
Gender equality and specific sectors

Health



This chapter explains how to integrate gender equality into health programming. You can find information on why it is important to incorporate gender equality into health programming as well as and key standards and resources for future reference.

The chapter begins with an overall checklist which explains key actions for a health programme which need to be carried out at each stage of the Humanitarian Programme Cycle (HPC). After this checklist, you can find more detail on how to go about gender equality programming in each phase of the HPC. This includes practical information on how to carry out a gender

analysis, how to use the gender analysis from the design through to implementation, monitoring and review and how to incorporate key approaches of coordination, participation, GBV prevention and mitigation, gender-adapted assistance and a transformative approach into each phase. Relevant examples from the field are used to illustrate what this can look like in practice.

Why is it important to incorporate gender equality in health programming?

Humanitarian crises impact the safe access to available, acceptable and appropriate health information, services and facilities for women, girls, men and boys in different ways. There are gender differences in both physical and psychological health impacts on women, girls, men and boys as well as their capacity to recover. When delivering health care in crisis situations, the design of health programmes requires gender analysis from the very beginning and at every stage of the HPC.

Effectively integrating gender equality into health care in crises requires an understanding of the specific health needs and potential barriers to accessing services to ensure that women, girls, men and boys access health services equally. This should include reproductive health services and services for GBV survivors addition to wider health-care services and information. Assessment of the health status of a population is by definition stratifying data and analysis by age and gender. Implementation of medical interventions is also traditionally quite gender- and age-sensitive, e.g., in the health sector there are paediatricians, gynaecologists, geriatrists, etc.. Just as gender and age need to be scrutinized when dealing with health in a stable

setting (diseases have sometimes different courses in males or females or young or old people), health effects and needs in emergency settings must be subjected to a gender/age analysis so as to detect specific effects or requirements that need to be addressed.

One way of assessing the development (reinforcement) of health services (in crisis situations) is to analyse the demand/offer (for services). Gender and age specificities are an integral part of such an analysis. On the demand side, issues such as reduced access for women because of financial dependency are just as important as an understanding of the full epidemiological picture of the area. On the side of the offer, we should question whether consultation rooms offer enough privacy to consult victims of GBV, as well as whether there is enough capacity to treat the caseload of patients with malaria or undernutrition.

Effectively integrating gender equality into health programming will achieve the following goals:

- **Safeguard the right to health.** Identifying sex- and age-related health needs is the only way to understand the full impact of a crisis on the health of women, girls, men and boys of different ages and backgrounds and secure adequate quality health service provision, which is a fundamental human right under international law.



• **Improve the health status of all.** Conflicts are known for inducing an increase of GBV, unwanted pregnancies, sexually transmitted diseases, etc.. Conflicts also tend to increase the need for general surgery. The extra burden of health problems (gender-/age-specific or not) needs to be acknowledged and met by an increase of (specific) services. In some contexts, women are more likely to wait longer before seeking care as they often fear disrupting household functions. Women are also less likely to have access to resources for preventative and curative medications. Bringing gender equality into programming helps humanitarians both to identify specific groups especially vulnerable to health conditions and to determine suitable strategies, including public messaging, to reduce poor health consequences.

• **Promote access to sexual and reproductive health services and rights.** The well-being of the entire community improves by identifying and addressing the specific sexual and reproductive health needs and priorities of women, girls, men and boys from the onset of a humanitarian emergency. For instance, in every emergency approximately 4 to 16 per cent of women of reproductive age will be pregnant with 15 per cent of women and girls predicted to experience life-threatening complications due to pregnancy and childbirth. Family planning services often are disrupted during emergencies which can lead to unwanted, high-risk pregnancies that increase health and socioeconomic burdens on affected families. As an example, pregnant adolescents, particularly those under the age of 16, have a higher chance of obstructed labour, a life-threatening obstetric emergency. Delay in treatment may result in obstetric fistulas, uterine rupture, haemorrhage and the deaths of mother and child. Emergency obstetric services are often unavailable during crises, thus increasing the risk of morbidity and mortality among adolescent mothers and their babies.

• **Promote the safety and dignity of women, girls, men and boys.** Involving them in assessments of health needs and design and location of facilities results better use of health programmes by the community. For example, quality free-of-charge, youth-friendly reproductive health services increase the numbers of female and male youth seeking reproductive health services. The selection of gender-appropriate health service providers who speak local languages greatly encourages women, girls, men and boys to seek preventative services for sexually transmitted infections. It also provides an opportunity for survivors of sexual violence to seek care.

• **Promote ownership and sustainability.** Advancing the leadership of women and adolescent girls and boys in health service coordination at all levels (communities and health facilities) can transform traditional gender roles and promote a sense of community ownership that endures beyond the emergency.

Integrating gender equality and health in the Humanitarian Programme Cycle

This section outlines the necessary actions front-line humanitarian actors in the health sector, such as United Nations agencies, local and international NGOs and government agencies, need to take to promote gender equality at each stage of the HPC.



KEY GENDER EQUALITY ACTIONS FOR HEALTH PROGRAMMING AT EACH STAGE OF THE HUMANITARIAN PROGRAMME CYCLE

1 Needs assessment and analysis

- Collect and analyse sex-, age- and disability-disaggregated data on needs, priorities and capabilities relating to health.
- Conduct a gender analysis as part of health needs assessments and analyse the findings.

2 Strategic planning

- Integrate gender equality into health programme design for the response, utilizing the findings from the gender analysis and other preparedness data.
- Ensure a demonstrable and logical link between the gender-specific needs identified for the health sector, project activities and tracked outcomes.
- Apply gender markers to health programme designs for the response.

3 Resource mobilization

- Apply gender markers to health programmes in the response.
- Include information and key messages on gender and the health sector for inclusion in the initial assessment reports to influence funding priorities.
- Report regularly to donors and other humanitarian stakeholders on resource gaps on gender within the health sector.

4 Implementation and monitoring

- Implement health programmes which integrate gender equality and inform women, girls, men and boys of the available resources and how to influence the project.
- Develop and maintain feedback mechanisms for women, girls, men and boys as part of health projects.
- Apply gender markers to health programmes in the response
- Monitor the access to health assistance by women, girls, men and boys and develop indicators designed to measure change for women and girls or boys and men based on the assessed gaps and dynamics.

5 Gender operational peer review and evaluation

- Review projects within the health sector and health response plans.
- Assess which women and girls, boys and men were effectively reached and those that were not and why.
- Share good practices around usage of gender markers and address gaps.

1 Needs assessment and analysis

Gender analysis takes place at the assessment phase and should continue through to the monitoring and evaluation phase with information collected throughout the programme cycle. The rapid gender analysis tool in section B (pages 30–39) provides a step-by-step guide on how to do a gender analysis at any stage of an emergency. Gender markers should be used at this stage of the HPC (see section B, pages 52–53 for more information).

When collecting information for the health sector, the analysis questions should seek to understand the impact of the crisis on women, girls, men and boys. Standard health assessments can be adapted to put greater emphasis on gender and the particular experiences, needs, rights and risks facing women, girls, men and boys, LGBTI individuals, people with disabilities, people of different ages and ethnicities and other aspects of diversity. The assessment should ask questions about the needs, roles and dynamics of women, girls, men and boys in relation to the health factors brought on by crisis, as well as the level of access to services, and how the other dimensions of diversity (e.g., disability, sexual orientation, gender identity, caste, religion) intersect with them. Ensure that these align with good practices and key standards on coordination, participation, and GBV prevention and mitigation and use a transformative approach as per the table on pages 234–236 on “Key approaches and standards for needs assessment and analysis in health programming”.

Sex- and age-disaggregated data (SADD) are a core component of any gender analysis and essential for monitoring and measuring outcomes. To be effective, SADD must be both collected and analysed to inform health services for women, girls, men and boys. For the health sector, it is important to ensure that health information systems at the primary health care level

and referral facilities are included. SADD on major causes of illness and death at the community and health facility levels help to improve health service delivery through specific activities. SADD should be collected on the number of males and females aged 0–5 years, 6–11 years, 12–17 years, 18–25 years, 26–39 years, 40–59 years and 60+ years, including other diversity factors to respond to specific needs (disability, pregnant and lactating women, etc.). In circumstances where collection of SADD is difficult, estimates can be provided based on national and international statistics, data gathered by other humanitarian and development actors or through small sample surveys. When SADD are not available or very outdated, there are methods can be used to calculate it (see section B, page 43). (See more on data in section B) In addition to using SADD, depending on the context, it can be important to disaggregate the data based on other diversity factors, such as ability, ethnicity, language spoken, level of income or education.

The following table gives a summary of the key moments during an emergency response where gender analysis should be carried out and what kind of deliverables should be produced. These should be produced at the level of the cluster (with the cluster lead accountable) and/or the individual agency (with the emergency response coordinator accountable).

KEY ASSESSMENT TOOLS:

- IASC. *Health Resources Availability Mapping System (HeRAMS)*. 2014. <https://tinyurl.com/y92pnty>

KEY ACTIVITIES FOR GENDER ANALYSIS DURING A HUMANITARIAN RESPONSE

TIMEFRAME	ACTIVITY	DELIVERABLE
Preparedness	Develop gender snapshot/overview for the country; review pre-existing gender analysis from NGOs, the Government and United Nations agencies.	Snapshot (6 pager) https://tinyurl.com/yowk3r7z Infographic
First week of a rapid-onset emergency	<p>Review of gender snapshot prepared before the emergency and edited as necessary. Circulate to all emergency response staff for induction.</p> <p>Identify opportunities for coordination with existing organizations working on gender issues</p> <p>Carry out a rapid gender analysis, which can be sectoral or multisectoral, integrating key questions for the health sector (see later on in this chapter for examples). Conduct sectoral or multisectoral rapid analysis and consult organizations relevant to the sector.</p>	<p>Briefing note (2 pager) identifying strategic entry points for linking humanitarian programming to existing gender equality programming https://tinyurl.com/yao5d8vs</p> <p>Map and contact details of organizations working on gender in the country</p> <p>Rapid gender analysis report https://tinyurl.com/y9fx5r3s</p>
3 to 4 weeks after the rapid analysis	Carry out a sectoral gender analysis adapting existing needs analysis tools and using the types of questions suggested later on in this chapter. Carry out a gender-specific analysis of data collected in the needs assessment.	Sectoral gender analysis report https://tinyurl.com/y9xt5h4n

TIMEFRAME	ACTIVITY	DELIVERABLE
<p>2 to 3 months after the start of the emergency response</p>	<p>Identify opportunities for an integrated comprehensive gender analysis, building on pre-existing gender partnerships. Ensure there is a baseline that captures SADD, access to humanitarian assistance, assets and resources and level of political participation. Analyse the impact of the crisis, changes in ownership patterns, decision-making power, production and reproduction and other issues relating to the sector.</p> <p>Use the gender analysis inputs to inform planning, monitoring and evaluation frameworks including M&E plans, baselines and post-distribution monitoring.</p> <p>Carry out an analysis of internal gender capacities of staff (identify training needs, level of confidence in promoting gender equality, level of knowledge, identified gender skills).</p>	<p>Concrete questions into (potentially ICT-enhanced) questionnaire.</p> <p>Comprehensive gender assessment report https://tinyurl.com/ybyerydk and https://tinyurl.com/ybsqzvzj</p> <p>Inputs to planning, monitoring and evaluation-related documents</p> <p>1-page questionnaire</p> <p>Survey report</p> <p>Capacity-strengthening plan</p>
<p>6 months after the response (assuming it is a large-scale response with a year-long timeline)</p>	<p>Conduct a gender audit/review of how the humanitarian response is utilizing the gender analysis in the programme, campaigns and internal practices.</p> <p>The report will feed into a gender learning review half way through the response.</p>	<p>Gender equality review report with an executive summary, key findings and recommendations.</p>
<p>1 year or more after the humanitarian response</p>	<p>Conduct an outcome review of the response looking at the response performance on gender equality programming. This needs to be budgeted at the beginning of the response. The report is to be shared in the response evaluation workshop and to be published.</p>	<p>Gender equality outcome evaluation with an executive summary, findings and recommendations. https://tinyurl.com/p5rqgut</p>

Sources for a gender analysis include census data, Demographic and Health Surveys, gender analysis reports, humanitarian assessment reports, protection and GBV sector reports, as well as gender country profiles, such as those produced by WHO, UNICEF, ACF and others. These should be supplemented with participatory data collection from everyone affected by the crisis and/or the programme such as through surveys, interviews, community discussions, focus group discussions, transect walks and storytelling.

THE GENDER ANALYSIS FOR THE HEALTH SECTOR SHOULD ASSESS:

- **Population demographics.** What was the demographic profile of the population disaggregated by sex and age *before the crisis*? And what has changed since the crisis or programme began? Look at the number of households and average family size, number of single- and child-headed households by sex and age, number of people by age and sex with specific needs, number of pregnant and lactating women. Are there polygamous family structures?
- **Gender roles.** What were the roles of women, girls, men and boys related to health prior to the crisis? How have the roles related to health of women, girls, men and boys changed since the onset of the crisis? What are the new roles of women, girls, men and boys related to health and how do they interact? How much time do these roles require?
- **Decision-making structures.** What structures did the community use to make health decisions before the crisis and what are these now? Who participates in decision-making spaces? Do women and men have an equal voice? How do adolescent girls and boys participate?
- **Protection.** What health and protection risks did specific groups of women, girls, men and boys face before the crisis? What information is available about protection risks since the crisis began or the programme started? How do legal frameworks affect gender and protection needs and access to justice?
- **Gendered needs, capacities and aspirations.** What are the health-related needs, capacities and aspirations of women, girls, men and boys in the affected population and/or programme? This should include needs, capacities and aspirations relating to reproductive health services and services for survivors of GBV, in addition to wider health care services and information (including as these relate to the availability of health facilities, health workers, drugs and equipment).



POSSIBLE QUESTIONS FOR A GENDER ANALYSIS SPECIFIC TO THE HEALTH SECTOR INCLUDE:

- What are the mortality rates disaggregated by sex and age? Are there disproportionate deaths among women, girls, men and boys?
- What was the health situation for women, girls, boys and men before the crisis and how has it changed since? Has there been an increase in a specific disease since the crisis and who does it affect?
- What are the roles and responsibilities of women and men for health care at household level?
- What are the cultural and religious aspects related to the provision and access of health care?
- Who provides health care to women and girls or men and boys? Do local practices influence whether male health workers can provide care for women?
- What are cultural expectations regarding pregnancy, childbirth and breastfeeding? What are the cultural practices regarding menstruation?
- What are the cultural practices around washing, water use, cooking and disposal of dead bodies? How do these impact on the health and time of women, girls, men and boys?
- Are there barriers to women's, girls', boys' and men's access to health services or health information (including around safe hygiene practices)? Are LGBTI persons able to access health facilities? Is there equitable access to reproductive health care for adolescent girls and boys who are single or in relationships? Is there equal access to health care for elderly men and women?
- Are survivors of GBV able to access health services? Are referral systems in place for GBV survivors in health facilities? Do women, girls, men and boys consider GBV-related health services to be safe and confidential? Have health-care staff been trained on GBV care?

Good practice

The Zika and Ebola outbreaks highlighted that women's socioeconomic status, which is always a determining factor in their experience of gender inequality and gender discrimination, takes on heightened significance during complex emergencies. For example, even in a country where there are restrictive abortion laws, such as Brazil, women with higher education and socioeconomic status are more likely to gain access to safe abortion. While public health interventions to support women in making autonomous sexual and reproductive choices are vital, advice and programming may not adequately address the socioeconomic options open to these young women that determine their sexual and reproductive 'choices'. Therefore, in a public health emergency, where a virus (like Ebola and Zika) can be spread by sexual relations, attention to the location and equality of the women and girls affected by the disease outbreak is vital to ensure that advice on containment and treatment compensates for the limited choices likely to be available to this population.

ADAPTED FROM: SARA, E. DAVIES AND BELINDA BENNETT. 2016. A GENDERED HUMAN RIGHTS ANALYSIS OF EBOLA AND ZIKA: LOCATING GENDER IN GLOBAL HEALTH EMERGENCIES. *INTERNATIONAL AFFAIRS*

Good practice

There is a significant relationship between HIV and tuberculosis (TB). Most TB cases and deaths occur among men, but it remains among the top three causes of female deaths worldwide.

Although there is a higher HIV prevalence amongst women in sub-Saharan Africa, the incidence of TB is higher in men (except in women who are 15–24 years old in areas of high HIV prevalence). This is due to male-specific risks associated with the transmission of TB, for example, men tend to have more social contacts, work in high-risk settings, smoke, possibly have higher alcohol consumption and seek health care less frequently. Females experience a specific set of risks, including higher stigma, delayed diagnosis and less access to treatment services. Higher rates of extrapulmonary TB among women also mean they are harder to screen and diagnose. Moreover, the gendered dynamics of TB treatment and cure rates are not uniform; in some countries men have better outcomes than women, while in others women have better outcomes than men.

Recognizing the need for a systemic assessment tool from a gender perspective to inform TB and HIV responses, the Stop TB Partnership and UNAIDS developed the HIV/TB gender assessment tool to help ensure that responses are gender-sensitive. Using tools such as this, which take into account the gendered elements of a disease outbreak, helps to identify gender-related barriers to services as well as the specific needs of women, men, transgender people and key vulnerable populations, which in turn enables countries and teams to respond better to specific barriers and needs of these groups.

ADAPTED FROM: UNAIDS AND STOP TB PARTNERSHIP.2016. "GENDER ASSESSMENT TOOL FOR NATIONAL HIV AND TB RESPONSES: TOWARDS GENDER-TRANSFORMATIVE HIV AND TB RESPONSES"



KEY APPROACHES AND STANDARDS FOR NEEDS ASSESSMENT AND ANALYSIS IN HEALTH PROGRAMMING

Coordination

GOOD PRACTICE

- » Work with women's rights organizations and inter-agency/intersectoral gender working groups (if established) to understand what approaches and solutions other agencies are adopting to provide gender equality in health programming.
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BE AWARE!

- » Be aware of possible biases in information collection and analysis. For instance, if women were not consulted, the identified priorities do not reflect the needs and priorities of the whole community.
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Participation

GOOD PRACTICE

- » Ensure an equal balance of men and women on the health assessment team to ensure access to women, girls, men and boys. Where feasible, include a gender specialist and protection/GBV specialist as part of the team.
- » Look for particular expertise or training by local LGBTI groups where possible to inform the analysis of the particular needs of these groups relating to health.
- » Undertake a participatory assessment with women, girls, men and boys. Set up separate focus group discussions and match the sex of humanitarian staff to the sex of the beneficiaries consulted to better identify their capacities and priorities. This approach facilitates a clearer understanding of the differing levels of the beneficiaries consulted to better identify their needs, capacities and priorities relating to health.
- » Adopt community-based approaches building on existing community structures to motivate the participation of women, girls, men and boys in the health response.
- » Ensure access to childcare to enable the participation of women and girls, who often carry responsibility for care work, throughout the programme cycle.

Participation (continued)

BE AWARE!

- › There are certain questions to ask women, girls, men and boys and LGBTI individuals in separate groups such as those concerning sexual and reproductive health or the risk of GBV.
- › Advertise meetings through accessible media for those with disabilities, low literacy and from linguistic minority groups. Engage female and male translators to assist beneficiaries.
- › Be mindful of barriers and commitments (childcare, risk of backlash, ease of movement, government ban of open LGBTI population in some cultures, etc.) that can hinder the safe participation of women, girls and LGBTI individuals in community forums.
- › Where women, girls, men and boys participate in mixed groups, address any barriers that stem from gender norms such as men's voices carrying more weight.
- › Ensure that meeting spaces are safe and accessible for all. Where women's voices cannot be heard, look for other ways to get their opinions and feedback.
- › In some contexts, it may be necessary to negotiate with community leaders prior to talking with women community members in order to avoid backlash.

GBV prevention and mitigation

GOOD PRACTICE

- › Use this handbook together with the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Response.
- › Train staff on how to refer people to GBV services.
- › Ensure safe access to health facilities for women, girls, men and boys of all ages and people with disabilities.
- › Ensure that health facilities have sex-segregated latrines lockable from the inside.
- › Ensure that health facilities monitor who is entering the facility (through guards or others).

BE AWARE!

- › Don't collect information about specific incidents of GBV or prevalence rates without assistance from GBV specialists.
- › Be careful not to probe too deeply into culturally sensitive or taboo topics (e.g. gender equality, reproductive health, sexual norms and behaviours, etc.) unless relevant experts are part of the assessment team.
- › Always be aware of the ethical guidelines in social research when directly collecting information from vulnerable groups and others.

Gender-adapted assistance

GOOD PRACTICE

- » Identify groups with the greatest health support needs and the underlying factors that potentially affect health status, disaggregated by sex and age.
 - » Assess the barriers to equitable access to health programmes/services, disaggregated by sex and age.
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BE AWARE!

- » To identify the differentiated needs of women, girls, men and boys, be aware of potential barriers to their participation in the needs assessment (see participation section in this table for further advice on this).
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Transformative approach

GOOD PRACTICE

- » Identify opportunities to challenge structural inequalities between women and men, and to promote women's leadership within the health programme.
 - » Invest in targeted action to promote women's leadership, LGBTI rights and reduction of GBV.
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BE AWARE!

- » Ensure that any negative effects of actions within the health programme that challenge gender norms are analysed in order to mitigate them and to ensure the programme upholds the do no harm principle (see section B, page 88 for more information on this concept)

2 Strategic planning

Once the needs and vulnerabilities of all members of the crisis affected population have been identified during the needs assessment and analysis phase of the HPC, this data and information can be used to strategically plan the response intended to address them.

Using the information and data gathered through the gender analysis process, the programme planner can establish a demonstrable and logical link between the programme activities and their intended results in the health sector, thus ensuring that the identified needs are addressed. This information needs to be developed in the results-based framework that will be the base for monitoring and evaluation later on in the programme cycle.

The strategic planning should also take into account the key approaches explained in the previous HPC phase (needs assessment and analysis) of coordination, participation, GBV prevention and mitigation, and transformative approach. If these have been considered

adequately in that phase together with the gender analysis, the planning should be adequately informed. Gender markers should also be applied at this phase (see section B, pages 52–53 for more information).

At the strategic planning stage, **indicators** should be developed to measure change for women, girls, men and boys.

Use sex- and age-sensitive indicators to measure if all groups' needs are being met. Check the following: expected results; provision of quality assistance with respect to gendered needs; monitor rates of service access; satisfaction with the assistance provided; how the facilities were used; and what has changed due to the assistance, for whom and in what timeframe. Compare the different rates by sex and age of the respondents.

The following table shows examples of the development of objectives, results and activities with associated indicators based on the outcomes of a gender analysis:

GENDER ANALYSIS QUESTIONS	ISSUES IDENTIFIED	SPECIFIC OBJECTIVES <i>What specific objective is the operation intended to achieve?</i>	SPECIFIC OBJECTIVE INDICATORS <i>Indicators that clearly show the specific objective of the operation has been achieved</i>
Are referral systems in place for GBV survivors in health facilities?	Poor ability of health facilities to respond to GBV.	GBV survivors have access to well-established referral systems to support them in the various aspects of their lives.	Number and percentage of GBV survivors who turn to the established referral systems
Is there access to sexual and reproductive health (SRH) services and information for adolescent girls and boys?	Absence of gender balance of staff inhibiting access for adolescent girls to SRH services. SRH information not reaching adolescent girls or boys. Cultural barriers present the subject as taboo.	More adolescent boys and girls have age appropriate knowledge about SRH.	Number and percentage of adolescent boys and girls who have improved knowledge of age-appropriate SRH over baseline (or pre-intervention results)
What are the roles and responsibilities of women and men for health care at household level? How have these been impacted by the crisis?	Women traditionally care for the sick at home, which is impacting their ability to engage in paid work. This has been exacerbated by the crisis as women are caring for more sick family members.	Women are more able to access the income-generating activities due to alternative ways of caring for the sick at the household level.	Percentage of women who join income-generating activities as a result of not having to care for the sick at the household level

EXPECTED RESULTS

The outputs of the intervention that will achieve the specific objective

Staff knowledge and capacity of standard operating procedures acquired/improved.

A referral mechanism linking GBV survivors with assistance in various sectors is established.

Gender balance is achieved in the staffing of SRH services.

Adolescent boys and girls have age-appropriate access to information about SRH.

Sick family members can benefit from health-care services by professional staff.

Men and boys take more responsibilities towards caring for the sick at the household level.

EXPECTED RESULTS INDICATORS (OUTPUT INDICATORS)

Indicators to measure the extent the intervention achieves the expected result

Percentage of staff who have acquired and improved knowledge of the referral mechanism over baseline (or pre-intervention results)

Number of key partners who provide services to GBV survivors disaggregated by the type of service provided

Ratio of female to male health workers for SRH services

Number and percentage of adolescent boys and girls who access age-appropriate SRH information through the programme

Number and percentage of the sick who access professional health care

Percentage of women, girls, men and boys who report shifts in roles assignments in caring for the sick at the household level

GENDER-ADAPTED PROGRAMMING ACTIVITIES

Build staff knowledge of and capacity to implement standard operating procedures for multisectoral care for GBV.

Establish a referral mechanism with key local partners who can support GBV cases (legal, medical, rehabilitation, shelter).

Support the recruitment of more female staff within SRH services

Adapt health information messaging for adolescent girls and boys and present it in a scientific way

Targeted outreach of SRH information to adolescent girls and boys

Provision of accessible health services for those affected by the crisis

Raise the awareness of men and boys on shared responsibilities for health care at the household level

3 Resource mobilization

Following the strategic planning phase and the production of a results-based framework (log frame) based on the needs assessment and analysis, the next phase in the HPC is resource mobilization.

Key steps to be taken for effective resource mobilization include:

- Humanitarian actors need to engage in advocacy and partnership with donors to mobilize funds for addressing gaps in the particular needs, priorities and capacities of women, girls, men and boys.
- To mobilize resources around priority actions, support the health cluster with information and key messages on the distinct needs of women, girls, men and boys and plans developed to meet these needs.
- Use **gender markers** to assess how well a programme incorporates gender equality into planning and implementation and provide guidance on how to improve the process. There are several different but related markers (see section B, pages 52–53 for more information).

Examples of commitments, activities and indicators that donors typically look for can be consulted in the IASC Gender Marker Tip Sheets. In the health tip sheet, examples of commitments include:

- Ensure that women, girls, men and boys benefit equally from training and other capacity-building initiatives,
- Ensure that male and female health providers are trained on the clinical management of rape;
- Design services to meet the needs of women, girls, men and boys equally by ensuring that teams of community health workers are gender-balanced.

4 Implementation and monitoring

Once the resources have been mobilized, the next stage of the HPC cycle is the implementation and monitoring of the programme.

Implementation

In order to ensure that health programmes integrate gender equality throughout, the following key actions need to be taken into consideration:

- Tailor health programme activities to the specific health-related needs, capacities and priorities of all women and girls, men and boys.
- Inform women, girls, men and boys of the available resources and how to influence the programme.
- Develop and maintain feedback mechanisms for women, girls, men and boys as part of health programmes.

Note that the ability to safely access these mechanisms can be different for women, girls, men and boys and as such provisions should be made to facilitate their inclusion. Other diversity factors such as caste, age and disability should also be taken into account to ensure access to all aspects of the health programme.

To ensure that the programme adheres to good practice, several key standards relating to gender equality should be integrated across the planning, implementation and monitoring stages. These standards relate to the following areas (and are explained in the more detail in the table that follows).

- Coordination
- Participation
- GBV prevention and mitigation
- Gender-adapted assistance
- Transformative approach

Good practice

Local assembly of clean delivery packages for birth can present a good opportunity to identify and organize women's groups. Such groups can then encourage all pregnant women to deliver in a health facility and educate women about early recognition and referral for obstetric complications. The women's group can make up the simple packages and distribute them to visibly pregnant women free of charge. This is particularly helpful because, as the women's groups are part of the displaced population, they most likely already know which women are close to their delivery times and are in need of the materials. Those provided with the kits should also be informed about the nearest facilities and the importance of delivering with a skilled attendant so that they can pass this information on to other women they visit.

ADAPTED FROM WOMEN'S REFUGEE COMMISSION. 2006 [REVISED 2011]. 'MINIMUM INITIAL SERVICE PACKAGE [MISP] FOR REPRODUCTIVE HEALTH IN CRISIS SITUATIONS: A DISTANCE LEARNING MODULE'

KEY APPROACHES AND STANDARDS FOR PLANNING, IMPLEMENTATION AND MONITORING IN HEALTH PROGRAMMING

Coordination

GOOD PRACTICE

- » Identify local women's rights groups, networks and social collectives, in particular informal networks of women, youth, people with disabilities and LGBTI groups, support their participation in programme design, delivery and monitoring and ensure that they have a role in coordination.
- » Coordinate with other humanitarian service providers to ensure that gender-related health considerations are included across all sectors.
- » Support the Humanitarian Needs Overview and Humanitarian Response Plan using a gender analysis of the situation of women, girls, men and boys relating to the health sector and sex- and age-disaggregated data.

BE AWARE!

- » Be aware that the experiences and needs of LGBTI people may be very different, so coordination with local groups that represent these individuals is important to fully understand their needs and how to tailor a response.

Participation

GOOD PRACTICE

- » Implement a representative and participatory design and implementation process that is accessible to women, girls, men and boys to develop community-based and sustainable health programmes.
- » Strive for 50 per cent of health programme staff to be women. Distribute significant and appropriate roles such as health monitors and hygiene promoters equally between men and women.
- » Ensure that women, girls, men and boys participate meaningfully in health sector programmes and are able to provide confidential feedback and access complaint mechanisms by managing safe and accessible two-way communication channels.
- » Women, girls, men and boys must be able to voice their concerns in a safe and open environment and if necessary can speak to female humanitarian staff.
- » Consult diverse women, girls, men and boys in assessing the positive and possible negative consequences of the overall response and specific activities. Include people with mobility issues and their care providers in discussions.
- » Be proactive about informing women about forthcoming meetings, training sessions, etc. and support them in preparing well in advance for the topics.
- » Ensure access to childcare to enable the participation of women and girls, who often carry responsibility for care, throughout the programme cycle.

Participation (continued)

BE AWARE!

- » Ensure that women at heightened risk have a mechanism to raise their concerns and participate in decision-making, while guaranteeing confidentiality regarding their personal situations and without exposing them to further harm or trauma. Some mechanisms such as confidential hotlines run outside the community are more effective.
- » Avoid placing women in situations where the community is simply responding to the expectations of external actors and there is no real, genuine support for their participation.
- » Be mindful of barriers and commitments (child care, risk of backlash, ease of movement, government ban on LGBTI individuals etc.) that can hinder the safe participation of women, girls and LGBTI individuals in community forums.
- » Where women, girls, men and boys participate in mixed groups, address any barriers that stem from gender norms such as men's voices carrying more weight.
- » Ensure that meeting spaces are safe and accessible for all. Where women's voices cannot be heard, look for other ways to get their opinions and feedback.
- » In some contexts, it may be necessary to negotiate with community leaders prior to talking with women community members in order to avoid backlash.

GBV prevention and mitigation

GOOD PRACTICE

- » Follow the guidance provided on the health sector in the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.
- » Prevention and response to GBV is a key cross-cutting priority in health programming and requires a coordinated effort across planning, implementation and monitoring of response efforts.
- » Ensure provision for 24-hour access to GBV health-related services for survivors and additional referral mechanisms. These must protect confidentiality and ensure safety, security and non-discrimination. Obtain informed consent prior to performing a physical examination. Ensure that follow-up services are provided for survivors, including long-term mental health and psychosocial support as needed.
- » Do no harm: identify early potential problems or negative effects by consulting with women, girls, men and boys, using complaint mechanisms, doing spot checks and, where appropriate, using transect walks around distribution points. Measures to ensure safety, respect, confidentiality and non-discrimination in relation to survivors and those at risk are vital considerations at all times. (See section B, page 88 for more information on this concept.)
- » Employ and retain women and members of other at-risk groups as staff members.
- » Train health staff on how to orient people to services towards GBV referral and identification of GBV (this should not include routine inquiry).
- » Reduce protection risks by making sure that women, girls and other at-risk groups utilize the quickest and most accessible routes to health services.

KEY APPROACHES AND STANDARDS FOR PLANNING, IMPLEMENTATION AND MONITORING IN HEALTH PROGRAMMING (CONTINUED)

GBV prevention and mitigation (continued)

BE AWARE!

- » Don't share data that may be linked back to a group or an individual, including GBV survivors.
- » Avoid singling out GBV survivors: Speak with women, girls and other at-risk groups in general and not explicitly about their own experiences.
- » Don't collect information about specific incidents of GBV or prevalence rates without assistance from GBV specialists.
- » The environment in which assistance is provided should, as far as possible, be safe for the people concerned. People in need should not be forced to travel to or through dangerous areas in order to access assistance.

Gender-adapted assistance

GOOD PRACTICE

- » Assess all health programming to ensure that gender-related considerations are included throughout.
- » Analyse, share with relevant actors and use the results and data to inform humanitarian response priorities and target the right people.
- » Culturally appropriate mental and psychosocial support (i.e., psychological first aid) should be made available to all women, girls, men and boys.
- » HIV/AIDS control and prevention services should be reinstated when disrupted by crises, including targeted messaging for women and men, active and demobilized members of the armed forces, IDPs and refugees.
- » Maternal health care should be supported through emergency health kits for clean and safe deliveries for use by trained personnel, alongside emergency obstetric care (including transportation). Immediate postnatal (maternal and newborn) care should also be provided.
- » Comprehensive abortion care should be provided in line with national laws.
- » Distribute sanitary napkins/towels, female and male condoms, post-exposure prophylactic kits where necessary, emergency contraceptives and pregnancy tests.
- » From the earliest stage of an emergency, the minimum initial service package for reproductive health should be in place.
- » Designate and train specific health providers with clear responsibilities related to the care of survivors (e.g., triage, clinical care, mental and psychosocial support and referral) including specific protocols for compassionate and confidential care.
- » Information on health, including health-related implications of GBV, should be included in community advocacy campaigns.
- » Ensure that health information systems disaggregate data by sex and age.

Gender-adapted assistance (continued)

BE AWARE!

- » Ensure that an adequate number of female staff are trained on clinical management of GBV.
- » Do not assume that all will benefit from health programming equally. Use the distinct needs, roles and dynamics for women, girls, men and boys (as per the gender analysis) to define specific actions to address each need and consider options suggested by women, girls, men and boys.
- » Special measures to facilitate the access of vulnerable groups should be taken, while considering the context, social and cultural conditions and behaviours of communities. Such measures might include the construction of safe spaces for people who have been victims of abuse such as rape or trafficking, or putting in place means that facilitate access for people with disabilities or certain LGBTI individuals who face discrimination. Any such measures should avoid the stigmatization of these groups.

Transformative approach

GOOD PRACTICE

- » Challenge structural inequalities. Engage men, especially community leaders, in outreach activities regarding gender-related health issues.
- » Support gender equality for paid positions in the health workforce to promote women's economic empowerment (including equal pay).
- » Source materials for dignity kits from local women's organizations groups.
- » Promote women's leadership in all health management committees and agree on representation quotas for women with the community prior to any process for elections.
- » Work with community leaders (women and men) to sensitize the community about the value of women's participation.
- » Raise awareness with and engage men and boys as champions for women's participation and leadership in the health response.
- » Engage women, girls, men and boys in non-traditional gender roles in health.
- » Support women to enable them to build their negotiating skills and strategies and support them to become role models within their communities by working with them and encouraging them to take on leadership roles.
- » Help establish women's, girls' and youth groups within the community and enable them to undertake leadership roles.

BE AWARE!

- » Attempting to change long-held gender dynamics in society can cause tensions. Keep lines of communication open with beneficiaries and ensure that measures are in place to prevent backlash.
- » Powerful refugee and displaced men often feel most threatened by strategies to empower women in the community, as they see this as a direct challenge to their own power and privilege (even if limited).

Monitoring

Monitor the access to and quality of health sector assistance for women, girls, men and boys as well as the changes relating to meeting women's strategic needs. The monitoring should also address how the health programme has contributed through meaningful and relevant participation and a transformative approach including promotion of women's leadership. **Sex- and age-disaggregated data** (SADD) are a core component of any gender analysis and essential for monitoring and measuring outcomes. Use **gender markers** to assess how well a programme incorporates gender equality into planning and implementation and provide guidance on how to improve the process (see section B, pages 52–53). Monitoring for the health sector can, for example, measure birth rate results prior to and after providing family planning services, and measure cases of sexually transmitted infections prior to and after the distribution of condoms. Monitor rates of access such as the number of

women attending pre- and postnatal care or the number of GBV survivors who received clinical management of rape care within the first 72 hours.

Monitor the health programme's adherence to the **"do no harm"** principle: (see section B, page 88 for more information on this concept) conduct ongoing consultation with women, girls, men and boys, and undertake observation/spot checks to identify early potential problems or negative effects (e.g., aid workers assuming that people who appear resilient may not need psychosocial support can result in negative mental health outcomes). Feedback mechanisms as part of monitoring are also critical (see section B, pages 84–87 for more information on these). These measures allow early identification of negative effects of the programme so they can be addressed in a timely manner so as to prevent GBV or further abuse of women's rights.

Good practice

In West Darfur, midwives were identified as sexual violence protection "focal points" and let internally displaced women know they could approach these focal points confidentially; these focal points then referred women to receive medical care. In North Darfur, traditional birth attendants delivered messages on sexual violence to the community. In South Darfur, women's health teams conducted community outreach to survivors of sexual violence.

ADAPTED FROM WOMEN'S REFUGEE COMMISSION. 2006 [REVISED 2011]. 'MINIMUM INITIAL SERVICE PACKAGE [MISP] FOR REPRODUCTIVE HEALTH IN CRISIS SITUATIONS: A DISTANCE LEARNING MODULE'

5 Gender operational peer review and evaluation

The primary purpose of the operational peer review and evaluation stage is to provide humanitarian actors with the information needed to manage programmes so that they effectively, efficiently and equitably meet the specific needs, and priorities of crisis-affected women, girls, men and boys as well as build/strengthen their capacities (See section B, page 60 for more information on this). Evaluation is a process that helps to improve current and future health programming to maximize outcomes and impacts, including analysing how well the transformative approach has been integrated and whether women's leadership has been promoted, ensuring that strategic as well as practical needs have been addressed.

To ensure people-centred and gender-responsive impacts, it is necessary to review methodologies and processes to determine good practice in providing equal assistance to women and men. Projects need to be reviewed based on equal participation and access to services by women, girls, men and boys, from the onset of programme planning to implementation. It is necessary to also assess gaps in programming, focusing on which women, girls, boys or men were not effectively reached. The use of the gender markers collectively helps to identify gaps to improve programming and response.

KEY STANDARDS

1. WHO. *Health Cluster Guide*. 2009. <https://tinyurl.com/ydyqft2h>
2. IASC. "Health." *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*. 2015. <https://tinyurl.com/y9ynutoj>
3. The Sphere Project. "Minimum Standards in Health Action." *Humanitarian Charter and Minimum Standards in Humanitarian Response*. 2011. <https://tinyurl.com/y7zrnoz>

KEY RESOURCES

1. Interagency Working Group on Reproductive Health in Crises. *Field Manual on Reproductive Health in Humanitarian Settings*. 2010. Revision due November 2017. <https://tinyurl.com/y9z8exbb>
2. Interagency Working Group on Reproductive Health in Crises. *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A distance learning module*. 2011. <https://tinyurl.com/y7y6em8d>

3. UNHCR. *Operational Guidance Mental Health and Psychosocial Support for Refugee Operations*. 2013. <https://tinyurl.com/y8kq3e3t>
4. UNFPA, Save the Children. *Adolescent sexual and reproductive health tool kit for humanitarian setting*. 2009. <https://tinyurl.com/ybn9dbem>
5. WHO. *Health Resources Availability Monitoring System (HeRAMS): Technical Guidelines*. <https://tinyurl.com/y8ypauhc>
6. Sommer, Marni. *Key standards on menstrual hygiene management*. 2012. <https://tinyurl.com/y8srxrh2>
7. UNDP et.al. 2016 Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions (the "TRANSIT"). <https://tinyurl.com/kbh3eyd>
8. UNFPA et al. Implementing comprehensive HIV and STI programmes with men who have sex with men. 2015. <https://tinyurl.com/y9lhob3z>