, a total of PhP60 billion in Philhealth funds were transferred to the National Treasury of the Philippines. The fourth tranche of PhP29.9 billion was supposed to be transferred in November 2024. Several petitions were filed at the Philippine Supreme Court which issued a Temporary Restraining Order on the transfer of the remaining PhP29.9 billion. Oral arguments started in January 2025 for the status quo ante order for the return of the funds to the coffers of Philhealth [29].

Lack of political support for GAD programmes

The current Secretary of Health, Dr Teodoro J. Herbosa, is perceived to be unsupportive of GAD programmes in the Health Department. His appointment sparked a backlash, largely due to controversies surrounding perceived mismanagement of the COVID-19 response and past social media statements [26]. In one particularly controversial post he joked about sexual assault, which led to public criticism from the University of the Philippines, forcing him to apologize and undergo gender-sensitivity training. As a result, many feminists and female leaders in the health sector remain sceptical about the potential for meaningful progress in GAD mainstreaming under Herbosa's leadership.

Discussion and conclusion

The deliberate, systematic and consistent implementation of the GFPS at BGHMC has strengthened the integration of gender-responsive approaches in healthcare, fostering a more inclusive environment to better address the health needs of diverse populations. Institutionalization of the GFPS across all hospital departments, which involves regular gender analysis, GPB and evaluation of GAD implementation has led to improved collaboration and accountability in addressing gender-related issues within the healthcare system and enhanced the quality of services.

These achievements were the result of sustained efforts over long periods of time. Although the GFPS is mandated by law, BGHMC initially had only one department compliant with its implementation in 2014. It was not until 2016 that the GFPS was effectively integrated across all departments, highlighting a process that offers transferable lessons for other healthcare institutions aiming to enhance gender-responsive practices.

Several key ingredients of success stood out in this case study, including the following:

a. **Champions in leadership positions.** Leaders at the highest levels of the hospital demonstrated strong support for gender-focused policies and initiatives by appointing gender champions to leadership positions within the GFPS. This support ensures that gender integration is addressed as a priority. These champions are actively involved in the process by leveraging their authority and expertise to not only mobilize staff, but also to take steps to enhance their capacity to implement the GFPS through ongoing training. The dedication and support from key champions had a significant impact in framing the importance of gender integration within the hospital, moving beyond its perceptions as a mere government mandate (or "tick-box" exercise) to improved accountability and an environment where gender-related issues are now recognized and addressed.

b. **Supportive culture and social networks based on values and ethics.** BGHMC has earned a favourable reputation for providing quality and affordable services, thanks to the dedication and commitment of staff at all levels. Social networks among staff, along with their ties to the community and supportive cultural values, motivate their dedication to delivering quality care. This has also fostered an institutional culture that prioritizes teamwork, inclusivity and a strong commitment to compliance, rooted in the ethics of care and a mission of patient-centred service.

c. **Legal frameworks and a dedicated government agency to advance and protect gender equality.** Legal frameworks and the presence of a dedicated government agency were essential for providing support and resources to initiatives at BGHMC and promoting broader institutional accountability in advancing gender equality. Progressive legal frameworks adopted by the Government have played a key role in ensuring that institutions like BGHMC comply with national gender policies and fulfil their legal obligations, including mandatory reporting requirements. PCW has supported ongoing training and enhancing the hospital's capacity to deliver gender-sensitive healthcare services.

d. **Active women's movement bolstering political will and driving gender-related policy change.** For decades, the women's movement has played a critical role in facilitating a supportive environment for advancing gender equality. The collective power among various women's networks has resulted in the establishment of a national women's machinery, ensuring that gender equality is prioritized in government and policymaking. Further, members of the women's movement have joined government bodies, facilitating the development of a national gender mainstreaming strategy and coordinating activities for effective implementation.

The BGHMC case demonstrates how a very favourable legal and policy framework related to gender equality and development has been conducive to integrating gender into health programmes. The mandatory implementation of GPB in all government units resulted in the institutionalization of gender mainstreaming, mainly through the GFPS. BGHMC's commitment to implementing the GFPS stands as an exemplar, in spite of various challenges.

The hospital has implemented a GFPS in all departments, and these regularly undertake gender analyses, GPB and evaluation of GAD plans, in addition to quarterly meetings. Whereas other government agencies have failed to meet the minimum 5 per cent GAD budget requirement, this hospital committed up to 20 per cent of its budget to GAD in 2022 [7, 26]. The GFPS TWG has been fundamental in institutionalizing change through in-depth training sessions. From a lone gender champion who started mainstreaming gender in 2014, there are now many gender champions thanks to the GAD training. This training also deepened an understanding of gender issues among hospital staff, resulting in strong commitment to its integration in a number of programmes and services. Perhaps this raising of gender consciousness can start not just through hospital staff training, but earlier by including gender integration in the curriculum of medical schools and other allied health courses.

There is still a need for a more systematic selection and recruitment process for selecting GAD focal point persons at BGHMC. A proper evaluation of the importance of GAD work needs to be matched with proper remuneration and incentives for the already overburdened staff doing GAD work. Overall, the relative success of the BGHMC in implementing the GFPS can be viewed as a result of certain sociocultural, economic and other institutional contexts, support from key officials and the dedication of the GAD Secretariat and members of the TWG and GFPS. The experiences documented here are worthy of adopting in other settings.

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Appendix 1: Open call for the Regional Promising Practices Project

Call for Submissions

What works? Integrating gender into government health programmes across Africa, South Asia and Southeast Asia

Summary

United Nations University International Institute on Global Health (UNU-IIGH), Public Health Foundation of India (PHFI), and the School of Public Health at University of Western Cape (UWC) in South Africa, invite organisations and professionals to submit information on government health programmes in Africa, South Asia, or Southeast Asia that have successfully integrated gender. To participate, complete the online submission form or submit it to whatworks.regional@gmail.com with the subject: "What works Call". **Deadline for submissions is 30 May 2022**.

Submissions will be reviewed by PHFI, UNU-IIGH, and UWC. The selected case studies will be further explored and documented in the project 'What works Africa, South Asia and Southeast Asia'.

Background

To further advance on the gains made in improving health outcomes and gender equality, particularly given the setbacks due to COVID-19, it is critical to take stock of how gender has been integrated into large scale health programs to generate learning supporting policy transfer across regional contexts. Yet, there is limited documentation and information sharing in global, regional, and national spaces on good practices that promote effective gender integration in health programmes and health systems at scale.

As part of efforts to address this gap, The United Nations University International Institute for Global Health (UNU-IIGH) in partnership with PHFI through the Ramalingaswami Centre on Equity and Social Determinants of Health in India, and the School of Public Health at UWC in South Africa are working together to identify and analyse successful cases of gender integration in government health programmes in Africa, South Asia, and Southeast Asia to understand what worked, where, for whom, why, and how. Through this work, the project aims to distil commonalities and lessons learned to constructively inform existing and future health programmes to improve gender integration with the ultimate goal of advancing gender equality. This call is part of the effort to identify promising cases of government health programmes that have successfully integrated gender and responded to the different needs and situations of women, men and non-binary people or successfully addressed harmful gender-based social norms or power inequalities.

Who can nominate?

Anyone who has been involved with or knows of a government health programme that meets eligibility criteria.

What are the eligibility criteria?

Health programmes[1] that **meet all of the following criteria** are eligible:

- Implemented in Africa or South Asia or Southeast Asia[2].
- Involved at least one government body either at national or subnational level, including Ministries of Health or other Ministries, in programme design, implementation, or monitoring & evaluation.
- Successfully addressed a health issue (as defined by the programme and can include but is not limited to changes in service utilisation, access to health services and resources, service provision, outreach, health knowledge, issues related to health workforce, health financing, etc)[3].
- Successfully responded to the needs and/or situations of particular gender groups (women, men, or non-binary people) **and** addressed power inequalities or harmful gender norms (e.g., transforming gender norms to abandon and end female genital mutilation, transforming power relations within the health workforce).
- Have been active for at least 3 years.

Submission process and deadlines

To participate and make a submission as part of this call either complete the google form which can be accessed via this link or complete the form attached and submit it via email to whatworks.regional@gmail.com.

Multiple submissions by the same individual or organisation are allowed if there are several programmes that meet the eligibility criteria. In this case, please submit one entry per health programme. The form is available in English, should you need the form translated into another language please contact the team directly to make this request. **All submissions must be received by 30 May 2022.** Please contact the team via whatworks.regional@gmail.com if you have any questions.

What happens after the submission?

After the call has been closed, all submissions will be reviewed by a team of partners and other relevant stakeholders. A shortlist of programmes will be created based on criteria including, sustainability, how gender was integrated into the design and implementation, the impact the programme had from a health and gender perspective, and any unintended consequences. Contacts of shortlisted programmes will be approached to provide further information about the programme which will be used to determine whether the programme will be selected for the final deep-dive analysis of what works, for whom, where, why and how.

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[1] Health programmes can include initiatives implemented by Ministries of Health, as well as other Ministries, that contribute to improved health outcomes, which relate to and are not limited to community mobilisation, water and sanitation, nutrition, regulation of food, tobacco and alcohol, as well as health service delivery, health information systems, access to essential medicines, health workforce, health financing, leadership and governance.

[2] **Countries in Africa: North Africa:** Algeria, Egypt, Libya, Morocco, Tunisia, Islamic Republic of Mauritania, Sahrawi Arab Democratic Republic. **West Africa:** Benin, Burkina Faso, Cape Verde, Côte d'Ivoire (Ivory Coast), Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo. **Central Africa:** Burundi, Cameroon, Central African Republic, Chad, Congo Democratic Republic (Kinshasa), Congo Republic (Brazzaville), Equatorial Guinea, Gabon, São Tomé & Príncipe. **East Africa:** Comoros, Djibouti, Ethiopia, Eritrea, Kenya, Madagascar, Mauritius, Rwanda, Seychelles, Somalia, South Sudan, Sudan Tanzania, Uganda. **South Africa:** Angola, Botswana, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe; **Countries in South Asia**: Bangladesh, Bhutan, India, Pakistan, Maldives, Nepal, and Sri Lanka; **Countries in South-East Asia:** Brunei, Cambodia, Timor-Leste, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Vietnam.

[3] Success in addressing gender and health outcomes will be based on the programmes self-defined goals (health and gender outcomes)

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About UNU-IIGH

The UNU International Institute for Global Health (UNU-IIGH) in Kuala Lumpur, Malaysia, operates as the designated UN think tank specialising in global health. With a mandate to facilitate the translation of research evidence into policies and tangible actions, UNU-IIGH serves as a hub connecting UN member states, academia, agencies, and programmes.

Established through a statute adopted by the United Nations University Council in December 2005, the institute plays a pivotal role in addressing inequalities in global health. UNU-IIGH contributes to the formulation, implementation, and assessment of health programmes.

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