GENDER EQUALITY PROGRAMMING IN EMERGENCIES IN HEALTH

WHY DOES GENDER EQUALITY MATTER IN EMERGENCY HEALTH INTERVENTIONS?

Conflicts and natural disasters affect women, girls, boys and men differently; they have different needs, perceptions and experiences which need to be considered by humanitarian actors in ensuring that appropriate assistance is delivered to all segments of the population without putting any group at risk. In crises, the health needs of women, girls, boys and men are different due to biological, psychological, social and cultural factors. The risk of exposure to communicable and non-communicable diseases and other health conditions (including sexual, reproductive and mental health issues) differs according to sex and age, among other factors. Furthermore, the way women, girls, boys and men cope with health issues varies, depending on their experience, as well as their perception of and access to health services and facilities. It is vital to guarantee equal access to timely and appropriate health interventions of good quality, and use a variety of strategies to optimize their use. For health interventions to have a positive impact on affected individuals, families and communities, a gender-sensitive, participatory approach at all stages of the project cycle can help ensure that an adequate and efficient response is provided. Health assessments and activities that take into consideration the needs, priorities and capacities of women, girls, boys and men are more likely to improve the lives of affected populations.

GEP IN HEALTH SECTOR NEEDS ASSESSMENTS, ACTIVITIES AND OUTCOMES

A **NEEDS ASSESSMENT** is the essential first step in providing emergency health programming that is safe, effective, and restores physical and mental well-being and dignity. A gender analysis is critical to understanding the social and gender dynamics that could help or hinder aid effectiveness. Here are examples of questions that can enrich the design of health projects:

1. What are the demographics of the affected group (# of households and household members disaggregated by sex and age; # of single heads of household who are women, girls, boys or men; # pregnant and lactating women (PLW); and # (M/F) of unaccompanied children, older people, persons with disabilities, and the chronically ill)?
2. Do cultural norms allow women and men participate equally in decision-making in household and community on health issues?
3. Is action needed to create permission and space for girls and boys and for older women and men to voice their needs and ideas, as well as participate in age-appropriate ways?
4. Who provides health care to whom? Ex. What are local beliefs and practices concerning same or opposite-sex care?
5. How many male and female health workers, at each level, are available?
6. What are the cultural beliefs and practices regarding pregnancy and birthing, menstruation and women's and men's RH?
7. How do the roles of women, girls, boys and men affect disease transmission - care of the sick, disposal of human (including baby) and animal faeces, household water management, play or work activity in or with contaminated water, food preparation and handling, cleansing and disposal of dead bodies?
8. What do women/girls and men/boys require to safely access health services (ex. opening hours, safe transport or escorts, well-lit and clear access paths)?
9. Who are the local groups and stakeholders in the health sector that can contribute a male or a female perspective to health response (ex. women's organizations, men's organizations, youth groups, traditional healers, midwives, etc.)?

Examples of ways to incorporate gender concerns into a health project: The gender analysis in the needs assessment will identify gender gaps, such as unequal access to health services for women/girls and men/boys, that need to be addressed. These should be integrated into **ACTIVITIES**.

Gender Analysis in Needs Assessment	Activities
The needs assessment shows that women and, therefore, their children (both girls and boys), are not attending the health clinic due to cultural restrictions on their mobility.	Monitor women's participation in decision-making on design of the health service and facilities (incl. health clinics, mobile units and community-based services); be sure their needs are discussed and met.
The needs assessment shows that the RH project, which aims to address the issue of STIs targets women only and, therefore, is unsustainable and ineffective.	Hold single-sex focus discussion group sessions with men to determine their beliefs and practices, as well as their needs related to safe-sex in particular and RH services in general.

OUTCOMES should capture the change that is expected for female and male beneficiaries. Avoid outcome statements that hide whether or not males and females benefit equally. Examples of gender outcomes include:

- The safety of health facilities has been enhanced after health care providers responded to women's and men's feedback on protection issues (ex. more day-light opening hours, partitions and curtains, presence of male and female health workers, better triage and eliminating loiterers)
- Capacity in health response and preparedness has been enhanced in NGOs through gender training and a mix of women and men on their implementing teams [representative % or female and male personnel]
- [% of] health facilities with basic infrastructure, equipment, supplies, drug stock, space and qualified staff for RH services, including delivery and emergency obstetric care services (as indicated in the MISP)
- [% of] health facilities providing confidential care for survivors of sexual violence according to the IASC GBV Guidelines.

THE ADAPT & ACT-C FRAMEWORK: A PRACTIAL TOOL TO DESIGN/REVIEW EDUCATION PROJECTS THROUGH A GENDER EQUALITY LENS:

The ADAPT & ACT-C Framework is a tool for use when designing or vetting a project/programme to integrate gender dimensions. While the order of the steps in the framework may vary, as many as possible of the steps - ideally all nine - should be taken into account in the design of humanitarian interventions to ensure that the services and assistance they provide meet the needs and concerns of women, girls, boys and men equally.

A	**ANALYSE the impact of the crisis on women, girls, boys and men** and what this entails in terms of division of tasks/labour, workload and access to health services and facilities. Ex. Ensure that focus group discussions on the design of and operations within health centres are conducted with women, girl, boys and men of diverse backgrounds and results feed into programming.
D	**DESIGN services to meet the needs of women and men equally.** Health actors should review the way they work to ensure that girls and boys, women and men can benefit equally from their services. Ex. the timing, staffing and location of health facilities/services ensure women and men can access them equally.
A	**Make sure that girls and boys of all age groups can ACCESS health services equally.** Ex. Proportion of women, girls, boys and men – disaggregated by age – with access to health services, including RH services.
P	**Ensure women, girls, boys and men PARTICIPATE equally** in the design, implementation, monitoring and evaluation of health projects, programmes and strategies, and that women are in decision-making positions. Ex. Women represent 50% of participants of meetings to discuss and decide on the location, layout, staffing hours of operations of services.
T	**Ensure that women and men benefit equally from TRAINING or other capacity-building initiatives**, as well as any employment opportunities offered by the project.

and

A	**Make sure that the project takes specific ACTIONS to prevent risks of GBV.** Ex. 24-hour access to post-rape care, staff aware of and abide by guiding principles for working with GBV survivors, staff are trained on the clinical management of rape, multi-sectoral referral mechanisms exist for GBV survivors, information campaigns conduction targeting men and women about the health risks of sexual violence. The *IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings* includes a chapter on 'Health & Community Services', which should be used as a tool for planning and coordination.
C	**COLLECT, analyze and report sex- and age-disaggregated data**; analyze and develop profiles on the different needs and realities of males and females in at-risk populations and how and whether their needs are being met by the response. Ex. Sex- and age-disaggregated data on programme coverage are regularly collected, analyzed and reported on.
T	**Based on the gender analysis, make sure that women, girls, boys and men are TARGETED with specific actions when appropriate**. Ex. Communication strategies are developed and implemented to highlight the specific health risks affecting women and men, as well as targeting adolescent girls and boys.
C	**Ensure COORDINATION** and gender mainstreaming in all areas of work. Ex. Partners in the health sector liaise with actors in other sectors – including WASH, Shelter & NFIs, Protection and CCCM – to coordinate on gender issues, including participating proactively in meetings of the gender network.

DESIGNING MINIMUM GENDER COMMITMENTS FOR HEALTH

In order to translate the Health sector's commitments to gender-responsive projects into reality, minimum gender commitments can be developed and applied systematically to the field response. The commitments must be articulated in a way that can be understood clearly by all, both in terms of value added to current programming and in terms of the concrete actions which need to be taken to meet these commitments. They should constitute a set of core actions and/or approaches (maximum five) to be applied by all partners in the sector. They should be practical, realistic and focus on improvement of current approaches rather than on drastic programme reorientation. Finally, they should be measurable for the follow-up and evaluation of their application.

The commitments should be the product of a dialogue between Health sector members and within each of the member organizations. A first list of commitments should be identified and then discussed, amended and validated by the Health sector at national level, as well as sub-national sectoral groups and/or staff of organizations working in the sector. It is important to note than commitments need to reflect key priorities identified in a particular setting.

The commitments, activities and indicators below are samples only:

1. **Consult women, girls, boys and men at all steps in the project design, implementation and monitoring.**

Sample Activities	Sample Indicators
Focus group discussions on health service/facility location and modalities (clinic, mobile clinic, community-based services, etc.) conducted with women, girls, boys and men of diverse backgrounds and results fed into programming.	*% of the affected population – disaggregated by sex and age - engaged in participatory consultations on health service/facility location and modalities*

2. **Health care providers are trained on the clinical management of rape.**

Sample Activity	Sample Indicator
Female and male health professionals from [number of] health facilities are trained in the clinical management of rape.	*% of health facilities with health professionals (disaggregated by male and female) trained in the provision of the clinical management of rape*

3. **Women, adolescent girls, adolescent boys and men have access to the priority RH services of the Minimum Initial Service Package (MISP) at the onset of an emergency and to comprehensive RH as the situation stabilizes.**

Sample Activity	Sample Indicator
Identify a lead RH agency within the health sector/cluster to facilitate the coordination and implementation of the MISP.	*An RH agency has taken the lead on coordinating and implementing the MISP in the affected area*
Ensure that an RH officer (nominated by the lead RH agency) is in place and functioning within the health sector/cluster.	*An RH officer is in place and is taking the lead in the health sector/cluster on coordination and implementation of RH activities*

Ensure that Community Health Worker teams are gender-balanced.

Sample Activity	Sample Indicator
Consult women on what arrangements – childcare, transport, lodgings, etc. - would need to be in place for them to work as Community Health Workers	*[Representative %] of all Community Health Worker teams are women*

5. **Strengthen the systematic engagement of men in reproductive health programmes and services**

Sample Activity	Sample Indicator
Hold single-sex focus group discussions with women/girls men/boys to determine culturally-appropriate RH services.	*Extent to which the results of the focus group discussions with the affected female and male beneficiaries has informed the design and delivery of RH services.*

FOR FURTHER GUIDANCE

- For more information on gender in health, see **The Sphere Handbook (2011)** and **WHO's Gender Policy (2009).**
- For more information on GEP in the health sector, see
  - **IASC Gender Handbook in Humanitarian Action** (Dec. 2006) at http://www.humanitarianinfo.org/iasc/gender.
  - **IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings:** *Focusing on Prevention of and Response to Sexual Violence in Emergencies* (Sept. 2005) at http://www.humanitarianinfo.org/iasc/gender.
  - **IASC Guidelines for HIV/AIDS Interventions in Emergency Settings** (2003) at http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf.
  - **IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings** (2008) at http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-search-spfastsearch&query=mental%20health%20guidelines.
  - WHO's **Gender Considerations in Disaster Assessments** *(*2005) at http://www.who.int/gender/other_health/en/gwhdisasterassessment.pdf.
  - WHO's **Reproductive health during conflict and displacement** *(*2000) at http://www.who.int/reproductive-health/publications/conflict_and_displacement/index.htm.
  - WHO/UNHCR/UNFPA. **Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons** *(*revised edition 2004) at http://www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/index.html.
- For more information on the **Gender Marker** go to www.onereponse.info
- For the e-learning course on ***Increasing Effectiveness of Humanitarian Action for Women, Girls, Boys and Men*** register at http://www.iasc-elearning.org or ask OCHA Myanmar for CD-version.
- For Myanmar-specific support please contact Maria Caterina Ciampi, Senior Inter-Agency Gender Capacity (GenCap) Advisor, IASC Gender Standby Capacity Project, hosted by OCHA in Myanmar, by calling +95 (0) 92 50 15 19 52 or by sending an email to caterina@un.org.