Have you read section A ?

GENDER AND HEALTH IN EMERGENCIES

In crises, the health of women, girls, boys and men is affected differently. Social, cultural and biological factors increase the risks faced by women and particularly girls. Available data suggest that there is a pattern of gender differentiation in terms of exposure to and perceptions of risk, preparedness, response and physical and psychological impact, as well as capacity to recover.

Women and girls are often at **increased risk of violence** and **may be unable to access assistance** and/or to make their needs known. They are usually insufficiently included in community consultation and decision-making processes; as a result their health needs are often not met. Men may suffer other disadvantages in different situations and for different reasons than women because of their gender role socialization. For example, men's roles as protectors may place a greater responsibility on them for risk-taking during and after a disaster.

When you are delivering health care in crisis situations you must first take account of the different needs, second recognize the potential barriers that people may face and third ensure that women and men can access health services equally. Health projects and programmes must include gender analysis *from the beginning and at every stage of* the project cycle. Women and men, especially those from vulnerable or marginalized groups, must participate equally in the planning, management and delivery of health services in humanitarian crises, and women must be part of the decision-making and implementation process at all levels. Remember to take the views of girls and boys into account. Coordinate with health and other partners to avoid overlap and duplication.

Recognizing that it will not be possible to collect information on all issues outlined on the following page, it is important that you disaggregate data by sex and age and apply a gender analysis.

THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH IS A HUMAN RIGHT FOR ALL

- The right to health is a fundamental human right indispensable for the exercise of other human rights.
- Article 25 of the UDHR laid the foundations for the right to health.
- Article 12 of the ICESCR provides protection of the right to health in international law. It introduces legally binding provisions that apply to all ratifying States. The additional right to health protection for marginalized groups is contained in group-specific international treaties.
- The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation; healthy occupational and environmental conditions; and access to health-related education and information, including on sexual and reproductive health. (ICESCR)
- The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health. (ICESCR)
- The right to health includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
- The right to health requires that health facilities, goods and services must be available, accessible, acceptable and of good quality.
- Further standards relating to the right to health of specific groups are set out in other documents, such as the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare and the Declaration on the Elimination of Violence against Women.
- Several regional instruments also include the right to health. (Refer to Table 1, page 82.)

WHAT DO WE NEED TO KNOW TO PLAN AND IMPLEMENT GENDER-RESPONSIVE HEALTH SERVICES?

What are the population demographics?

- Total number of households/family members — disaggregated by sex and age.
- Number of single female- and male-headed households and number of households headed by children (girls and boys).
- Number of unaccompanied children, elderly, disabled, pregnant and lactating women.

What is the social, political, cultural and security context? What has changed as a result of the emergency?

- Are there differences between women and men in the community/households in relation to their roles, responsibilities and decision-making power? What are they?
- How are women, girls, boys and men affected differently by the crisis?

What was the health situation before the emergency?

- What is the baseline health information and how has it changed since the crisis?
- What diseases affect women and men differently within the context of the crisis?
- What is the crude mortality rate disaggregated by sex and age? Are there disproportionate deaths among women, girls, boys and/or men? If so, what are the reasons?

What are the cultural and religious aspects related to the provision of health care?

- Who provides health care to whom? For example, what are local beliefs and practices concerning whether male health care workers can provide care to women?
- What are the cultural beliefs and practices regarding pregnancy and birthing, the disposal of dead bodies, care of the sick, washing, water use, cooking, animal husbandry and menstruation? Do these negatively affect women, girls, boys or men?
- What are the linguistic factors (such as illiteracy and use of minority or foreign languages) that may affect the access of certain groups/communities to health care services and health information (including information on underlying determinants of health, such as access to water and sanitation facilities)? Is there any difference between women and men in terms of ways of communication and/or access to information?

ACTIONS TO ENSURE GENDER EQUALITY PROGRAMMING IN THE HEALTH SECTOR

Joint needs assessments

Cluster/sector actors should jointly undertake health assessments in order to use resources efficiently, enhance coordination and reduce burden on communities.

- Ensure assessment teams include female assessors and translators.
- Collect and disaggregate all data by sex and age and apply a gender analysis.
- Find out which groups are hard to reach (physical and social access) and/or marginalized, and the barriers preventing access.
- Identify community response mechanisms to psychosocial problems and strengthen those that can support individuals, ensuring they respect human rights standards.
- Identify local practices and beliefs about caring for sick members of the community, including through home-based care. Do these particularly burden women, girls, boys or men?
- Map the availability, location, capacity and functional status of health facilities and public health programmes, including sex-specific essential services for women and men (e.g. maternal and child health services and reproductive health services for men).
- Ensure maximum protection to those facilities (e.g. lighting for the area and paths leading to them; provision of transport and/or escorts where possible).
- Identify existing trained health professionals (doctors, nurses, midwives and others) in the community (keeping in mind that they may not be working due to destruction/closure of facilities or family responsibilities which keep them at home) and enable them to return to work, including through provision of transport, security measures, child care and flexible work schedules as needed.
- Compile an inventory of local groups and key stakeholders in the health sector, including gender theme groups, traditional healers, women's organizations, etc., to find out what is being done, where, by whom and for whom.
- Assess the availability of medical drugs and equipment, for example the availability of New Emergency Health Kits (NEHK) for the provision of basic health services for women and men.

- Ascertain the availability of standardized protocols, guidelines and manuals in line with current international guidance and find out whether they include provisions for equitable access for women, girls, boys and men to services and benefits. If not, apply international standards.
- Conduct qualitative assessments to determine perceptions about health services provided to the community and identify recommendations to address their concerns.

Community mobilization and participation

- Involve from the outset women, girls, boys and men, including those who belong to vulnerable groups, in health assessments, priority setting, programme design, interventions and evaluation.
- Analyse, together with the community through participatory assessments, the impact of the humanitarian crisis on women, girls, boys and men to identify physical and mental health needs and to ensure equal access to health services and benefits.
- Provide child care support to enable women and men — especially those from single-parent-headed households — to participate in meetings.

Provision of health services

- Actively engage women and men from the community and the health workforce, including those who belong to vulnerable groups, equally and at all levels in the design and management of health service delivery, including the distribution of supplies.
- Ensure ongoing and coordinated health service delivery strategies that address the health needs of women, girls, boys and men. For instance:
  - Provide Minimum Initial Service Packages (MISP) so that women and men and adolescent girls and boys have access to priority sexual and reproductive health services in the earliest days and weeks of new emergencies and comprehensive sexual and reproductive health services, including GBV-related services, as the situation stabilizes.
  - Ensure prevention of and response to GBV as described in the IASC *Guidelines on Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, including treatment, referral and support mechanisms for GBV survivors.
  - Make culturally appropriate social and psychological support available to women, girls, boys and men. (IASC guidance forthcoming.)
  - Ensure privacy for health consultations, examinations and care.
  - Ensure coverage of HIV/AIDS control and prevention methods, with particular attention to responding to GBV and women's health risks such as sexually transmitted infections (STIs), including HIV/AIDS.
  - Distribute new emergency health kits for safe and clean deliveries and emergency obstetric care (UNFPA clean home delivery kits, UNICEF midwifery kits, UNICEF obstetric and surgical kits), sanitary towels for women, female and male condoms, post-exposure prophylactic (PEP) kits where necessary, emergency contraceptives and pregnancy tests.
  - Hire and deploy female and male local health workers.
  - Train and mobilize traditional birth attendants.
  - Ensure equal pay and opportunities for women and men in the health sector.
  - Make sure that women and men have equal opportunities for capacity building and training on health issues; provide child care or family support to enable their participation.
  - Disseminate HIV/AIDS prevention messages with a particular focus on men, active and demobilized members of armed forces, IDPs and refugees.

Advocacy, health information and education

- Advocate for equitable (according to need) distribution of and access to resources (human, financial, technological, logistical and medical supplies) in the health sector to respond to the health needs of women, girls, boys and men.
- Ensure health personnel (women and men) are adequately represented in gender theme groups, GBV working groups and IASC health cluster/health sector meetings.
- Develop and implement communication strategies to highlight the specific health risks affecting women and men, as well as targeting adolescent girls and boys.
- Provide information in local languages to women and men on available physical and mental health services and their location. Ensure that all hard-to-reach and

vulnerable members of the community are fully aware of the existing services and how they may benefit from accessing and utilizing them.

- Work with the media, civil society and partner agencies to raise health awareness, targeting special health events such as opening of new health facility, water collection points, etc., as points of entry.
- Advocate for the hiring/deployment of women and men at all levels.

Monitoring, reporting and evaluation

- Collect and report data by sex and age and apply a gender analysis.
- Involve women and men, including those who belong to vulnerable groups, in the monitoring and evaluation process.
- Share the results with all stakeholders, including the women, girls, boys and men in the target population.

CHECKLIST TO ASSESS GENDER EQUALITY PROGRAMMING IN THE HEALTH SECTOR

The checklist below is derived from the activities section in this chapter, and provides a useful tool to remind sector actors of key issues to ensure gender equality programming. In addition, the checklist, together with the sample indicators in the Basics Chapter, serves as a basis for project staff to develop context-specific indicators to measure progress in the incorporation of gender issues into humanitarian action.

HEALTH – GENDER CHECKLIST
Analysis of gender differences
1. Balanced ratio of women and men assessors and translators. 2. Balanced ratio of women, girls, boys and men who participate in the assessments. 3. Balanced ratio of women and men consulted about their health needs. 4. The following data are available and a gender analysis applied: • age- and sex-disaggregated cause-specific mortality rates • age- and sex-disaggregated case fatality rates • female-, male- and child-headed households • social structures, including positions of authority/influence, and the roles of women and men • groups with specific needs (including physically and mentally handicapped) by age and sex
Design of services
1. The timing, staffing and location of health services ensure equal opportunity for women and men to access them. 2. Health care delivery strategies and facilities address the health needs of women, girls, boys and men equitably. 3. Percentage of health facilities with basic infrastructure, equipment, supplies, drug stock, space and qualified staff for reproductive health services, including delivery and emergency obstetric care services (as indicated in the MISP). 4. Percentage of health facilities providing confidential care for survivors of sexual violence according to IASC GBV guidelines. 5. Ratio of health care providers disaggregated by profession, level and sex. 6. Ratio of community-based psycho-social care disaggregated by sex and age.

Access
1. Proportion of women, girls, boys and men with access to sanitary materials (including household-level sanitary disposal facilities for women). 2. Proportion of women, girls, boys and men with access to safe water supply. 3. Proportion of women, girls, boys and men with access to food aid. 4. Proportion of women, girls, boys and men with access to health services.
Participation
1. Balanced ratio of women and men participating in the design, implementation, monitoring and evaluation of humanitarian health responses. 2. Balanced ratio of women and men in decision-making positions. 3. Balanced ratio of local women and men hired/deployed in health sector. 4. Balanced ratio of international women and men hired/deployed in health sector. 5. Women and men participate regularly in group meetings or activities.
Training/Capacity building
1. Balanced/proportionate number of women and men from the community trained to provide health care. 2. Balanced/proportionate number of women and men from the community given employment opportunities in the health sector after training.
Actions to address GBV
1. 24-hour access to sexual violence services. 2. Staff are aware of and abide by medical confidentiality. 3. Staff are trained on the clinical management of rape. 4. Confidential referral mechanism for health and psycho-social services for rape survivors. 5. Information campaigns for men and women about the health risks to the community of sexual violence.
Targeted actions based on gender analysis
1. Men, active and recently demobilized members of armed/security forces, displaced persons and refugees are targeted with HIV/AIDS messages. 2. Communication strategies are developed and implemented to highlight the specific health risks affecting women and men, as well as targeting adolescent girls and boys.
Monitoring and evaluation based on sex- and age-disaggregated data
1. Data on demographics, mortality, morbidity and health services are routinely collected and are disaggregated and reported by age and sex and a gender analysis is applied. 2. Percentage of participatory assessment reports addressing the needs of women, girls, boys and men equally. 3. Formal monitoring and participatory evaluation mechanisms reporting the health impact of humanitarian crises on women, girls, boys and men.
Coordinate actions with all partners
1. Actors in your sector liaise with actors in other sectors to coordinate on gender issues, including participating in regular meetings of the gender network. 2. The sector/cluster has a gender action plan, has developed and routinely measures project-specific indicators based on the checklist provided in the IASC Gender Handbook.

RESOURCES

1. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP). *ALNAP Global Study on Consultation and Participation of Disaster-Affected Populations: Practitioners' Handbook*. London, 2003. http://www.odi.org.uk/alnap/publications/participation_study.htm
2. Health Canada. Women's Health Bureau. *Exploring Concepts of Gender and Health*. Ottawa, Ontario, 2003. http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/exploring_concepts.pdf
3. Inter-Agency Standing Committee (IASC). *Guidelines for HIV/AIDS Interventions in Emergency Settings*. Geneva, 2003. http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf
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7. United Nations Children's Fund (UNICEF). *Mainstreaming Gender in Unstable Environments*. New York, 2005. http://www.reliefweb.int/library/GHARkit/files/GenderInUnstableEnvironments.pdf
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9. United Nations Food and Agriculture Organization (FAO). *Emergency and Rehabilitation Programmes: Does Gender Matter?* Rome, 2005. http://www.fao.org/documents/show_cdr.asp?url_file=/docrep/007/y5834e/y5834e0a.htm
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13. WHO/UNHCR/UNFPA. *Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons*, revised edition. 2004. http://www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/index.html

Table 1: Further Information on the Right to Health in the International Legal Framework

TREATIES	ARTICLES
International Covenant on Economic Social and Cultural Rights (IC-ESCR)	Article 12: cornerstone protection of the right to health in international law
International Convention on the Elimination of All Forms of Racial Discrimination (CERD)	Article 5: protection for racial and ethnic groups in relation to "the right to public health (and) medical care"
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Articles 11, 12 and 14: protection of women's right to health
Convention on the Rights of the Child (CRC)	Article 24: right to the health of the child Articles 3, 17, 23, 25, 32 and 28: protection for especially vulnerable groups of children
Several regional instruments which include the right to health	The European Social Charter, The African Charter on Human and Peoples' Rights and The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Additional Protocol to the American Convention on Human Rights (Protocol of San Salvador)