Health Cluster Coordinators' call on Rapid Gender Analysis

(17 May 2022, 13.30 – 15.00)

Note for the record – DRAFT V1

Agenda

- General open discussion about Rapid Gender Analysis (RGA)– Form filled prior to the meeting

Participants

Health cluster coordinators (HCC) and teams from the following countries: Afghanistan, Central African Republic, Cox's Bazar, Ethiopia, Iraq, Lebanon, Libya, Madagascar, oPT, Sudan, Ukraine, Venezuela, Syria – Damascus, Zimbabwe; Global Health Cluster,
WHO Jerusalem, PAHO Regional Focal Point

Presentations

Presenters:

- Isadora Quay – CARE International Global Gender in Emergencies Coordinator

See attached related documents for more information

Discussion

Isadora Quay, CARE International: guided the group in an open conversation on RGA with the following questions/prompts as guidance:

- What kind of gender data (including disaggregated data: age, disabilities, etc. and/or qualitative and quantitative data) is being used, collected, shared by health clusters and partners?

Lebanon HCC: Responded by explaining the data points currently collected by the HC: Age and Sex, as part of the Emergency Response Plan (ERP) and talked about the current health system limitations in collecting disability data points mainly due to two reasons: the system is not collecting / requiring this data, and partners are not trained to effectively collect this information. She further explained that collecting this data has been relevant for the HCC to analyze populations and their limitations when accessing healthcare services.

Sudan HCC: Elaborated further on the topic by mentioning a standard list of indicators that are collected by health clusters, which include disaggregated that data on children under and above 5, and under 18 and other indicators on reproductive health trauma and disability. Barriers have been found when analyzing this data which provides very limited "two-dimensional" snapshot of the current situation since in many countries, including Sudan, there is a lack of baseline data (Census) leaving an incomplete picture in terms of data analysis. These barriers are further expanded when dealing with nomadic populations, IDPs, refugees and other massive population movements.

Cox's Bazar HCC: Provided with strategies to collect disaggregated disability data, including the "Washington Group general measure on disability" (Washington Shorts) by measuring the number of disability infrastructure available, mentioned that most of the time collecting data is a challenge due to its time-consuming nature adding to the already short-staffed burden of health service facilities.

IQ: Prompted the conversation towards more qualitative uses for gender data.

Iraq HCC: Shared the experiences acquired by the Iraq HC when developing the 2020 COVID-19 response RGA conducted by partners and how it provided insights about vaccination status in the country; around 36% of the vaccinated population is female, versus a 60-65% male population. Upon further analysis it was found that females in reproductive age have various limitations such as lack of information, and not being the household decision-makers.

IQ

- What are some of the reproductive and health issues, sexual reproductive health issues that come into your work?

Lebanon HCC: Talked about the current Maternal and Child mortality situation in Lebanon, which has more than doubled in the past year, and it's not entirely due to COVID-19. Thanks to the data available there is evidence of other structural issues going on, such as service barriers, migration, refugees, and other restrictions. This information has encouraged the HC to further analyze what is happening. Some information is available and that has helped to set targets within the emergency response plan for 2022 to better target elements along the care value chain for women identifying shortcomings since early prenatal consultation to identifying substantial risk patients. Unfortunately, this effort has been limited since the Lebanese health system has seen a steady decline over the last 24 months.

Sudan HCC: taking on the previous participation, commented about the high maternal mortality rate in Sudan, which has declined in the past years, but continues to be high due to lack of knowledge of the regional dynamics, conflicts, lack of infrastructure, etc. And explained the need of more localized, cost-effective community interventions addressing these issues rather than larger-scale, centralized projects at tertiary care facilities that are unreachable for vulnerable populations.

Cox's Bazar HCC: Explained how surveys have contributed to the detection on the need for better reproductive health interventions, and the provision of family

planning, as well as strengthening Gender-Based violence prevention and response interventions steering these services to be seen as essential healthcare provision.

Iraq HCC: Talked about the short staffing/bureaucracy issue that directly affects Reproductive Health Services, which has improved slightly but it is a concern since this cluster is transitioning out and must ensure that these issues are not limited by a slow government response.

IQ:

- If no impediments existed, what kind of gender data would be more useful to collect on a regular basis?

Sudan HCC: The "other side perception". There are gaps left from the lack of data coming from census, ministries databases, cannot be addressed properly, aside from guesswork done. On the other side attempting to fill these gaps with rigid scientific based approaches often misses the full scope of the intervention needs including what communities also want.

IQ: Reinforced that the purpose of the RGA is to respond in a less rigid way to identify needs but also mentioned the importance of what communities want.

Lebanon HCC: Emphasized the need of practical tools that can adapt to the already complex context where these assessments are done and expressed the concern of the chances of these tools missing less visible populations.

IQ and Sudan HCC: Agreed on the importance of knowing how to respond to the context, including how people often seek solutions in the gaps left by shortcoming interventions, like seeking for traditional medicine providers or other attainable solutions. And assessments on needs should not constrict the analysis to the point of excluding these facts.

IQ: proceeded to talk about the work done on RGA by her team, focusing mainly in bringing the "human" part into assessments, as both a qualitative and quantitative tool, hence providing a broader spectrum of results but ultimately a gender analysis that works best when focused and targeted towards communities' perception about specific subjects.

Emma Fitzpatrick, GHC: Concluded the session by questioning how HCs would benefit from assessments such as this one and if there is continued interest on this, plus the areas of opportunity and improvement in various ongoing crises. There might be the possibility of further training on the practical application of this tool in Q3 (September 2022)

Leonardo Hernandez, PAHO: Talked about how these interventions are applied in the Americas and how it is important to advocate for LGBTQ+ when operationalizing in various settings (refugee camps, migrants) as well as increasing funding availability for data collection and analysis.

Action points

- The HCCs agreed to include a follow-up session specifically on the RGA during the Health Cluster Coordinators' Forum 4-6 July 2022.

Related Documents

Care Insights – In practice: Rapid Gender Analysis