HEALTH

DOES GENDER EQUALITY MATTER IN EMERGENCY HEALTH INTERVENTIONS?

In crises, the health of women, girls, boys and men is affected differently; social, cultural and biological factors often increase the risk faced by women and girls in particular. Available data suggests that there is a pattern of differentiation in terms of women's, girls', boys' and men's exposure to and perceptions of risk, preparedness, response and physical and psychological impact, as well as their capacity to recover. However, providing health services and facilities for essential health care (control of communicable diseases, child health, sexual and reproductive health, injury, mental health and non-communicable diseases) will not guarantee a positive impact on individuals or on the affected population automatically. A gender and age-sensitive, participatory approach at all stages of the project cycle can help ensure that an effective response is provided. In order for a health project to have a positive impact, women, girls, boys and men must be involved equally in the process of design and implementation.

Projects that analyse and take into consideration the needs, priorities and capacities of both the female and male population of all ages are far more likely to improve the lives of affected populations. The IASC Gender Marker is a tool that codes, on a 2 -0 scale, whether or not a humanitarian project is designed to ensure that women/girls and men/boys will benefit equally from it, and that it will contribute to increasing gender equality. A full description of the IASC Gender Marker and its application can be found in the Gender Marker Overview Tip Sheet.

NEEDS ASSESSMENTS → ACTIVITIES → OUTCOMES

A **NEEDS ASSESSMENT** is the essential first step in providing emergency health programming that is effective, safe and restores dignity. A gender analysis is critical to understanding the social and gender dynamics that could help or hinder aid effectiveness. 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**. The project's **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.

GENDER IN HEALTH PROJECT NEEDS ASSESSMENTS
✓ What are the demographics of the affected group? (# of households and household members disaggregated by sex and age; # and age of single heads of household who are women, girls, boys or men; # and age of pregnant and lactating women (PLW) and age; and # (M/F) of unaccompanied children by age, older people, persons with disabilities, the chronically ill) ?
✓ Do cultural norms allow women and men participate equally in decision-making in household and community on health issues?
✓ Who provides health care to whom? E.g. what are local beliefs and practices concerning same or opposite-sex care?
✓ How many male and female health workers, at each level, are available?
✓ What do women/girls and men/boys require to safely access health services (e.g. opening hours, safe transport or escorts, well-lit and clear access paths)?
GENDER IN HEALTH PROJECT ACTIVITIES
✓ Hold single-sex, age segmented 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.
✓ 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.
✓ Provision of basic health services with times, staffing, and locations that ensure the needs of men, women, boys, and girls are addressed equitably.
✓ Hire and train female and male health workers.
✓ Disseminate HIV/AIDS prevention messages with a particular focus on men, active and demobilized members of armed forces, IDPs, and refugees.
GENDER IN HEALTH PROJECT OUTCOMES
✓ The safety of health facilities has been enhanced after health care providers responded to women's and men's feedback on protection issues (e.g. 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.

DESIGNING MINIMUM GENDER COMMITMENTS FOR EMERGENCY HEALTH SERVICES:

In order to translate the cluster and organisational commitments to gender-responsive health 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 by all, in terms of value added to current programming and in terms of the concrete actions that 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 cluster partners; they should be practical, realistic and focus on improvement of current approaches rather than on 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 with cluster members and/or within the organisation. A first list of commitments should be identified and then discussed, amended and validated by the national cluster and sub-clusters and/or organisation's staff working in the sector. It is important to note than commitments need to reflect key priorities identified in a particular setting. The **ADAPT and ACT-C Gender Equality Framework** (detailed in the Gender Marker Overview Tip Sheet) outlines basic actions that can be used when designing or vetting a gender integrated project, and can be a useful reference in designing minimum gender commitments. *The commitments, activities and indicators below draw on elements of the ADAPT and ACT-C Gender Equality Framework and are provided as samples only*:

1. **Ensure women, men, boys, and girls PARTICIPATE equally in all steps of the project; .Consult women, adolescent girls and boys, and men at all steps in the project design, implementation and monitoring**

Sample Activity	Sample Indicator
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. **Ensure that women and men benefit equally from TRAINING and other capacity-building initiatives; male and female health care providers are trained on the clinical management of rape**

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

3. **Make sure that women, adolescent girls and boys, and men can ACCESS health services equally, including priority RH services of the Minimum Initial Service Package (MISP) at the onset of an emergency and to comprehensive RH as the situation stabilises.**

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

4. **DESIGN services to meet the needs of women, men, boys, and girls equally by ensuring 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. **ANALYSE the impact of the crisis on women, girls, boys and men and what this entails in terms of division of labour, workload, and access to health care services and facilities.**

Sample Activity	Sample Indicator
Conduct single sex, age segregated focus groups to establish an understanding of women's and men's health care needs and priorities and their roles with regard to decision-making related to health care.	*Project design is informed by gender and age analysis and more effectively addresses the different health care needs within the affected population.*

For more information on the **Gender Marker** go to www.onereponse.info

For more information on Emergency Health Services, see **The Sphere Handbook 2011**

For the e-learning course on **"Increasing Effectiveness of Humanitarian Action for Women, Girls, Boys and Men"**, see www.iasc-elearning.org