IASC Gender Marker Tip Sheet

HEALTH

The IASC Gender Marker (GM) is required in all Consolidated Appeals Processes (CAPs) and other humanitarian appeals and funding mechanisms. Cluster Leads should support their partners in the use of the GM so that all cluster projects ensure that ALL segments of the affected population have equal access to health services and that targeted support to advance gender equality is based on a gender analysis. This makes health activities more effective.

By uploading gender codes onto the global Online Project System (OPS) and Financial Tracking System (FTS), donors are better placed to identify and to fund high quality, gender-informed projects.

The purpose of this Tip Sheet is to help Health Cluster Leads and their partners design quality projects that reflect the distinct needs of women, girls, boys and men. The aim is to:

1. Train users in GM coding skills and provide an opportunity to practise with the Vetting Form
2. Practice improving projects using practical examples and tips, by bringing gender dimensions into the needs analysis, the activities and the outcomes

WHY DOES GENDER EQUALITY MATTER IN EMERGENCY HEALTH INTERVENTIONS?

Conflicts and natural disasters affect women, girls, boys and men differently; they face different risks and, accordingly, are victimised in different ways. Humanitarian actors should understand these differences and ensure that services and aid delivered assist all segments of the population and do not put some at risk.

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. 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 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 automatically guarantee a positive impact on individuals or on the affected population. A gender-sensitive, participatory approach at all stages of the project cycle can help ensure that an adequate and efficient 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 are far more likely to improve the lives of affected populations.

GENDER EQUALITY IN THE PROJECT SHEET

The GM allows Cluster Vetting Teams to code projects 0, 1, 2a or 2b; each code represents the degree to which the project is designed to meet the needs of various segments of the population and/or targets groups with specific needs. The gender code is based on three elements: **Gender Analysis in NEEDS ASSESSMENT → ACTIVITIES → OUTCOMES**

Designing and implementing a project that achieves a gender code 2a or 2b makes sense as it will enhance both the project performance and the funding potential.

The **Title, Objectives** and **Beneficiaries** sections of the project can also provide useful additional information in order to indicate how well the different needs of women, girls, boys and men are mainstreamed into projects.

VETTING FORM

To code projects correctly and consistently, Cluster Vetting Teams are encouraged to use the GM Vetting Form:

Gender analysis in **NEEDS ASSESSMENT**	Gender in **ACTIVITIES**	Gender in **OUTCOMES**	No. of Checkmarks	**GENDER CODE**
✓	✓	✓	**3**	**2a or 2b**
✓	✓	-	**2**	**1**
-	✓	✓	**2**	**1**
✓	-	✓	**2**	**1**
✓	-	-	**1**	**1**
-	✓	-	**1**	**1**
-	-	✓	**1**	**0**
-	-	-	**0**	**0**

GENDER MARKER	DESCRIPTION
GENDER CODE 0 ***No visible potential to contribute to gender equality***	**Gender is not reflected** anywhere in the project sheet or only appears in the outcomes. There is risk that the project will unintentionally fail to meet the needs of some population groups and possibly even do some harm. These projects are considered gender-blind.
GENDER CODE 1 ***Potential to contribute in some limited way to gender equality***	*There are gender dimensions in **only** one or two components of the project sheet: i.e. in needs assessment, activities and outcomes**. The project does *not* have all three: i.e. 1) gender analysis in the needs assessment which leads to 2) gender-responsive activities and 3) related gender outcomes ****Note: Where the gender dimension appears in outcomes only, the project is still considered gender-blind.***

GENDER CODE 2A – GENDER MAINSTREAMING *Potential to contribute significantly to gender equality (Equivalent to Code 2 for UNDP and UNICEF projects)*	GENDER CODE 2B – TARGETED ACTION *Principal purpose of the project is to advance gender equality (Equivalent to Code 3 for UNDP and UNICEF projects)*
A **gender analysis** is included in the project's needs assessment and is **reflected in *one or more* of the project's activities and *one or more* of the project outcomes.** ***Gender mainstreaming*** in project design is about making the concerns and experiences of women, girls, boys and men an integral dimension of the core elements of the project: 1) gender analysis in the needs assessment which leads to 2) gender-responsive activities and 3) related gender outcomes. Gender mainstreaming in project design promotes the flow of gender equality into implementation, monitoring and evaluation.	**The gender analysis in the needs assessment justifies this project in which *all* activities and *all* outcomes advance gender equality**. All **targeted actions** are based on gender analysis**.** Most targeted actions are single-sex interventions responding to the disadvantage, discrimination or special needs of one sex or a sub-group of one sex. Other targeted actions can specifically aim to advance gender equality, such as a project that are designed exclusively to provide a gender assessment/baseline for the health response or a project where all activities contribute to women or men having equal access as men or women in general health or reproductive health services respectively. Examples of persons with special needs in the emergency health sector might include girls and boys under five years, unaccompanied girls and boys and older women and men, survivors of sexual violence, torture and trauma, women and men in need of emergency RH services and care, persons affected by chronic illness, HIV/AIDS and disability, etc. *A gender analysis will identify how many 2b projects are warranted. It is anticipated that 2b projects would make up approximately 10-15% of projects but, in some contexts, this could be more or less.*

NOTE: STAND-ALONE REPRODUCTIVE HEALTH AND GBV RESPONSE projects are coded on the 0-1-2B scale while general health projects that include RH and/or GBV response activities are coded on the 0-1-2A scale.

The same criterion for Code 0 (gender-blind) and Code 1 (gender is reflected in some limited way) are applied to stand-alone RH and GBV response projects. To code 2b, a well-designed stand-alone RH or GBV project includes a gender analysis in the needs assessment and responds to the specific needs of women, girl, boys and/or men accordingly and/or justifies the project's focus on a segment of the population (e.g. women/girls only).

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. Here are examples of questions that can enrich the design of emergency 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, 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? E.g. 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 (e.g. 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? (E.g. women's organisations, men's organisations, youth groups, traditional healers, midwives, etc.)

See the IASC Gender Handbook (Dec. 2006) p 77 – 82 and GBV Guidelines (Sept. 2005) p. 62 – 71.

Examples of ways to incorporate gender concerns in 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**. Example:

Gender Analysis in Needs Assessment	Activity
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 (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.

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

The ADAPT & ACT-C Framework is a tool for use when designing or vetting a project to integrate gender dimensions. While the order of the steps may vary, as many as possible - ideally all nine - should be taken into account in the design of projects to ensure that the services and aid 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. Ensure, for example, 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, e.g. 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.** E.g. 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. E.g. 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.

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A	**Make sure that the project takes specific ACTIONS to prevent risks of GBV**. The IASC GBV Guidelines includes a chapter on 'Health & Community Services', which should be used as a tool for planning and coordination.
C	**COLLECT, analyse and report sex- and age-disaggregated data**; analyse 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. For example, sex- and age-disaggregated data on programme coverage are regularly collected, analysed and reported on.
T	**Based on the gender analysis, make sure that women, girls, boys and men are TARGETED with specific actions when appropriate**. E.g. 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. E.g. 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 EMERGENCY HEALTH SERVICES:

In order to translate the cluster and organisational commitments to gender-responsive education 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 cluster. 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 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 commitments, activities and indicators below are provided as samples only*:

1. Consult women, girls, 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. 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 stabilises.

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

4. 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 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 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