

GENPAR

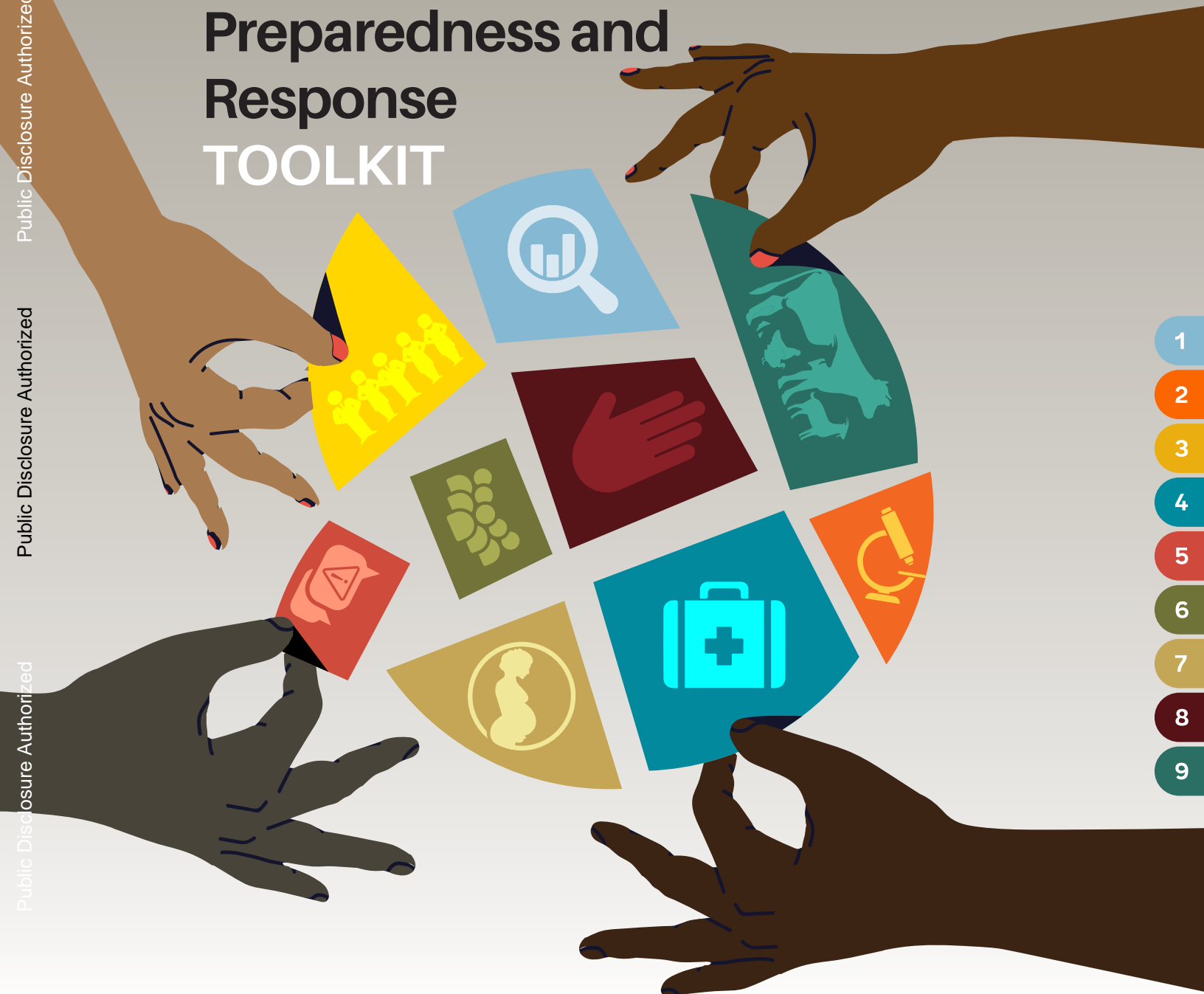
Gender in Infectious Disease Epidemic Preparedness and Response TOOLKIT

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HOW TO USE GENPAR

GENPAR is not a linear document to be read in its entirety from start to finish, but rather a set of tools structured to respond to a range of operational needs and priorities in epidemic preparedness and response.

Each module is a stand-alone chapter; each tool is a stand-alone tool. The entire toolkit is navigable through internal links, between and within Modules, to facilitate readers in navigating to areas of interest, as follows:

- ▶ **In the Table of Contents, all Module section and sub-section headings are clickable and will take the reader to the requisite section or sub-section.**
- ▶ **In each Module, each tool's name is clickable and will take the reader to that tool. The tool can then be viewed online or printed for use.**
- ▶ **On each page, there are color-coded, numbered and clickable tabs on the right-hand side that allow a reader to navigate between Modules.**
 - ☐ Numbers align to the Module number in the Table of Contents.
 - ☐ Each Module is assigned a specific color.
- ▶ **On each page, there is also a tab labeled "TC" on the right-hand side that allows a reader to go directly back to the Table of Contents.**

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List of Acronyms

AAR	After Action Review	PHE	Public Health Emergency
ANC	Ante-Natal Care	PHEMC	Public Health Emergency Management Committee
CBS	Community Based Surveillance	PHEOC	Public Health Emergency Operations Center
CDC	Centers for Disease Control	PHEPR	Public Health Emergency Preparedness and Response Plan
EBS	Event Based Surveillance	PHERRT	Public Health Emergency Rapid Response Team
EID	Early Infant Diagnosis	PMTCT	Prevention of Mother to Child Transmission
EVD	Ebola Virus Disease	POC	Point Of Care
FAO	Food and Agricultural Organization	PPE	Personal Protective Equipment
FELTP	Field Epidemiology and Laboratory Training Program	PPR	Prevention, Preparedness and Response
FETP	Field Epidemiology Training Program	REDISSE	Regional Disease Surveillance Systems Enhancement
GAP	Gender Action Plan	RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
GENPAR	Gender in Infectious Disease Epidemic Preparedness and Response Toolkit	SARS	Severe Acute Respiratory Syndrome
HIV	Human Immunodeficiency Virus	SGBV	Sexual and Gender Based Violence
HPV	Human Papilloma Virus	SLIPTA	Stepwise Laboratory Quality Improvement Process Towards Accreditation
HR	Human Resources	SOP	Standard Operating Procedure
IBS	Indicator Based Surveillance	SPAR	State Party Self-Assessment Annual Reporting
IDSR	Integrated Disease Surveillance and Response	ToR	Terms of Reference
IHR	International Health Regulations	UNDP	United Nations Development Programme
IMS	Incident Management System	WAHO	West African Health Organization
IPC	Infection Prevention and Control	WHA	World Health Assembly
JEE	Joint External Evaluation	WHO	World Health Organization
M&E	Monitoring & Evaluation		
MERS	Middle East Respiratory Syndrome		
MOH	Ministry Of Health		
MOU	Memorandum of Understanding		
PCR	Polymerase Chain Reaction		

Introduction

Why integrate gender in preparedness and response?

Both biological sex differences and social gender differences can result in gender-differentiated risks, exposure, infection and outcomes of infectious diseases, including in epidemics. If these differences are not integrated into measurement and reporting of symptoms and alerts to track infectious diseases, they will not be incorporated into planning for prevention, preparedness and response (PPR). This lacuna, in turn, results in incomplete planning, programming and targeting of PPR actions, and thus ineffective control of outbreaks such that persons of the disadvantaged gender have inadequate access to health and other services. PPR then does not reach the entire population at risk. Effective PPR also necessitates addressing gender gaps in human resources. For example, in their roles as frontline health workers, household caregivers of the sick, livestock managers, and those responsible for water and food preparation, women can be enormous resources for PPR in communities. **Annex 1** provides more details on the role of gender in PPR.

What is GENPAR?

GENPAR, or the Gender in Infectious Disease Epidemic Preparedness And Response Toolkit, is a set of benchmarks and tools to integrate gender into select core capacities of the International Health Regulations (IHR) 2005, namely:

- 1 Surveillance
- 2 National laboratory system
- 3 Human resources
- 4 Emergency preparedness and emergency response operations
- 5 Risk communication
- 6 Community engagement

And capacities such as:

- 7 RMNCAH as essential services in outbreaks
- 8 Gender-based violence in epidemics, and
- 9 Animal health

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Genesis and purpose of GENPAR

GENPAR was developed under the World Bank Group's Regional Disease Surveillance Systems Enhancement (REDISSE) Program.¹ The capacities were selected based on the core capacities covered by the REDISSE project.

Established in the aftermath of the 2014-16 Ebola outbreak in West Africa, the REDISSE Program is an inter-dependent series of projects that was jointly developed by the Health and Agriculture Global Practices of the World Bank, to:

- 1 Address weaknesses within the animal and human health systems that hinder effective cross-sectoral and cross border collaboration for disease surveillance and response; and,
- 2 Provide an immediate and effective response in the event of an eligible health emergency.

However, the REDISSE program only minimally integrated gender into infectious disease epidemic prevention, preparedness and response. GENPAR was initially commissioned in 2020 to provide benchmarks and tools to address this gap in REDISSE but has been developed to be more widely relevant.

A wealth of evidence over the decades has demonstrated the importance of gender as a determinant of exposure, risk, transmission, infection, treatment, and outcomes of infectious diseases and outbreaks (**Annex 1**).

In line with this evidence, and during its COVID-19 Response, the Independent Review Committee on the Functioning of the International Health Regulations (2005) recommended several improvements be made to the IHR Monitoring and Evaluation Framework to integrate gender more meaningfully, stating “ignoring the gender aspects of outbreaks hinders prevention and response management by obscuring critical risk factors and trends, as well as ignoring expertise and perspective including from the front line of the COVID-19 response” (World Health Organization 2021b).

The recommendations resulted, among other changes, in the introduction of a new indicator on Gender Equality in Health Emergencies within the State Parties Self-Assessment Annual Reporting (SPAR) and Joint External Reporting (JEE) tools (World Health Organization 2021a; 2022). The introduction of this indicator also responds to WHA Resolution 73.8 (2020) which calls on Member States to “engage and involve women in all stages of preparedness processes, including in decision-making, and mainstream gender perspective in preparedness planning and emergency response” and WHA Resolution 74.7 (2021) which states the need “to develop strategies and tools for managing the impact of health emergencies on gender equality, health systems and health service delivery”.

¹ The REDISSE Program provides financing to: Senegal, Sierra Leone, Guinea, WAHO (REDISSE 1); Guinea-Bissau, Liberia, Nigeria, Togo (REDISSE 2); Benin, Mali, Mauritania, Niger (REDISSE 3); Angola, Chad, Central African Republic, Republic of Congo, Democratic Republic of Congo, and Economic Community of Central African States (ECCAS) in REDISSE 4. See <https://projects.worldbank.org/en/projects-operations/project-detail/P154807> for more details.

Table 1 summarizes this indicator and Annex 2 provides the accompanying definitions, notes, technical, and conceptual questions from the JEE.

TABLE 1: GENDER INDICATOR IN JEE (P1.2) AND SPAR (C1.2)		
Level	P1.2. Gender equity and equality in health emergencies	Select level
Level 1	No systematic assessment of gender gaps in any of the IHR capacities has been conducted	
Level 2	Systematic assessment of gender gaps has been conducted in at least one IHR capacity	
Level 3	An action plan to address identified high priority gender gaps in at least one IHR capacity is developed and incorporated in annual workplans	
Level 4	The developed action plan(s) to address gender gaps in at least one IHR capacity is funded and being implemented, with mechanisms in place for monitoring, evaluation and reporting	
Level 5	Systematic gender analysis of IHR capacities is conducted, and action plans to address gender gaps and inequalities are developed, funded and operationalized in at least three IHR capacities, with mechanisms in place for monitoring, evaluation and reporting	

Source: (World Health Organization 2022), pp 8 and 9

In order to facilitate application of the GENPAR tool by users interested in integrating gender in IHR core capacities, GENPAR has been constructed to align with the format and structure of the WHO Benchmarks for IHR capacities (World Health Organization 2019). When used in conjunction with JEE and SPAR, GENPAR facilitates operationalizing the Gender Equality Indicator. GENPAR also provides benchmarks and tools for integrating gender into animal health, outside of the JEE and related frameworks, and for other operational work on PPE that may be conducted outside of the JEE and related frameworks.

Who is the audience?

The main audiences for GENPAR are:

- ☒ Prevention, preparedness, and response programs of the World Bank Group and other national, local and international partners in this space;
- ☒ State Parties to the IHR, to operationalize the gender core competency;
- ☒ Donors, civil society and other organizations engaged in prevention, preparedness and response activities, to enable systematic integration of gender in design, implementation, and supervision, monitoring and evaluation;
- ☒ All other actors engaged in prevention, preparedness and response activities.

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Structure of GENPAR

As noted at the start of this Toolkit, GENPAR is structured in modules. The entire toolkit is navigable through internal links, between and within Modules. Thus, **GENPAR is not a linear document to be read in its entirety, but rather, a set of tools from which any one or more tool(s) can be selected and used to respond to a range of operational needs and priorities in epidemic preparedness and response.**

IHR and additional capacities covered by GENPAR tools

GENPAR covers six of the 13 core IHR core capacities.² In addition, consultations with national counterparts and technical experts identified the need to provide guidance on how to better address three additional areas of work in health emergencies which are not fully covered by the IHR: (1) gender-based violence (not included in the IHR); (2) RMNCAH in maintenance of essential health services (the IHR and JEE/SPAR include essential health services overall), and (3) animal health (not addressed as a stand-alone capacity in the JEE/SPAR but integrated into other capacities).

Each human health-related module mirrors the structure of the SPAR and JEE and is intended to be used in concert with these in prevention, preparedness and response activities. Each module focuses on a core capacity. Furthermore, each module offers definitions for distinct levels of achievement, gender dynamics to each core competency, and annexes with operational tools. The animal health module follows a different structure; it is built around developing a Gender Action Plan for Animal Health within a One Health approach with examples of integrating gender into livestock activities, and into monitoring and evaluation of animal health.

Across all modules, tools can be selected and adapted as needed based on local context, human resource capacity, financial capacity, and time frame. GENPAR is intended to be a living document and it is expected that benchmarks and tools will continue to be added, revised, and improved with use.

When to use GENPAR?

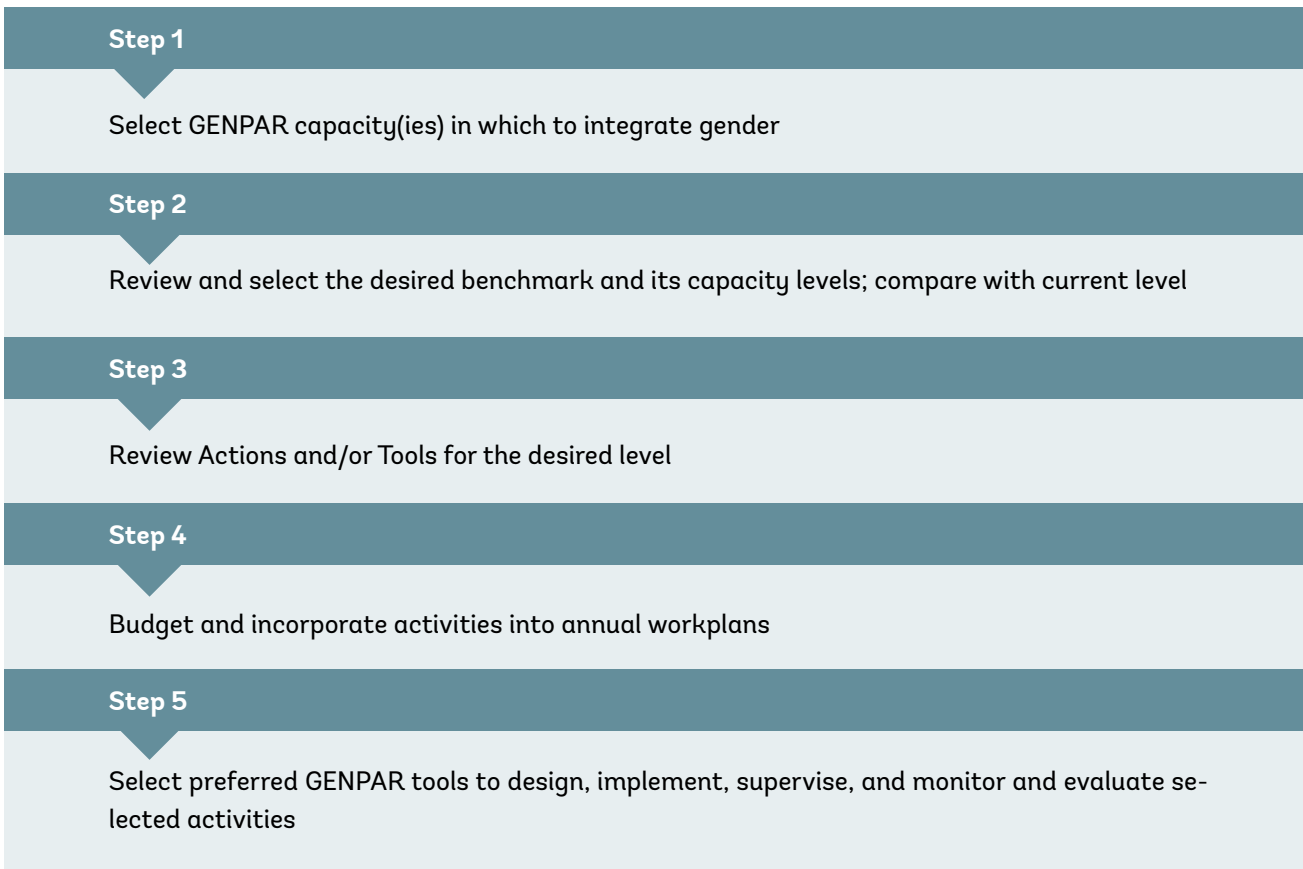
GENPAR benchmarks and tools can be used at any stage of a project, including project assessment, preparation of an action plan, implementation, and monitoring and evaluation. In compliance with the IHR (2005), State Parties are required to complete the SPAR on an annual basis. The tools offered in the GENPAR can provide State Parties with guidance on how to improve scoring through gender integration through the application of specific tools.

ANNEX 3 details actions required to integrate gender into each project stage.

2 The Benchmarks for Gender in two core capacities, namely Emergency Preparedness and Emergency Response Operations, are provided in one combined Module in GENPAR. Conversely, in the IHR, Community Engagement is subsumed under the core capacity of Risk Communication. Benchmarks for Gender for Community Engagement and for Risk Communication are provided in two separate Modules in GENPAR.

How to use GENPAR and its tools?

GENPAR provides a set of actions (WHAT to do) as well as a range of tools (HOW to do it) to achieve each benchmark in integrating gender into the preparedness and response capacities covered by the toolkit. Using GENPAR, gender can be integrated into selected capacities step-by-step as follows:



GENPAR scope

What GENPAR does

- ▶ Recognize that often country health systems and actors have limited capacity to address sex and gender gaps in infectious disease epidemic preparedness and response programs and interventions.
- ▶ Based on this recognition, provide a menu of guidance and tools aligned to the IHR (2005) from which countries can choose what is most pertinent and feasible for them given the level of a particular benchmark they choose to target at any point in time.³
- ▶ Include attention to both human and animal health with guidance and tools for both.

What GENPAR does not do

- ▶ Include tools for every aspect of gender in infectious disease outbreak preparedness and response.
- ▶ Provide tools to address gender in public health outside of infectious disease outbreaks.
- ▶ Provide tools to address the intersectionality⁴ between gender and other vulnerabilities.
- ▶ Provide tools to address underlying gender norms or address behavioral change, sexual orientation, and gender identity.



³ GENPAR tools use an illustrative version of the levels of a health system engaged in epidemic preparedness and response and a framework of community, health post, district, sub-region, region and national levels. However, different countries have differing nomenclature and levels for their health system and can revise tools accordingly.

⁴ Sex and gender intersect with other vulnerabilities to create disadvantage but these are not explicitly included here; however, the tools provided can easily be modified to be applied to other areas of disadvantage as well. These can include, but are not limited to, minority ethnicity, disability, groups such as pastoralists, herders or other similar minorities, and sexual and gender minorities.

Annex 1: Gender in infectious disease outcomes – Literature summary

“Sex” and “gender” are different though related concepts that play an important role in public health, including in the transmission and course of infectious disease outbreaks (World Health Organization and Regional Office for the Western Pacific 2011). Sex differences that influence infection risks, transmission and outcomes typically relate to differences in male and female anatomy (especially reproductive) and immune responses. For example, women, but not men, experience pregnancy. Pregnancy, in turn, can affect immune, respiratory and/or cardiovascular systems—among others— and thereby increase pregnant women’s risks of adverse outcomes for infectious diseases. Gender differences arise from gender-unequal norms, and the roles, responsibilities, decision-making, mobility and resources that are defined by these norms. Gender norms define prescribed roles and responsibilities in a society for men and women. These roles and responsibilities, in turn, define men’s and women’s behavior, access to and control over resources, and agency over aspects of life such as decision-making and mobility. These are some of the ways in which gender norms can contribute to differentials in disease-related risks between men and women, as well as in care, treatment, and outcome of disease. Biological sex differences are typically similar across contexts whereas gender differences can vary significantly by context.

Gender-unequal norms are typically likely to disadvantage women compared to men in an epidemic (Nkangu, Olatunde, and Yaya 2017). This is because in most societies gender-unequal norms place women in subordinate positions in households and society in ways that can increase women’s infection risks and place more barriers to their access to and use of testing and treatment-seeking than is the case for men (Sen, Östlin, and George 2007; Heise et al. 2019). For example, women – more so than men – are typically expected in most settings be the primary caregivers for sick family members. In some countries, women are responsible for the cleaning and preparation of the dead. These factors placed women and girls at higher risk of infection than men during the EVD (Ebola Virus Disease) epidemic of 2014–16 in Guinea, Liberia and Sierra Leone (UNDP (United Nations Development Group) 2015; Minor 2017). Constraints on women’s mobility limited their involvement in EVD prevention and treatment efforts in the 2014–16 outbreak in west Africa, (Minor 2017) including being excluded from meetings where community leaders shared EVD prevention and treatment messages (Carter, Dietrich, and Minor 2017).

Some traditional norms of masculinity can, however, put men and boys at higher risk of infection than women and girls. For instance, norms of masculinity can contribute to behaviors thought to put men at higher risk of COVID-19 than women, such as smoking and engaging less than women in preventive health activities like mask-wearing or washing hands (Baker, White, and Morgan 2020; Betron et al. 2020).

Women have higher exposure to zoonotic pathogens than men in the many parts of the Global South where they are primarily responsible for livestock. About two-thirds of the estimated 600 million low-income livestock keepers in the world are rural women, who are responsible for day-to-day animal management as well as the processing, marketing and selling of animal products.⁵ Through these activities women are likely to be more exposed to zoonotic pathogens than are men but at the same time have less information about these pathogens than do men (FAO 2013). Women also typically are likely to have less access than men to extension and other services for livestock handling for several reasons, including having less time than men to access such services because of their care responsibilities. In addition to their role in livestock, because some zoonoses are transmitted to humans through food, women’s responsibility for food preparation, storage and management in most

⁵ <https://www.ilri.org/research/themes/gender>

societies puts them at increased risk. It also means, however, that with the right information and tools on safe livestock and food management, women can play an important role in prevention (FAO 2013).

A failure to maintain “essential services,” especially related to maternal and child health, also impacts women more than men. A study in Guinea on the use of Sulfadoxine-pyrimethamine (SP) to prevent malaria among pregnant women found that, primarily because women could not access antenatal care in the study’s Ebola-affected district, the average number of pregnant women treated with SP during the epidemic decreased by 45 percent in the affected district compared to 27 percent in the non-affected district (Kolie 2019). Evidence from the EVD outbreaks in DRC (McKay et al. 2019) and Sierra Leone, Severe Acute Respiratory Syndrome (SARS) in Asia, (Lam et al. 2004) H1N1 in South Africa (Klein et al. 2010) and COVID-19 in many countries, shows that women find it significantly harder to access regular maternal, reproductive health or family planning services during an infectious disease outbreak.

Health emergencies can also increase risks of sexual and gender-based violence (SGBV). Research shows that in all epidemics where such data are available, women face heightened risks of SGBV, especially intimate partner violence and sexual exploitation and abuse (Fraser 2020; O’Donnell 2020). This can occur due to economic stress, quarantine and lockdowns which can place women in the same space as their abusers, or the breakdown of services to prevent SGBV.

Women may face a higher risk of infection in disease outbreaks than men because they make up the majority of frontline health workers. Globally, women make up 70 percent of the health and social care workforce, mostly at the frontline; in Africa, 65 percent of nurses are women (de Paz et al. 2020). This increases their exposure and thus risk of infection (Azcona et al. 2020). Because of the lower prestige of these professions relative to doctors (who are primarily men), women health workers may also not get appropriate protective equipment, as was reported in the 2014 EVD epidemic in Nigeria (Fawole et al. 2016) and during the COVID-19 pandemic.

At the same time, where women have been engaged, they have been an important part of the solution. Experiences across epidemics and countries show that women’s leadership, advocacy, and community engagement have been important in ensuring that services and information reach the population, especially vulnerable and marginalized people. Examples include the provision of psychosocial support during COVID-19 in Cameroun (Jaghab 2020); increasing awareness on EVD and its prevention methods in the DRC (WHO Africa 2018); and efforts to provide a range of post-COVID 19 social, health and financial services to rural women in India (Tankha 2021).



Annex 2: Gender Equity and Equality in Health Emergencies indicator in JEE and SPAR⁶

TABLE 1: GENDER INDICATOR IN JEE (P1.2) AND SPAR (C1.2)

Level	P1.2. Gender equity and equality in health emergencies	Select level
Level 1	No systematic assessment of gender gaps ⁷ in any of the IHR capacities has been conducted	
Level 2	Systematic assessment ⁸ of gender gaps has been conducted in at least one IHR capacity	
Level 3	An action plan ⁹ to address identified high priority ¹⁰ gender gaps in at least one IHR capacity is developed and incorporated in annual workplans	
Level 4	The developed action plan(s) to address at least one IHR capacity is funded and being implemented, with mechanisms in place for monitoring, evaluation and reporting	
Level 5	Systematic gender analysis of IHR capacities is conducted, and action plans to address gender gaps and inequalities are developed, funded and operationalized in at least three IHR capacities, with mechanisms in place for monitoring, evaluation and reporting	

Source: (World Health Organization 2022), pp 8 and 9

Contextual questions for gender indicator

- 1 To what extent do legal documents address equity?
- 2 How is health inequity related to gender inequality in the country?
- 3 How are existing IHR capacities limited or challenged by gender inequalities?
- 4 Are the perspectives of different genders taken into consideration to guide IHR implementation and the management of health emergencies?

6 Annex 2 reproduces verbatim the JEE indicator P1.2 and related footnotes and questions in the JEE 3rd Edition, pp 8-10 (World Health Organization 2022)

7 **Gender gaps** refers to differences between men, women and people of diverse gender identities in terms of their levels of participation, access, rights, remuneration or benefits. These gaps may arise because of biological, socioeconomic or sociocultural reasons (see JEE 3rd Edition Glossary, p123).

8 **Gender systematic assessment** refers to evidence-based identification of a gender gap to understand the causes of that gender gap (sometimes referred to as gender analysis). Without knowing the causes of a gender inequality it is not possible to develop an action plan to address it. Assessments can be done using secondary analysis of available data and research where possible, as well as with novel research (See JEE 3rd Edition Glossary, p123).

9 **Gender action plan** Refers to a planning document that includes: (i) Activity(ies) that will be undertaken to address identified and assessed gender gap(s) (ii) Indicators to assess progress in closing each gender gap; (iii) Data and measures required to track shifts in each indicator; (iv) Training and (human and institutional) capacity requirements and how these will be met; (v) An estimated line-item budget; (vi) A timeline (See JEE 3rd Edition Glossary, p123).

10 **Gender high priority gaps** refers to sex and gender gaps that are assessed to (i) inhibit implementation effectiveness, (ii) potentially affect a large proportion of the population of the disadvantaged gender and (iii) act as a constraint to effective and full preparedness and response that the whole population can access. Based on the gender analysis conducted, each country will determine which elements of gender inequalities are high priority, with consideration given to the differences across countries in sociocultural contexts and gender norms (See JEE 3rd Edition Glossary, p123).

Technical questions for gender indicator

- 1 To what extent do legal documents address equity?
- 2 Are there mechanisms and tools available for the collection, reporting and dissemination of data disaggregated by sex, age, education, income/economic status, ethnic origin, geographical location, disability and/or other variables, with respect to health emergencies and across IHR capacities? (e.g. Do surveillance mechanisms include sex disaggregation at all levels of data collection and analysis?) Have gender and equity gaps in data collection, management, analysis and use been assessed for one or more IHR capacity? (e.g., Analysis of gender-ratios in health workforce, including decision-making roles; analysis of who cares for livestock, and whether gender roles allow them to access information and services for the prevention of zoonotic diseases; immunization coverage across genders; etc.) To what extent do monitoring and evaluation indicators, advocacy and communication reflect gender differentials across IHR capacities? (e.g., Indicators measure differentiated exposure to risk across people of diverse gender identities, accounting for their differentiated roles in the communities they live in; press releases and public statements include sex-disaggregated data; etc.)?
- 3 Is there an action plan available, for one or more IHR capacities, which clearly draws on the gender and equity analysis to strengthen preparedness and response, with specific actions identified for implementation? (e.g., Targeted design of risk communication messaging to reach marginalized and vulnerable groups, and sub populations, including specific gender identities; design of laboratory testing facilities that allow accessibility by marginalized and vulnerable groups and people of diverse gender identities; measures to reduce gender pay gaps; training of women health care workers to balance surge-deployment rosters; action plan for the delivery of essential reproductive health care in emergency settings; national plan for mass vaccination response to outbreaks of vaccine preventable diseases (VPD) address barriers to vaccine access and uptake for marginalized and vulnerable groups and ensure equitable distribution and administration of vaccines; mechanisms to reduce risk-exposure of most vulnerable groups/ professions/cadres; prepositioning of personal protective equipment (PPE) for medical personnel that are tailored to a diversity of body-types; targeted campaigns for the prevention of zoonotic diseases that account for varying gender roles; etc.)?
- 4 Are these action plans costed and financed, with evidence of implementation, and monitoring mechanisms identified? Are reports providing detailed information on changes generated through implementation of these action plans available (e.g., increase in the sex ratio of most vulnerable population groups reached; reduction in gender inequalities in access to health services; increase in gender parity across decision-making roles within IHR capacities; etc.)?

Documentation or evidence for level of capacity for gender indicator

- ▶ Assessments and other evidence-based research documenting gender inequalities in IHR capacities' areas, by government and external partners including civil society organizations.
- ▶ Action plan(s) and strategies developed to prevent and address gender inequalities in areas related to IHR core capacities.
- ▶ Budget allocations to strategies and/or activities specifically aimed at addressing gender inequalities.
- ▶ Reports from civil society organizations, Ministry of Social Affairs/Ministry of Women and Family Affairs (or other institutional mechanisms for gender equality available in the country).

Source : (World Health Organization 2022; 2021a)

Annex 3: Gender integration by stage of project

PROJECT STAGE & ASSOCIATED BENCHMARK LEVEL	ACTIVITIES TO INTEGRATE GENDER	TOOLS IN GENPAR?
Project Assessment (Aligns with Benchmark Level 02)	Include in any formative assessments an assessment of gender roles & responsibilities and considerations & constraints	✓
	Define clear, gender-differentiated objectives in relation to the core capacity in question	✓
Preparation of an Action Plan (Aligns with Benchmark Level 03)	Define a set of gender-responsive indicators to track progress and results	✓
	Develop a results chain (or theory of change) for the project that includes gender-responsive indicators along the results chain	
	Integrate gender in M&E guidelines, and implementation manuals	
	Identify M&E tools to assess progress, implementation for gender responsive activities, the disaggregation of all data by sex, and monitoring of data completeness and quality on sex and gender	✓
	Ensure that a distinct budget is allocated for gender-responsive activities (for example, funds for gender expertise, gender analysis, gender training of staff)	
	Ensure that the terms of reference for the project staffing and project capacity development plans include gender	✓
Project Implementation (Aligns with Benchmark Levels 03-05)	For each activity that requires specifying the numbers of target beneficiaries, ensure that such estimates are sex-disaggregated	✓
	Integrate gender in the supervision and monitoring of the project	✓
	Ensure that all reporting includes a section that reports on activities for relevant gender dimensions; progress in addressing prioritized gender aspects, and in recommendations	✓
	Ensure that implementing agencies are committed to reporting on gender by supporting continuous sensitizing (including training and refresher training) on gender in M&E in the context of zoonotic outbreaks. Develop mechanisms to hold implementing agencies accountable	
Supervision, Monitoring and Evaluation (Aligns with all Benchmark Levels)	Modify evaluation processes and indicators to incorporate gender	✓
	Conduct evaluations of Integrated Disease Surveillance and Response (IDSR) core functions, qualitative and quantitative evaluations to assess progress and results in integrating gender in each component	✓
	Ensure that final evaluation reports highlight the findings of gender-specific evaluations, and report sex-disaggregated and gender-specific indicators	✓
	Disseminate within the project and to external stakeholders all lessons learned, materials, and results on gender in preventing, detecting, responding to and recovering from infectious disease outbreaks	

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Gender in surveillance¹¹

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for epidemic diseases? 18

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¹¹ "Surveillance" in this chapter includes surveillance activities related to prevention and preparedness (collection, collation and analysis of data) as well as to response (including contact tracing, data analysis, etc.)

GOAL: A surveillance system that fully and effectively integrates sex and gender, and is able to identify sex- and gender-differentiated patterns and trends in different infectious disease epidemics and their treatment.

Why integrate gender in surveillance for epidemic diseases?

If symptoms, cases and deaths are not disaggregated by sex, age and pregnancy status, the data, trends, and patterns reported will be incomplete and inaccurate. In addition, there can be gender gaps and biases in reaching the entire population for surveillance, for example, triggered by inequitable gender norms that hamper the access to surveillance officers or health services. Thus, segments of the population that are likely to be vulnerable – for example, young women in conservative areas – are less likely to be included in surveillance, and their risks, exposure, infection rate, and survival rates are incorrectly recorded and reported. The result is that PPR activities are less effective and efficient than they could be in preventing, preparing for, and responding to outbreaks.



Gender Benchmark 1.1: Capacity levels for Gender in Surveillance

CAPACITY LEVEL	<p>Gender Benchmark 1.1: Gender is integrated into the public health surveillance system Objectives:</p> <ul style="list-style-type: none"> • To integrate sex, age, and (as possible) pregnancy status (for women 15-49 years of age) in the collection, recording, reporting and analysis of public health surveillance data across incident-based and event-based surveillance. • To identify and mitigate gender biases that hamper the accuracy and completeness of collected surveillance data, across levels of the public health system.
01 NO CAPACITY	No systematic assessment has been conducted of existing gender gaps. (IF NO ASSESSMENT, START WITH ATTAINING LEVEL 02)
02 LIMITED CAPACITY	Systematic assessment has been conducted to identify existing gender gaps.
03 DEVELOPED CAPACITY	Action plans to address identified gender gaps are developed, budgeted and piloted.
04 DEMONSTRATED CAPACITY	Post-pilot activities are implemented in the field and surveillance systems demonstrate inclusion of gender in at least half of the areas of the country that are recognized as safely accessible.
05 SUSTAINABLE CAPACITY	Gender is integrated fully in public health surveillance systems across all areas of the country recognized as safely accessible, with mechanisms in place for supervision, monitoring, evaluation and reporting.

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Actions and Tools to achieve Level 02 (Limited Capacity)

1 Review IDSR surveillance forms.

A minority of data collection forms in the IDSR Technical Guidelines (3rd Edition) for indicator-based monitoring include space to document gender (WHO Regional Office for Africa 2019a), for example:

- ▶ No IDSR form template includes space to document pregnancy status;
- ▶ The community alert reporting form used to alert health posts to each potential case or unusual event does not include space to report sex;
- ▶ The case-based laboratory report form (part 2), i.e. the form completed by a laboratory recording test results, has no space to document sex;
- ▶ No log sheet, summary report form and other weekly or monthly summary reports provide for inclusion of sex, age (other than < 5 years and 5+ years) or pregnancy status.

Because each country modifies IDSR forms it uses, your country may collect data on sex and age. Thus:

- ☒ Revise IDSR Technical Guidelines being used in-country to ensure space to include data on sex, age and pregnancy-status for each case and death;
- ☒ Review all in-country modifications of IDSR Technical Guidelines forms and revise to include sex, age and pregnancy-status where there is no space to document these characteristics for each case and death.

2 Review completeness of sex-disaggregation in existing surveillance.

Available tools: *(To view tools: Click on the name of a tool or scroll to GENSURV Tools)*

- ☒ GENSURV 01: Decision tree to assess completeness of sex disaggregation in surveillance

3 Identify and document gender biases that could hamper the accuracy and completeness of collected surveillance data.

Gender biases can arise in:

- ▶ Contact tracing: When social norms require contact tracers to be of the same gender as the potential contact, having contact tracers of only one gender may result in lower access to contacts who are not of the same gender.
- ▶ Access and incentives to visit a health facility: Inequitable gender norms may place constraints in accessing care, e.g., for women, permission from a spouse, lack of access to transport or money, childcare and household responsibilities. Norms of masculinity may inhibit men from admitting to ill health.
- ▶ Obtaining and recording symptoms: Where people across gender are prohibited or discouraged from interacting, women may be reluctant to disclose health symptoms to male surveillance officers and vice versa; and/or staff across gender may not be trained to understand gender-specific symptoms, such as vaginal bleeding in the case of dengue hemorrhagic fever (Anker 2007). In all such situations, gender-specific symptoms may be reported inaccurately in health facility inpatient or outpatient records and/or community surveillance focal points.

4 Assess capacity of surveillance personnel to integrate sex-disaggregation.

Available tools: *(To view tools: Click on the name of a tool or scroll to GENSURV Tools)*

- ☑ **GENSURV 02:** Checklist to assess gender norms leading to gender bias in surveillance

5 Assess capacity of surveillance personnel to integrate sex-disaggregation.

Available tools: (To view tools: Click on the name of a tool or scroll to GENSURV Tools)

- ☑ **GENSURV 03:** Questions to assess staff capacity for gender-disaggregated surveillance data collection and use
- ☑ **GENSURV 04:** Questions to assess gender bias in health facility staffing and patients

Where a stand-alone assessment of staff capacity is not possible, select questions to assess staff capacity on gender can be added to other, planned assessments, including assessments planned as part of training activities.

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 Prioritize actions

It is unlikely that all identified sex and gender differentials for all notifiable diseases can be addressed simultaneously.

Determine priority actions based on existing capacity and areas for improvement.

Available tools: (To view tools: Click on the name of a tool or scroll to GENSURV Tools)

- **GENSURV 05:** Considerations for prioritizing actions in gender integration for surveillance

2 Modify surveillance forms to ensure documentation of sex in all cases and deaths

- ☑ Revise all surveillance forms used to collect, summarize, record, and report data feeding into prioritized actions to collect pertinent information on sex, age, and (if possible) pregnancy-status.
- ☑ Decide whether and which details of pregnancy status you will include in which IDSR forms or data collection processes. It is important to include pregnancy status (at least whether pregnant: yes/no), as it can exacerbate women's risks, for example in SARS and Middle Eastern Respiratory Syndrome (MERS) (Favre et al. 2020) and in EVD (Haddad, Jamieson, and Rasmussen 2018).
- ☑ Ensure that the same standardized definitions¹² of sex, age and pregnancy status are used in all forms.
- ☑ Ensure integration of sex in alerts in event-based surveillance (EBS).
- ☑ Available tools: (To view tools: Click on the name of a tool or scroll to GENSURV Tools)

¹² • Sex: The typical way to define sex would be "male" and "female" depending on the biological presentation of the male or female genitalia at birth. However, this definition does not take into account gender identity. Each country should decide how to address this aspect.

• Age: For children under age 1, measure completed months of age; for children under 5 years of age, measure completed years of age. For children over the age of 5 and for adults, 5-year-old age groups can be used, especially in contexts where people are unlikely to know their exact age.

• Pregnancy status : At a minimum, note whether or not a woman or girl in reproductive age groups (15-49 years typically) is pregnant at the time she is identified as a potential case. Additional pregnancy indicators such as danger signs, trimester of pregnancy, etc. may be recorded.

- ☒ **GENSURV 06:** Checklist to ensure integration of gender in alerts from EBS

3 Modify standard epidemiological analyses used to integrate gender-specific analysis of trends and patterns

Available tools: *(To view tools: Click on the name of a tool or scroll to GENSURV Tools)*

- ☒ **GENSURV 07:** Information and variables for gender-specific epidemiological analyses.
- ☒ **GENSURV 08:** Examples of gender-specific epidemiological analyses of outbreaks.

4 Establish gender-friendly community-based surveillance (CBS) and health facilities

- ☒ Modify the steps used to establish CBS as currently recommended by the revised IDSR Guidelines (3rd Edition), as follows:
- ▶ When defining sources of information in a community, identify and include sources and events particularly favored by a particular gender, such as, for example, places/events where women gather (community wells, community women's groups, weddings, religious ceremonies, festivals, etc.)
 - ▶ When selecting monitoring focal points, be sure to include people across gender, including women who have the trust of the community as well as other important women in the community such as the village midwife, village health worker, elderly women, etc.
 - ▶ Ensure that training for all community focal points regardless of gender includes:
 - ☐ Sex and gender in infectious diseases: how and why potential risks may differ by sex, age, pregnancy status, and where gender biases may play a role;
 - ☐ How to report sex, age, and pregnancy status in community monitoring forms modified to allow reporting of these characteristics.

Available tools: *(To view tools: Click on the name of a tool or scroll to GENSURV Tools)*

- ☒ **GENSURV 9:** Actions to mitigate gender biases in patient access to health facilities

5 Modify indicators and processes for supervision, M&E to integrate gender

Available tools: *(To view tools: Click on the name of a tool or scroll to GENSURV Tools)*

- ☒ **GENSURV 10:** Gender-based indicators to monitor community-based surveillance
- ☒ **GENSURV 11:** Performance indicators to monitor select gender data in IDSR core functions
- ☒ **GENSURV 12:** Matrix and checklist to evaluate integration of gender in surveillance systems

6 Pilot actions

Before scaling up through the country, actions should be piloted in one or more smaller areas of the country to test feasibility, costs, problems, and successes.

Tools to achieve Level 04 (Demonstrated Capacity)

No additional tools are required.

Tools to achieve Level 05 (Sustainable Capacity)

No additional tools are required



Tools to integrate gender in surveillance

Tools to assess completeness and quality of integration of gender in surveillance

GENSURV 01: Decision tree to assess completeness of sex disaggregation in surveillance	24
GENSURV 02: Checklist to assess gender norms leading to gender bias in surveillance	25
GENSURV 03: Questions to assess staff capacity for gender-disaggregated surveillance data collection and use	26
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Tools for actions to integrate gender in surveillance

GENSURV 05: Considerations for prioritizing actions in gender integration for surveillance	29
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Tools to monitor and evaluate integration of gender in surveillance

GENSURV 10: Gender-based indicators to moncommunity-based surveillance	39
GENSURV 11: Performance indicators to monitor select gender data in IDSR core functions	42
GENSURV 12: Matrix and checklist to evaluate integration of gender in surveillance systems	46

Note: all tools can be modified to fit individual project or country needs and context

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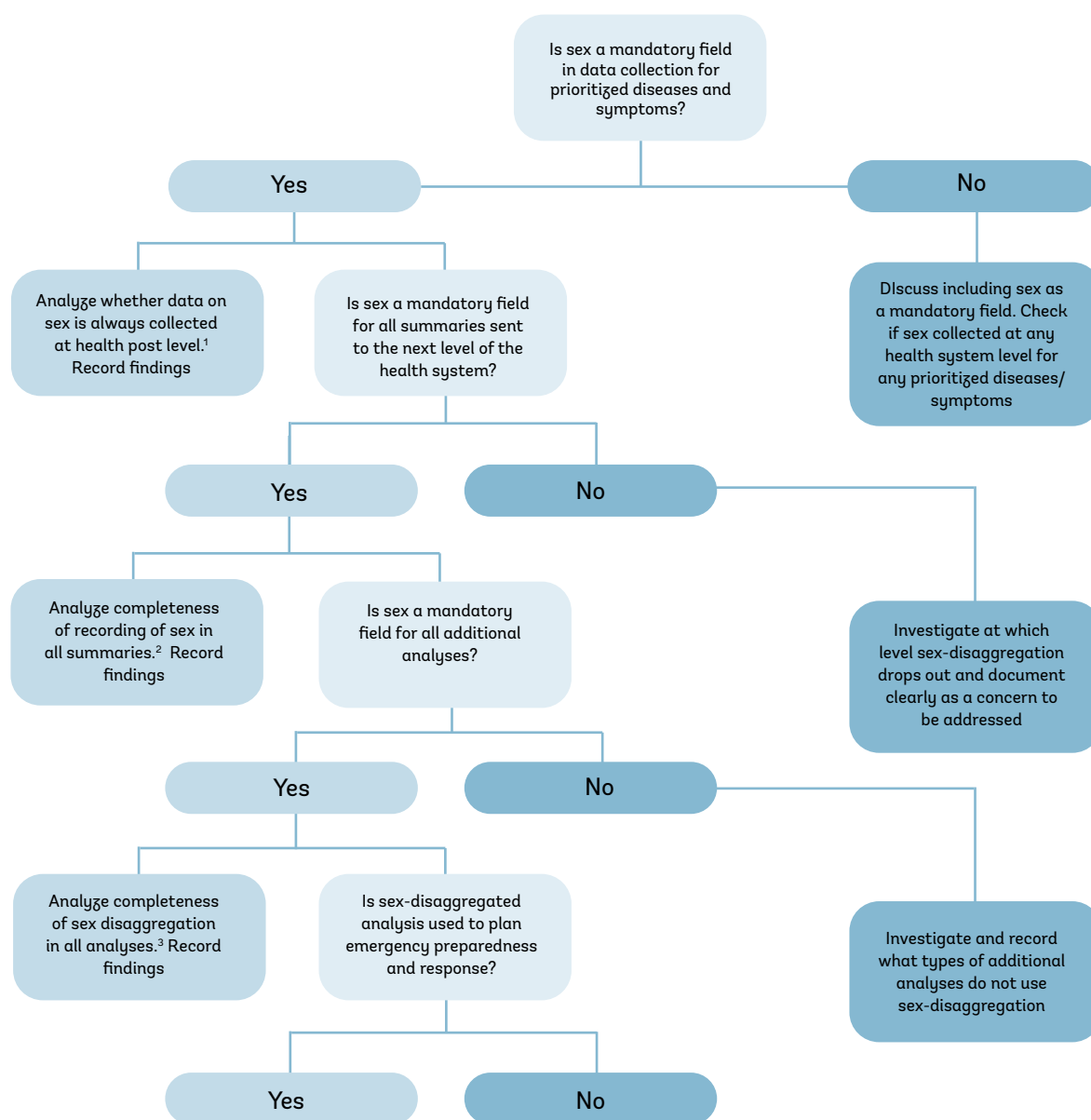
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GENSURV 01: Decision tree to assess completeness of sex disaggregation in surveillance

Note: replace “sex” with “age” or “pregnancy status” to assess completeness of those characteristics



1 Calculate percent with data on sex for all outcomes (potential cases, confirmed cases, inpatient records, deaths, etc.) in prioritized diseases/symptoms.

2 Completeness can be analyzed as follows:

- At each level of the health system, identify the facilities whose weekly/monthly summaries of cases, events etc. to the next level up disaggregate data by sex;
- Note whether sex-disaggregation occurs always or sometimes;
- Identify any particular level of health system or types of facilities prone to inconsistent or incomplete disaggregation by sex compared to others for further attention;
- Analyze any geographic patterns of sex-disaggregation in weekly/monthly summaries sent from one level of the health system to another.

3 Additional analyses includes epidemic curves, epidemiological bulletins, and all other analyses that are not part of the summaries.

GENSURV 02: Checklist to assess gender norms leading to gender bias in surveillance

BE MODIFIED as needed to reflect contextually-specific factors

QUESTION	YES	NO
Gender bias in recording symptoms or collecting data through contact tracing		
Is it typically frowned upon or not allowed for individuals of a particular gender to talk to an unrelated member of the other gender?		
Would women typically feel hesitant in sharing information on certain kinds of symptoms – for example related to the reproductive tract – with male health workers?		
Would men typically feel hesitant in sharing information on certain kinds of symptoms – for example related to the reproductive tract – with female health workers?		
Are there social or cultural perceptions about differential effects or manifestations of disease between different genders?		
Gender differentials in use of health services in case of an outbreak		
Are there gendered social or cultural perceptions about obtaining medical treatment that may make men unwilling to seek care?		
Are there gendered social or cultural perceptions about obtaining medical treatment that may make women unwilling to seek care?		
Do women have to seek the permission of husbands or others in the household to leave the home, including for their own health care?		
Would pregnant women typically face restrictions on leaving the home?		
Are women allowed to leave the home unattended by a male relative?		
Are women typically less likely than men to know where they can go to get health care?		
Do the laws (either customary or formal) create any restrictions to women's access to public spaces and facilities?		
Do women have less access to finances, information, and transport than do men?		
Gender-differentiated roles that may contribute to systematic differences in risk		
Are women typically responsible for all domestic chores, including caregiving for children and the elderly?		
Is one gender more likely than another to be responsible for preparation of dead bodies and/or burial than the other?		
Are frontline health workers predominantly from one gender?		
Is one gender more likely than another to be responsible for trading livestock?		
Is one gender more likely than another to be responsible for taking care of domestic livestock?		
Is one gender more likely than another primarily responsible for preparation of animal-based food?		
Is one gender more likely than another primarily responsible for hunting for meat?		

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GENSURV 03: Questions to assess staff capacity for gender-disaggregated surveillance data collection and use

For all levels of the health system from community to national, unless otherwise noted:

Question 1: What information do you include in any report being created in your[community/health facility] of a case or death?

Question 2: (*For all levels except national*) In the reports and/or analysis you generate and/or submit to the next level of the health system:

- a Do you highlight any patterns or trends in disease or symptoms that vary by gender?
- b Do you highlight any patterns or trends in disease or symptoms that vary by age?
- c Do you highlight any gender imbalance in use of your health post?
- d Do you highlight any patterns or trends in disease or symptoms that vary by pregnancy status for cases or deaths to girls or women between 15-49 years of age?

Question 3:

- a (*For all levels except national*) What information does the [next level up in the health system] require you to submit in summary forms? (Probe as needed: what about information on gender? Age? Pregnancy status?)
- b (Only for national level facilities): What information are you required to share at the national level and with partners on notifiable diseases?

Question 4: Do you think that it is or is not important to include in reports and analyses information on sex of cases and deaths?

(Probes for why or why not, and on respondent's thoughts on whether and how gender influences risks, and other biological or sociocultural reasons to disaggregate by gender)

Question 5: Do you think that it is or is not important to include in reports and analyses information on age of cases and deaths?

(Probes for why or why not, and on respondent's thoughts on whether there are age differentials in risks; whether age differentials vary by gender; whether people of particular age and gender categories tend to fall through the cracks of emergency response system data collection; and other biological or sociocultural reasons)

Question 6: Do you think it is important to include in reports and analyses pregnancy status (if the person about whom the report is being created is a woman between the ages of 15-49 years)?

(Probes for why or why not, and on respondent's thoughts on whether pregnant women may face higher risks; whether pregnant women tend to fall through the cracks of emergency response system data collection; and other biological or sociocultural reasons)

Question 7: How do you confirm pregnancy status when registering a female individual [event or symptoms in the case of community focal point; inpatient or outpatient female case for health facilities]?

(Probes: Possible responses include: Don't ask about pregnancy status unless obviously pregnant? Check the age of the case and, if between 15-49 years, ask the woman herself?

Ask all women regardless of age? Ask the person(s) who accompany her? Other? If this question is used as part of a quantitative survey, the above can be coded as response options; if in a qualitative interview or discussion, use possible response options as probes)

Question 8: How often would you say you are able to ensure that you are reaching all individuals regardless of gender so as to get to all unusual events or symptoms?

(Probe for differences by gender, for example: difficulties in reaching women; reluctance to talk about symptoms to a provider of a different gender than the case/patient; women/men are too busy; etc.)

Question 9: What are the main constraints you face in providing complete and accurate sex-disaggregation of cases and deaths in the reports and/or summaries or and/or analyses you produce? What can be done to alleviate these constraints?

Question 10: What are the main constraints you face in providing complete and accurate age-disaggregation of cases and deaths in the reports and/or summaries or and/or analyses you produce? What can be done to alleviate these constraints?

Question 11: What are the main constraints you face in providing complete and accurate disaggregation by pregnancy status of cases and deaths to women in reproductive age groups in the reports and/or summaries or and/or analyses you produce? What can be done to alleviate these constraints?

Question 12: Have you ever received training on the importance of gender in infectious diseases?

If yes: when and by whom?

If no: would you be interested in such training?

Question 13: *(to check whether there has been any gender training at all):* List all the trainings you have received in the last 2 years and the approximate date and duration of each training.

GENSURV 04: Questions to assess gender bias in health facility staffing and patients

Documentation for the interviewer to collect either before or after the interview/survey:

- ▶ Ask for a list of the staff at the facility and their positions (to document gender distribution of staff)
- ▶ Ask for a record of patients seen in the last year: inpatient and outpatient (to document whether gender is documented and whether there are gender related patterns in who visits the health facility for particular diseases and symptoms)
- ▶ Ask for a list of all training courses conducted with staff at any level in the last 2 years (to document whether and what gender training was conducted, and with what level of staff)

Questions to ask the respondent(s):

- 1 From your point of view, do you more often see patients of one gender rather than the other?
 - a If yes: which gender? Why do you think this is the case?
- 2 What is the most common set of symptoms that have presented at your health post in the last month? 6 months? In the last year? [choose appropriate time period for your surveillance data collection program]
 - a Have you noted any particular gender-related, age-related or other demographic or occupational patterns in symptoms? (Probes: are they likely to manifest more in one gender than another? Pregnant vs. non-pregnant women?)
 - b Is the gender, age, and (for women of reproductive age) pregnancy status of the person reporting symptoms noted as part of surveillance data collected? (Probe for how often; if never or seldom – ask why)
- 3 In your opinion, are individuals of one gender more likely than others to visit your health post if they feel sick? (Probes: If yes: who? Why? If no gender difference: why?)
- 4 What might be some constraints in your area that could inhibit individuals of one gender from coming to the health post as easily as others? (Probes: financial, childcare, permission, can't go alone, transport, distance, knowledge/literacy, etc.)

Source: adapted from (World Health Organization 2001)

GENSURV 05: Considerations for prioritizing actions in gender integration for surveillance

WHAT: Mandate collection of sex, pregnancy status (at least whether pregnant, for women 15-49 years of age) and age information for diseases, symptoms, alerts and unusual events for which sex and gender biases are most likely to occur. This could include:

- ☑ Diseases for which there have been frequent outbreaks and it is known that infection rates, disease outcomes, treatment during the epidemic, and/or consequences of an outbreak vary by sex, pregnancy status, and/or age;
- ☑ Symptoms, events or unusual findings that are first identified among pregnant women;
- ☑ Diseases or symptoms for which the literature strongly suggests sex, age and/or pregnancy status differentials in infection rates, disease outcomes and/or treatment for particular diseases;
- ☑ Diseases or symptoms for which either experience and/or literature has found a gender difference in willingness, access and use of prevention or treatment;
- ☑ New and emerging diseases or symptoms for which patterns by sex, age and/or pregnancy status are as yet unknown.

WHERE: It may not be possible or advisable to integrate data collection and analysis of gender and age information at all levels of a surveillance system. Assess the financial, human resource and other capacities of each level of the surveillance system to absorb the systematic integration of gender in data collection, reporting and analysis to determine where to focus such efforts. For instance, it may be advisable to focus gender-disaggregated analyses at the national level because the capacity may be greatest at the national level. However:

- ☑ Gender-specific data **MUST** be collected at the community and health post levels. This is critical because these data form the foundation of a surveillance system;
- ☑ Trends, patterns and other analyses **MUST** be gender-disaggregated at the national level. This is critical because national level analyses inform policymaking, budgeting and prioritization for preparedness and response activities, and inform global epidemic knowledge and response via national reports to the WHO and other global partners.

GENDER BIAS: At the minimum:

- ☑ Ensure that community level surveillance data are fully and accurately gender-disaggregated;
- ☑ Train community based focal points to address identified gender biases in data collection;
- ☑ Ensure male-female teams of contact tracers (if culturally required or preferred);
- ☑ Brainstorm with the team and experts in your country on other ways in which identified gender biases specific to your country context could impact the accuracy and completeness of data and its analysis for specific notifiable diseases and how to address these biases.

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GENSURV 06: Checklist to ensure integration of gender in alerts from EBS

Action	
EBS Hotline questions to caller include information about the person's gender	
EBS Hotline questions to caller include information about the person's age	
The alert log includes a line to record the gender of the person about whom the alert is recorded	
The alert log includes a line to record the age of the person about whom the alert is recorded	
The alert log includes a line to record the pregnancy status (whether pregnant: yes/no) of the person about whom the alert is recorded, if the person is a woman between 15-49 years of age	
Information gathered from media analysis documents gender whenever it is available in the media sources used	
Information gathered from media analysis documents age whenever it is available in the media sources used	
Information gathered from media analysis documents pregnancy status whenever it is available in the media sources used	
The verification of alerts into the indicator-based system (IBS) includes ensuring that the gender of the person about whom the alert is reported is recorded	
The verification of alerts into the IBS system includes ensuring that the age of the person about whom the alert is reported is recorded	
The verification of alerts into the IBS system includes ensuring that the pregnancy of the person about whom the alert is reported is recorded, if the person is a woman between 15-49 years of age	
For information on gender, age and/or (where relevant) pregnancy status that could not be recorded at the time of the emergency regarding a particular unusual event or rumor, the designated person investigating the alert made every effort to subsequently access and record such information	

GENSURV 07: Information and variables for gender-specific epidemiological analyses

MINIMUM DISAGGREGATED INFORMATION TO INCLUDE IN SELECTED ANALYSIS PRODUCTS

Epidemiological bulletins (Weekly, monthly, or quarterly)	Epidemic curves, bar graphs, trend lines, histograms, etc.	<ul style="list-style-type: none"> ▶ A summary table with reported cases and deaths disaggregated by sex, age, and pregnancy status, for each priority disease ▶ Analyses of patterns of variation by sex, age, pregnancy status and (if data exists) relevant sociocultural gender dynamics
Summary fact sheets		<ul style="list-style-type: none"> ▶ Disaggregation of analyses and their interpretation by sex, age, pregnancy status ▶ Analyses and discussion of changes in the collection of sex, age, and pregnancy status over time
Regular newsletters		<ul style="list-style-type: none"> ▶ Summary information on trends by sex, age, pregnancy status and gender (sociocultural)

Variables for use in disaggregated analyses

BY MALE AND FEMALE SEX				
Outcome	Variable	Numerator	Denominator	Interpretation
Cases¹	Total female cases Total male cases	Total number of women/men identified as cases		The numbers of women and men identified as cases
	Percent of all cases that are women Percent of all cases that are men	Total number of women identified as cases Total number of men identified as cases	Total number of cases Total number of cases	Prevalence in the population, by sex
	Percent of women affected Percent of men affected	Total number of women identified as cases Total number of men identified as cases	Total number of women Total number of men	Prevalence among women Prevalence among men Comparison of prevalence among women vs. among men
	Sex ratio of cases (F:M)	Total number of women identified as cases	Total number of men identified as cases	Sex ratio of cases

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BY MALE AND FEMALE ² SEX				
Outcome	Variable	Numerator	Denominator	Interpretation
Treatment seeking (for each set of symptoms)	Numbers of women seeking treatment Numbers of men seeking treatment	Total numbers of women/men seeking treatment		Numbers seeking treatment, disaggregated by sex
	Percent of female cases that seek treatment Percent of male cases that seek treatment	Total numbers of female cases seeking treatment Total numbers of male cases seeking treatment	Total female cases Total male cases	Sex differences in treatment seeking
	Sex ratio of treatment seeking (F:M)	Total numbers of female cases seeking treatment	Total numbers of male cases seeking treatment	Sex ratio of treatment seeking
Numbers/ percent treated ² (for each set of symptoms)	Numbers of female cases treated Numbers of male cases treated	Total numbers of female/male cases treated		Numbers treated, disaggregated by sex
	Percent of female cases that seek treatment who are treated Percent of male cases that seek treatment who are treated	Total numbers of female cases treated Total numbers of male cases treated	Total female cases seeking treatment Total male cases seeking treatment	Sex differences in access to treatment among those who seek it
	Percent of female cases treated Percent of male cases treated	Total numbers of female cases treated Total numbers of male cases treated	Total female cases Total male cases	Sex differences in treatment of cases
	Sex ratio of treatment (F:M)	Total numbers of female cases treated	Total numbers of male cases treated	Sex ratio of treatment
Case-fatality rate for a set of symptoms/ disease	Numbers of female cases who die Number of male cases who die	Total numbers of deaths of female cases Total number of deaths of male cases	Total number of women with the disease/symptoms Total number of men with the disease/symptoms	Sex differences in case fatality rate
	Sex ratio of case fatality (F:M)	Case fatality rate for women	Case fatality rate for men	Sex ratio of case fatality

¹ "Cases" can be replaced by "tested" and "confirmed" across variable, numerator, denominator and interpretation to calculate sex differences in testing and confirmed cases

² "female", and "male" can be replaced by other characteristics of vulnerability and the same variables can be used for analysis of disadvantage from other vulnerabilities

Treated" can be replaced by "hospitalized" or "in intensive care", across variable, numerator, denominator and interpretation to calculate sex and gender differences in hospitalization or use of intensive care.

NOTE: The terms "sex

BY AGE GROUP ¹				
Outcome	Variable	Numerator	Denominator	Interpretation
Cases ²	Total cases in each age group	Total number of people in each age group identified as cases		The numbers of people in each age group who classify as cases
	Percent of all cases in each age group	Total number of cases in each age group	Total number of cases	Prevalence, by age group
	Percent of each age group affected	Total number affected in each age group	Total population in each age group	Prevalence within age group Comparison of prevalence across age groups
Treatment seeking (for each set of symptoms)	Numbers of cases in each age group seeking treatment	Total number of cases in each age group seeking treatment		Numbers of cases seeking treatment, disaggregated by age group
	Percent of cases in each age group that seek treatment	Total number of cases in each age group seeking treatment	Total cases in each age group	Age differences in treatment seeking
Numbers/ percent treated ³ (for each set of symptoms)	Numbers of cases in each age group treated	Total number of cases in each age group treated		Numbers treated, disaggregated by age
	Percent of cases treated in each age group among those in that age group seeking treatment	Total number of cases in each age group treated	Total cases in each age group seeking treatment	Age differences in access to treatment among those who seek it
	Percent of total cases in each age group treated	Total number of cases in each age group treated	Total cases in each age group	Age differences in treatment of cases
Case-fatality rate for a set of symptoms/disease	Numbers of cases in each age group who die	Total numbers of deaths in each age group	Total number of people in each age group with the disease/symptoms	Age differences in case fatality rate

Notes

¹ Age groups can be defined as considered relevant for each country and/or each disease/set of symptoms but the same age classification should be used for all outcomes calculated for that country/disease

² "Cases" can be replaced by "tested" and "confirmed" across variable, numerator, denominator and interpretation to calculate sex differences in testing and confirmed cases

³ "Treated" can be replaced by "hospitalized" or "in intensive care", across variable, numerator, denominator and interpretation to calculate sex and gender differences in hospitalization or use of intensive care.

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BY PREGNANCY STATUS (WHETHER PREGNANT, applies to women between 15-49 years of age)				
Outcome	Variable	Numerator	Denominator	Interpretation
Cases¹	Total cases among pregnant women	Total number of pregnant women identified as cases		The numbers of pregnant women who classify as cases
	Percent of all cases that are pregnant women	Total number of pregnant women identified as cases	Total number of cases in the population	Percent of all cases that are pregnant women
	Pregnancy as a risk factor: women of reproductive age	Total number of pregnant women identified as cases	Total number of women of reproductive age	Pregnancy as a risk factor among women of reproductive age
	Pregnancy as a risk factor: all women	Total number of pregnant women identified as cases	Total number of women	Pregnancy as a risk factor among all women
Treatment seeking (for each set of symptoms)	Numbers of pregnant cases seeking treatment	Total numbers of pregnant cases seeking treatment		Treatment seeking among pregnant cases
	Percent of pregnant cases that seek treatment	Total numbers of pregnant cases seeking treatment	Total number of pregnant women identified as potential cases	Treatment seeking as a percentage of cases among pregnant women
	Pregnancy ratio of treatment seeking (pregnant: all women)	Total numbers of pregnant cases seeking treatment	Total numbers of non-pregnant female cases seeking treatment	Comparison of treatment seeking among pregnant cases compared to all other female cases
	Pregnancy ratio of treatment seeking (pregnant: all cases)	Total numbers of pregnant cases seeking treatment	Total numbers of all cases seeking treatment	Comparison of treatment seeking among pregnant cases compared to all cases

BY PREGNANCY STATUS (WHETHER PREGNANT, applies to women between 15-49 years of age)				
Outcome	Variable	Numerator	Denominator	Interpretation
Numbers/ percent treated² (for each set of symptoms)	Numbers of pregnant cases treated	Total numbers of pregnant cases treated		Numbers of pregnant cases treated
	Percent of pregnant cases that seek treatment	Total numbers of pregnant cases that seek treatment	Total number of pregnant cases	Treatment-seeking among pregnant cases
	Percent of pregnant cases treated	Total numbers of pregnant cases treated	Total pregnant cases	Access to treatment for pregnant cases
	Pregnancy ratio of treatment (pregnant: all women)	Total numbers of pregnant cases treated	Total numbers of all non-pregnant female cases treated	Comparison of treatment among pregnant cases compared to all other female cases
	Pregnancy ratio for treatment (pregnant: all cases)	Total numbers of pregnant cases treated	Total numbers of all cases treated	Comparison of treatment among pregnant cases compared to all cases
Case-fatality rate for a set of symptoms/ disease	Numbers of pregnant cases who die	Total numbers of deaths to pregnant cases	Total number of pregnant cases	Case fatality rate for pregnant women
	Pregnancy ratio of case fatality (pregnant: all women)	Case fatality rate for pregnant cases	Case fatality rate for all female cases	Case fatality ratio for pregnant cases compared to all female cases
	Pregnancy ratio of case fatality (pregnant: all cases)	Case fatality rate for pregnant cases	Case fatality rate for all cases	Case fatality ratio for pregnant cases compared to cases in the general population

1 "Cases" can be replaced by "tested" and "confirmed" across variable, numerator, denominator and interpretation to calculate sex differences in testing and confirmed cases

2 "Treated" can be replaced by "hospitalized" or "in intensive care", across variable, numerator, denominator and interpretation to calculate sex and gender differences in hospitalization or use of intensive care.

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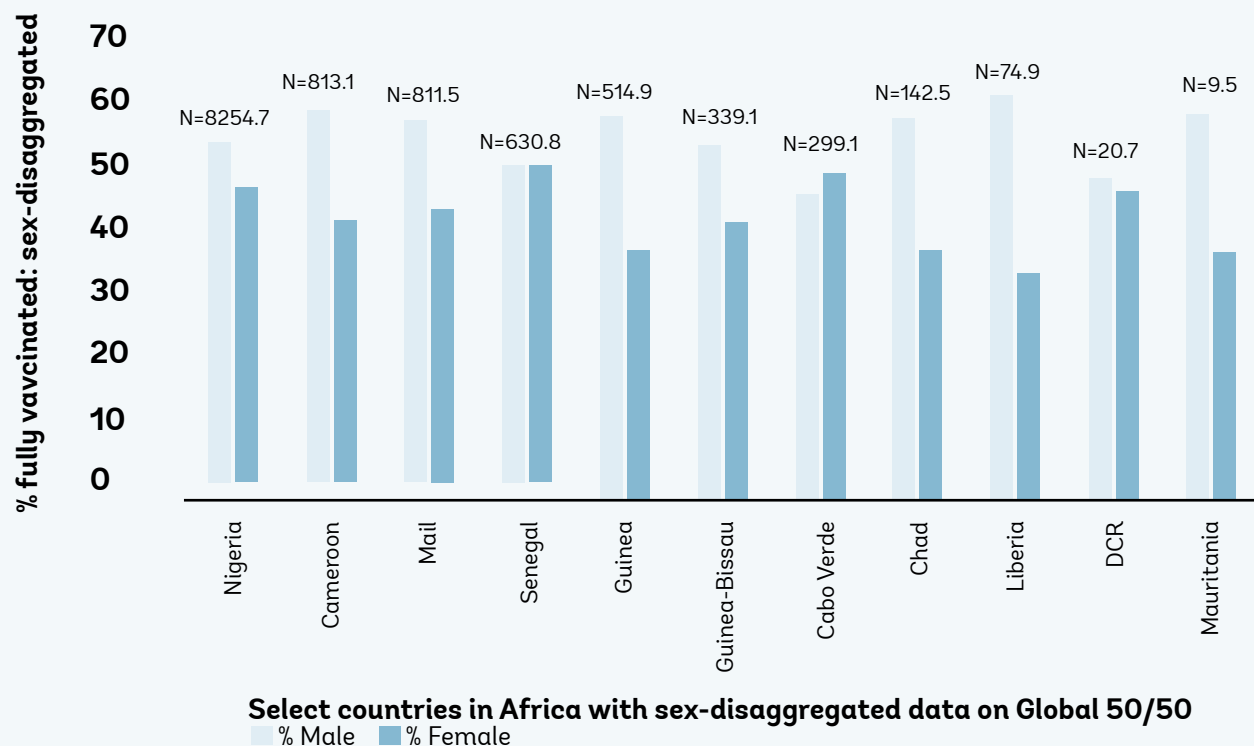
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GENSURV 08: Examples of gender-disaggregated epidemiological outbreak analysis

Example 1: COVID-19 vaccination by sex, select countries in sub-Saharan Africa



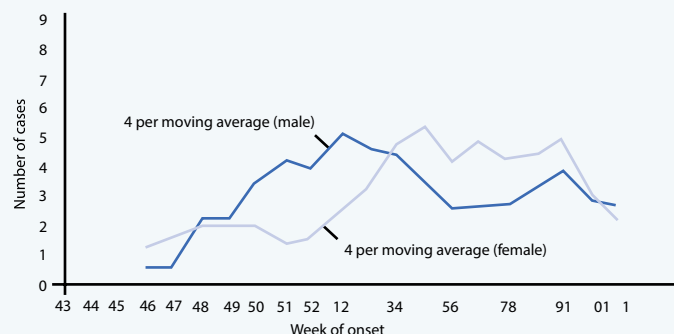
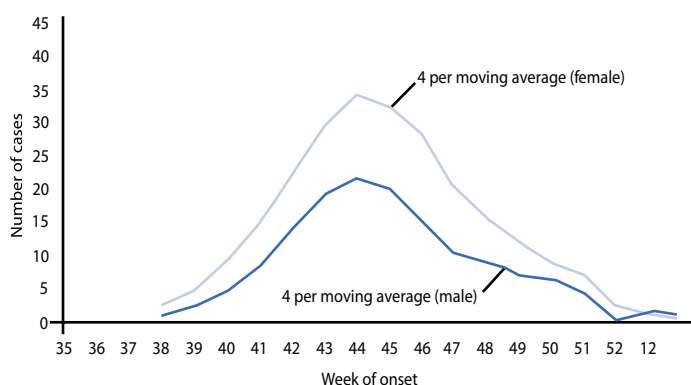
Source: Global 50/50, July 1, 2022 (<https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/>)

- DRC and Cabo Verde have more equitable sex ratios of vaccination even though they have vaccinated many fewer people than most countries represented above.
- Nigeria has a less equitable sex ratio than Senegal even though Nigeria has vaccinated 13 times more people than has Senegal.
- Guinea-Bissau and Cabo Verde have vaccinated similar numbers of individuals but have very different sex ratios of vaccination.

Example 2: Ebola viral fever epidemics in Uganda, Congo and Gabon in 2000-2001 (from Anker 2007)

During the Ebola viral fever outbreak in Gulu, Uganda (2000-2001), the number of cases in women was higher than the number of cases in men throughout the outbreak.

Four-week moving average of cases by sex per week (n=404), Uganda, week 35, 2000 – week 2, 2001



During the Ebola viral fever outbreak in Congo and Gabon (2000-2001), more men than women were infected at the beginning of the epidemic, but this reversed later, as more women than men began to be infected later in the epidemic.

Four-week moving average number of cases by sex per week (n=119), Gabon and Congo, week 43, 2001 – week 11, 2001

CONCLUSION: Totals AND data disaggregated by sex, age and (if possible) pregnancy-status have to be examined together else important patterns that are critical for accurate policy-making remain hidden.



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GENSURV 09 : Actions to mitigate gender biases in patient access to health facilities

KEY ACTION	HOW TO IMPLEMENT THE ACTION
Hire providers from different genders to increase all potential patients' comfort in using health facilities	<p>Use the checklist in GENSURV 07 to confirm whether gender norms prohibit, or make it otherwise difficult, for patients to engage with providers of a different gender;</p> <p>Look for service providers across gender:</p> <p>At the community and health post level: for example, identify and train female health workers and community midwives;</p> <p>At senior levels, advertise positions in universities to attract doctors across gender;</p> <p>In communities or health facilities with no female doctors, ensure female nurses or attendants.</p>
Make facilities suitable across gender of patients	<p>Projects funded to construct or rehabilitate health facilities can use such activities as opportunities to ensure the following:</p> <p>All facilities have functional and gender-specific toilets with separate entrances by gender;</p> <p>If the culture requires it or women prefer it, there are separate entrances for women and men; separate waiting areas; etc.;</p> <p>Facility rooms, and access to facilities, are well-lit to ensure safety, especially for women and girls.</p>
Train all staff to identify gender-specific symptoms to reduce the likelihood of misidentification of symptoms	<p>Make a list of all notifiable diseases in your country;</p> <p>Identify and list for each disease all symptoms that are more likely to occur in one gender than another;</p> <p>Train all (male and female) health care providers on how to ask questions to get information about these gender-specific symptoms and how to document these gender-specific symptoms.</p>
Systematically assess other gender-specific needs that could mitigate gender biases in patient access to health facilities	<p>Use the systematic assessment conducted to reach Level 02 to identify, prioritize and implement other context-specific measures to mitigate gender biases in patient access to health facilities at different levels of the health system.</p>

GENSURV 10: Gender-based indicators to moncommunity-based surveillance

MONITORING OUTCOME	MONITORING INDICATORS	NUMERATOR	DENOMINATOR	SOURCE OF INFORMATION
Gender distribution of community-based staff per catchment area	<ul style="list-style-type: none"> ▶ Number of community focal points of each gender ▶ Number of contact tracers of each gender 	<ul style="list-style-type: none"> ▶ Number of community focal points of each gender ▶ Number of contact tracers of each gender 	<ul style="list-style-type: none"> ▶ Not applicable 	<ul style="list-style-type: none"> ▶ Community meetings ▶ Meetings with community focal points ▶ Health posts to whom focal points report
Use of gender-specific sources of information	<ul style="list-style-type: none"> ▶ Number of usual sources of information that are favor a gender ▶ Number of usual sources of information that are gender-neutral 	<ul style="list-style-type: none"> ▶ Number of usual sources of information that favor a gender ▶ Number of usual sources of information that are gender-neutral 	<ul style="list-style-type: none"> ▶ Not applicable 	<ul style="list-style-type: none"> ▶ Community meetings ▶ Meetings with community focal points
Completeness of reporting of gender	<ul style="list-style-type: none"> ▶ % of alerts reported per [time period] that include the gender of the individual(s) about whom the alert is reported ▶ % of summaries to the health post in the last [time period] that included gender disaggregation for prioritized diseases and/or symptoms ▶ % of any analyses conducted in the last [time period] that were disaggregated by gender 	<ul style="list-style-type: none"> ▶ Number of alerts that report gender of the individual(s) about whom the alert is reported in a time period ▶ Number of summaries to the health post in the last [time period] that included gender disaggregation for prioritized diseases and/or symptoms ▶ Number of any analyses conducted in the last [time period] that were disaggregated by gender 	<ul style="list-style-type: none"> ▶ Total number of alerts reported in that time period ▶ Total summaries in that time period ▶ Total analyses in that period 	<ul style="list-style-type: none"> ▶ Community Alert Reporting Form ▶ CBS Monthly Log Sheet ▶ CBS Monthly Log Sheet ▶ CBS analyses reported to health post

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MONITORING OUTCOME	MONITORING INDICATORS	NUMERATOR	DENOMINATOR	SOURCE OF INFORMATION
Completeness of reporting of age (whether in individual years or age groups)	<ul style="list-style-type: none"> ▶ % of alerts reported per [time period] that include the age (in years or age group) of the individual(s) about whom the alert is reported 	<ul style="list-style-type: none"> ▶ Number of alerts that report age (in years or age group) of the individual(s) about whom the alert is reported in a time period 		
	<ul style="list-style-type: none"> ▶ % of summaries to the health post in the last [time period] that included age disaggregation (in years or age group) for prioritized diseases and/or symptoms 	<ul style="list-style-type: none"> ▶ Number of summaries to the health post in the last [time period] that included age disaggregation (in years or age group) for prioritized diseases and/or symptoms 	<ul style="list-style-type: none"> ▶ Total number of alerts reported in that time period ▶ Total summaries in that time period 	<ul style="list-style-type: none"> ▶ Community Alert Reporting Form ▶ CBS Monthly Log Sheet ▶ CBS Monthly Log Sheet
	<ul style="list-style-type: none"> ▶ % of any analyses conducted in the last [time period] that were disaggregated by age (in years or age group) 	<ul style="list-style-type: none"> ▶ Number of any analyses conducted in the last [time period] that were disaggregated by age (in years or age group) 	<ul style="list-style-type: none"> ▶ Total analyses in that period 	<ul style="list-style-type: none"> ▶ CBS analyses reported to health post

MONITORING OUTCOME	MONITORING INDICATORS	NUMERATOR	DENOMINATOR	SOURCE OF INFORMATION
Completeness of reporting of age (whether in individual years or age groups)	<ul style="list-style-type: none"> ▶ % of alerts reported per [time period] that include the pregnancy status for all women 15-49 years of age included in the alert ▶ % of summaries to the health post in the last [time period] that included the pregnancy status for women 15-49 years of age for prioritized diseases and/or symptoms ▶ % of any analyses conducted in the last [time period] that were disaggregated by the pregnancy status for women 15-49 years of age 	<ul style="list-style-type: none"> ▶ Number of alerts that report pregnancy status for all women 15-49 years of age included in the alert in a time period ▶ Number of summaries to the health post in the last [time period] that included pregnancy status for women 15-49 years of age for prioritized diseases and/or symptoms ▶ Number of any analyses conducted in the last [time period] that were disaggregated by the pregnancy status for women 15-49 years of age 	<ul style="list-style-type: none"> ▶ Total number of alerts of women 15-49 years of age reported in that time period ▶ Total summaries in the health post in that time period ▶ Total analyses in the last period 	<ul style="list-style-type: none"> ▶ Community Alert Reporting Form ▶ CBS Monthly Log Sheet ▶ CBS Monthly Log Sheet ▶ CBS analyses reported to health post
Gender training	Number of trainings in last [time period] that incorporated gender	Number of trainings in last [time period] that incorporated gender	Not applicable	Reports of training and training curricula

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GENSURV 11: Performance indicators to monitor select gender data in IDSR core functions

IDSR Core Function	Health Facility	District	Regional/Provincial	National
Identify	Availability of IDSR forms and/or registers with provision to incorporate data on sex, age and pregnancy status	Proportion of health facilities reporting information using Events-Based Surveillance (EBS) that incorporates sex, age and pregnancy status	Proportion of districts using IDSR guidelines that have been revised to systematically incorporate sex, age and pregnancy status	Proportion of districts with IDSR guidelines that have been revised to systematically incorporate sex, age and pregnancy status
	Sex, age and pregnancy status are mandatory fields in data entry	Proportion of health facilities (including hospitals) with standardized IDSR registers and forms that include provision to incorporate data on sex, age and pregnancy status	Proportion of districts reporting information using EBS that incorporates information on sex, age and pregnancy status	Proportion of districts reporting information using an EBS that incorporates information on sex, age and pregnancy status
			Proportion of events recorded in a logbook of rumor that have information on sex, age and pregnancy status of the person(s) associated with the rumor	Proportion of events recorded in a logbook of alerts that have information on sex, age and pregnancy status of the person(s) associated with the alert
			Proportion of districts with routine data validation systems that check for completeness and quality of data on sex, age and pregnancy status	Proportion of districts with routine data validation systems that check for completeness and quality of data on sex, age and pregnancy status

IDSR Core Function	Health Facility	District	Regional/Provincial	National
Report	Proportion of complete surveillance reports submitted to the district in which information on sex, age and pregnancy status is also complete	Proportion of health facilities (including hospitals) whose IDSR reports submitted on time include complete information on sex, age and pregnancy status	Proportion of monthly surveillance reports submitted from the district to the region/province on time in the last 3 months that include statistics disaggregated by sex, age and pregnancy status	Proportion of health facilities submitting IDSR reports on time to the district that include complete data on sex, age and pregnancy status
	Proportion of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance reported to the district using case-based or line-listing forms that included disaggregation by sex, age and pregnancy status	Proportion of cases of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance that are reported using case-based or line-listing forms which disaggregate by sex, age and pregnancy status	Proportion of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance reported from the district using case-based or line-listing forms that included disaggregation by sex, age and pregnancy status	Proportion of monthly surveillance reports submitted from the region/province on time in the last 3 months that included summaries disaggregated by sex, age and pregnancy status
		Proportion of hospitals submitting IDSR forms disaggregated by sex, age and pregnancy status, on time		Proportion of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance reported by the region/province using case-based or line-listing forms that included disaggregation by sex, age and pregnancy status

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IDSR Core Function	Health Facility	District	Regional/Provincial	National
Analysis and interpretation	Proportion of priority diseases slated for disaggregation for which line graphs with current data, and disaggregated by sex, broad age group, and pregnancy status are available	Proportion of priority diseases for which line graphs with current data, and disaggregated by sex, broad age group, and pregnancy status are available	Proportion of districts in which a line graph that disaggregates current data by sex, broad age group, and pregnancy status is available for priority diseases	Proportion of districts in which a line graph that disaggregates current data by sex, broad age group and pregnancy status is available for priority diseases
	Proportion of priority diseases slated for disaggregation for which current spot maps disaggregated by sex and pregnancy status are available	Proportion of health facilities that have current trend analyses with trends disaggregated by sex and pregnancy status	Proportion of districts in which an updated spot map of cases disaggregated by sex, age and pregnancy status is available for priority diseases that have been slated for disaggregated analyses	Proportion of districts in which an updated spot map of cases disaggregated by sex, age and pregnancy status is available for priority diseases that have been slated for disaggregated analyses
	Proportion of priority diseases slated for disaggregation for which there is a current lab data analysis that disaggregates by sex, age and pregnancy status (if health facility has a laboratory)	Proportion of health facilities that have current lab analysis data for priority disease analysis with information on sex, age and pregnancy status	Proportion of districts that report laboratory data disaggregated by sex, age and pregnancy status for diseases under surveillance	Proportion of districts that report laboratory data disaggregated by sex, age and pregnancy status for diseases under surveillance

IDSR Core Function	Health Facility	District	Regional/Provincial	National
Investigation and confirmation of suspected outbreaks	Proportion of suspected outbreaks of epidemic prone diseases and other PHE notified to the district level within 24 hours of surpassing the epidemic threshold that disaggregate findings by sex, age and pregnancy status	Proportion of reports of investigated outbreaks that include case-based data analyzed by sex, age and pregnancy status (in addition to totals)	Proportion of reports of investigated outbreaks that include case-based data analysis that disaggregates by sex, age and pregnancy status (in addition to totals)	Proportion of reports of investigated outbreaks that include case-based data analysis that disaggregates by sex, age and pregnancy status (in addition to totals)
	Proportion of specimens from suspected cases that are labeled by sex, age and pregnancy status	Proportion of investigated outbreaks with laboratory results within 7 days that are disaggregated by sex, age and pregnancy status	Proportion of investigated outbreaks with laboratory results that are disaggregated by sex, age and pregnancy status	Proportion of investigated outbreaks with laboratory results that are disaggregated by sex, age and pregnancy status
	Proportion of samples of suspected cases whose returned lab test results are disaggregated by sex, age and pregnancy status	Proportion of confirmed outbreaks with a nationally recommended public health response that pays attention to sex- and gender-based differences in designing the response	Proportion of confirmed outbreaks with a nationally recommended public health response that pays attention to sex- and gender-based differences in designing the response	Proportion of confirmed outbreaks with a nationally recommended public health response that pays attention to sex- and gender-based differences in designing the response

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GENSURV 12: Matrix and checklist to evaluate integration of gender in surveillance systems

STEP	ACTIONS TO TAKE	ACTION TAKEN (Y/N)?
Define objectives	<ul style="list-style-type: none"> ▶ Develop realistic, attainable, actionable objectives, such as: ▶ To assess the completeness and quality across health facilities in integrating sex, age and pregnancy status into disease surveillance data collection, recording and reporting ▶ To assess the quality of gender training provided to data managers and their staff ▶ To assess the understanding of gender in infectious disease outbreaks among data managers and their staff ▶ To assess gender bias in health facilities 	Y <input type="checkbox"/> N <input type="checkbox"/>
Develop evaluation indicators	<ul style="list-style-type: none"> ▶ Identify measurable indicators for each Objective ▶ Derive indicators as much as possible from monitoring indicators (see GENSURV tools for gendered monitoring indicators) ▶ Ensure indicators exist to capture gender bias 	Y <input type="checkbox"/> N <input type="checkbox"/>
Develop evaluation methods and tools	<ul style="list-style-type: none"> ▶ Decide whether a quantitative, qualitative or mixed-methods evaluation is most appropriate, based on objectives, data needs for indicators, finances, time, and capacity ▶ Decide on the target group (which levels of the health system? Which areas of the country?) and then select the evaluation sample (see GENSURV 03 for an illustrative sampling plan) ▶ Create a timeline for the evaluation, including time for testing tools, training enumerators (methods and gender training), field testing, data collection, data cleaning, and analysis 	Y <input type="checkbox"/> N <input type="checkbox"/>
Identify people to conduct the evaluation	<ul style="list-style-type: none"> ▶ Develop Terms of Reference (TOR) to hire a firm or organization to undertake the evaluation ▶ Ensure that the TOR requires at least one team member who has experience in or knowledge of gender in infectious diseases or in public health 	Y <input type="checkbox"/> N <input type="checkbox"/>

STEP	ACTIONS TO TAKE	ACTION TAKEN (Y/N)?
Collect data	▶ Gather monitoring and other data from multiple sources. For example:	Y <input type="checkbox"/> N <input type="checkbox"/>
	▶ Data source and type	
	▶ Use	
	▶ Annual plans: district and higher levels	
	▶ To evaluate extent of explicit attention to sex and gender in annual objectives	
	▶ Monthly summaries and other analyses of cases and deaths	
	▶ To evaluate extent to which summaries and analyses are disaggregated by sex, age and pregnancy status	
	▶ Results from any special surveys or quantitative or qualitative studies conducted in the sampled facilities	
Analyze data	▶ To evaluate whether special studies or surveys report sex, age and/or pregnancy status in analysis of disease trends and patterns	Y <input type="checkbox"/> N <input type="checkbox"/>
	▶ Case investigation forms and other reports from all sampled facilities	
	▶ To evaluate completeness and quality of data on sex, age and pregnancy status	
	▶ Information from community focal points and health staff themselves (qualitative or quantitative)	
	▶ To get the ground perspective on challenges and successes in collecting, reporting and analyzing sex, age and pregnancy status; and, in recognizing and addressing gender biases	
	▶ Implement a survey (if data does not exist) to collect qualitative or quantitative data on gender-related attitudes, knowledge, and practices of health providers at all sampled facilities (Questions from GENSURV 04 and GENSURV 05 can be used, either as is or modified)	
	▶ Analyze data to provide information on indicators and objectives selected for this evaluation	
	▶ Use facility data to answer the following types of process evaluation questions:	
Provide feedback and make plans to improve the integration of sex and gender	▶ Did supervisory visits assess the extent to which sex, age and pregnancy status was included in data collection and reporting?	Y <input type="checkbox"/> N <input type="checkbox"/>
	▶ Did supervisory visits discuss potential gender biases in data collection with staff?	
	▶ Analyze data to identify problems and their causes, such as:	
	▶ Did facilities fully incorporate sex, age and pregnancy-status in their data collection and reporting? If not, why?	
	▶ Were appropriate and timely actions taken to address gaps in integrating sex, age and pregnancy-status that were identified in the last evaluation or in the last monitoring exercise? If not, why?	
	▶ Provide feedback and analysis on successes and challenges in integrating gender	
	▶ If a sample was selected for the evaluation (rather than all facilities across the country), share the feedback with all facilities, anonymizing evaluated facilities and respondents if requested	
	▶ Work with weaker facilities to update and revise plans and targets to improve integration of gender before the next evaluation	

References

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Gender in Laboratory Quality

GOAL: A local, national and regional laboratory system that fully and effectively integrates sex and gender, and is able to identify sex- and gender-differentiated patterns and trends in symptoms and other laboratory findings and analyses.

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GOAL: A local, national and regional laboratory system that fully and effectively integrates sex and gender, and is able to identify sex- and gender-differentiated patterns and trends in symptoms and other laboratory findings and analyses

Why integrate gender into laboratory quality for surveillance of infectious diseases?

Laboratory testing and results are a key input into prevention, preparedness and response (PPR) by their role in confirming symptoms and cases of notifiable priority diseases. However, if samples are not labeled by sex, age and (for women 15–49 years of age) pregnancy status of patients, and recording and reporting of laboratory test results are not disaggregated by sex, age and pregnancy status, then patterns of symptoms and cases by these key demographic factors cannot be analyzed. Further, if there are gender differences in access to laboratory facilities, the disadvantaged gender will be less likely to be included in laboratory analysis than others, again leading to inaccurate assessment of risk, and ineffective and inefficient PPR. Finally, if gender norms or other factors prevent qualified people across gender from opportunities to serve as laboratory professionals, the program is not able to fully exploit all human resources for effective PPR.



Gender Benchmark 2.1: Capacity levels for Gender in Quality of Laboratory

CAPACITY LEVEL	<p>Gender Benchmark 2.1: Gender is integrated into the laboratory system at all levels</p> <p>Objectives:</p> <ul style="list-style-type: none"> To integrate sex, age and pregnancy status in the labeling of human biological samples and the recording, reporting and analysis of laboratory testing results. To identify and mitigate gender biases in access and use of laboratories.
01 NO CAPACITY	No systematic assessment has been conducted of existing gender gaps (IF NO ASSESSMENT, START WITH ATTAINING LEVEL 02)
02 LIMITED CAPACITY	Systematic assessment has been conducted to identify existing gender gaps.
03 DEVELOPED CAPACITY	Action plans to address identified gender gaps are developed, budgeted and piloted.
04 DEMONSTRATED CAPACITY	Post-pilot activities are implemented in laboratories at the national and regional levels in at least half of the areas of the country that are recognized as safely accessible.
05 SUSTAINABLE CAPACITY	Gender is integrated fully in laboratories across all areas of the country recognized as safely accessible, with mechanisms in place for supervision, monitoring, evaluation and reporting

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Actions and Tools to Achieve Level 02 (Limited Capacity)

1 Review data disaggregation by sex, age, and pregnancy status in existing laboratory human sample labeling and reporting of results.

Gaps in disaggregation by sex, age and pregnancy status can include:

- ▶ No – or inconsistent – recording of sex, age and pregnancy status of biological human samples in laboratory case investigation forms, including IDSR standardized forms;
- ▶ Variations across local, regional and national levels in laboratory Standard Operating Procedures (SOP) regarding the recording sex, age and pregnancy status;
- ▶ Variations across field, sub-national, national laboratories and referral laboratories in whether and how laboratory case investigation forms and protocols incorporate recording of sex, age and pregnancy status of biological human samples;
- ▶ Variable reporting standards across levels of the laboratory system in the transmission of specimen testing results, such that sex, age and pregnancy status are not always reported.

Available tools: *(To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)*

- ▶ **GEN-LAB 01** : Guidance to review disaggregation by sex, age and pregnancy status in laboratory documentation

2 Identify and document gender biases in access and use of laboratories for human and animal health

These can include:

- ▶ **Any absence in laboratory confirmation and reporting procedures of pathogens for which women are particularly at risk because of their biology**, such as maternal infections that are likely to trigger vertical transmission and/or impact optimal maternal health outcomes (for example, maternal rubella);
- ▶ **Gender differences in access to laboratory testing because of societal gender norms that disadvantage one gender compared to others**. This could be for use of human health laboratory services, or, in the case of animal health, a lack of access for female livestock herders, managers and/or caretakers to animal laboratory services.
- ▶ **Excluding “occupation” while recording demographic data for biological samples**. Laboratory sample labeling that captures sex and occupation will enable analysis of laboratory testing results to determine whether particular economic roles contribute to higher risks for a specific gender.
- ▶ **Lack of facilities in laboratories that can then act as a discouragement to women** in conservative settings to use the laboratory, such as the absence of functional sex-disaggregated toilets, separate entrance areas for women, female laboratory technicians, etc.
- ▶ **Gender-unequal** distribution of technical and other laboratory staff.

Available tools: *(To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)*

- ▶ **GEN-LAB 02** : Checklist to assess gender norms leading to gender bias in use of laboratories
- ▶ **GEN-LAB 03** : Illustrative questions to add to laboratory surveys to assess gender-friendliness of facility (this tool can be used in conjunction with laboratory stocktaking or needs assessments, for

The direction of inequality in gender of staffing is unclear due to lack of data. Data on the sex distribution of laboratory staff are hard to find. A recent COVID-19 investigation within South Africa's national laboratory medical service covering all laboratory staff recorded more women than men in laboratory staffing, with about 6000 female staff and about 2800 male

example those undertaken before constructing or rehabilitating a laboratory)

- 5 Assess capacity of laboratory personnel to integrate gender in the laboratory system at different levels in the country

Available tools: (To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)

- ▶ **GEN-SURV 02**, **GEN-SURV 03** and **GEN-SURV 04** can be modified to be applied to assessing capacity of laboratory personnel to integrate gender into the laboratory system, for disaggregation of sample identification, test results and reporting by sex, age and pregnancy status, as well as for addressing gender biases.

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 Prioritize actions

Available tools: (To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)

- ▶ **GEN-LAB 04** : Considerations for prioritizing integration of gender in laboratory functions and facilities

2 Integrate gender into core functions of laboratories

Available tools: (To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)

- ▶ **GEN-LAB 05** : Guidance to develop a plan of action to address data disaggregation across the laboratory system
- ▶ **GEN-LAB 06** : Modifications to IDSR case-based laboratory reporting form to integrate select sex and gender indicators
- ▶ **GEN-LAB 07** : Integration of gender into core lab functions by health system level

3 Establish gender-friendly laboratory facilities and testing options to increase gender equality in use of laboratories

Available tools: (To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)

- ▶ **GEN-LAB 08** : Case studies for use of rapid testing to facilitate access to women and girls
- ▶ **GEN-LAB 09** : Illustrative measures to increase women's and girls' access to laboratory testing

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4 Modify indicators and processes for supervision, M&E to integrate gender

Available tools: *(To view tools: Click on the name of a tool or scroll to GEN-LAB Tools)*

- ▶ **GEN-LAB 10** : Illustrative checklist to monitor actions to integrate gender in laboratory functioning
- ▶ **GEN-LAB 11** : Use of laboratory quality JEE indicators to monitor gender integration
- ▶ **GEN-LAB 12** : Illustrative integration of attention to gender in laboratory audits - The Example of the SLIPTA audit
- ▶ Pilot actions

Before scaling changes to the whole country, pilot actions in one or more regions to test for feasibility, cost, problems, and successes.

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are required.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are required.





Tools to integrate gender in laboratory quality

Tools to assess gender in laboratory quality

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Note: all tools can be modified to fit individual project or country needs and constraints

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GEN-LAB 01: Guidance to review disaggregation by sex, age and pregnancy status in laboratory documentation

Use the table below (as is or modified for context as needed) to document the extent to which laboratories for human health disaggregate data

Review of disaggregation of laboratory human biological sample labeling, testing and reporting									
PART A: Whether sample labeling, testing and reporting is disaggregated by sex, age and pregnancy status									
Notifiable diseases and events	Sample labeling disaggregated by (Yes/No):			Test results disaggregated by (Yes/No):			Reporting of results disaggregated by (Yes/No):		
	Sex	Age	If pregnant	Sex	Age	If pregnant	Sex	Age	If pregnant

PART B: Definitions used to label sex, age and pregnancy status		
Question	Categories	Response codes (circle correct response code)
How is "sex" labeled?	Not labeled M=male; F=female 0=male; 1=female 1=male; 2=female Other (specify):	0 1 2 3 4
How is "age" defined?	Not labeled By single years of age Under 12 months, 1-5, over 5 years By 5-year age groups Other (specify):	0 1 2 3 4
How is "pregnancy status" defined?	Not labeled Whether pregnant yes/no Trimester of pregnancy Other (specify):	0 1 2 3

STEP 1: List your country's priority diseases in Column 1 of Part A of the form above

- 1 Create as many rows as needed to enter in all priority notifiable diseases in your country

STEP 2: Filling in the form: collection of data and information

- 2 Make a list of all laboratories at all levels in the country used to test for symptoms of these notifiable diseases.
 - ▶ If there are too many laboratories in the country to assess simultaneously, make a list of the key ones, including reference laboratories, that are expected to take the lead in testing and reporting on the priority notifiable diseases.
- 3 Send the table above to the relevant persons in each identified laboratory to complete the information requested in Parts A (for each of the notifiable diseases listed) and Part B, as follows:
 - ▶ Special referral and national-level laboratories: send to all
 - ▶ Other sub-national laboratories: either send the form to all or to a sub-set of laboratories selected randomly, but assuring representation of different regions, rural areas, urban areas, etc.
- 4 Request the same laboratories to share their SOPs when they send back the completed form.

STEP 3: Data analysis

- 5 Use the data from the table to analyze the following, for sample identification, test results, and reporting of results (referred to below collectively as "disaggregation"):
 - ▶ For which notifiable diseases do laboratories disaggregate sex, age and (for women 15-49 years of age) pregnancy status?
 - ▶ What percentage of laboratories at each level of the health system disaggregate sex, age and (for women 15-49 years of age) pregnancy status?
 - ▶ What are the rural/urban patterns of consistent disaggregation by sex, age and (for women 15-49 years of age) pregnancy status?
 - ▶ Where are the largest gaps in consistent disaggregation by sex, age and (for women 15-49 years of age) pregnancy status? For example, are labeling of samples and results less consistently disaggregated in:
 - ☐ Laboratories in particular regions of the country?
 - ☐ Laboratories in rural vs. urban areas?
 - ☐ Laboratories at certain levels of the health system?
 - ☐ Particular notifiable priority diseases?
 - ▶ What are the patterns of inconsistency across laboratories in how sex, age and/or pregnancy status are defined?
- 6 Use the information from the SOPs to analyze:
 - ▶ Any variations in protocols determining whether and how to record sex, age and pregnancy status to identify human biological samples, to record test results, and to report results up the chain;
 - ▶ Any variations in protocols determining which priority notifiable diseases would include recording of sex, age and pregnancy status;
 - ▶ Which of any identified differences in protocol may be logistically (human resources, capacity, reporting capacity, etc.) and/or epidemiologically necessary;
 - ▶ Which of any identified differences in protocol need to be addressed and protocols standardized across which levels of the laboratory network.

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GEN-LAB 02: Checklist to assess gender norms leading to gender bias in use of laboratories

CAN BE MODIFIED as needed to reflect context-specific factors

QUESTION	YES	NO
Gender bias in diseases included for laboratory testing		
Are pathogens with risks for maternal infections typically included in priority notifiable diseases for which regular testing is conducted?		
Gender differentials in use of human laboratory testing		
Are there gendered social or cultural perceptions about getting tested to confirm illness that may make men unwilling to visit a laboratory to get tested?		
Are there gendered social or cultural perceptions about getting tested to confirm illness that may make women unwilling to visit a laboratory to get tested?		
Do women have to seek the permission of husbands or others in the household to leave the home, including for their own health care?		
Would pregnant women typically face restrictions on leaving the home, including to get tested in a laboratory?		
Are women allowed to leave the home unattended by a male relative?		
Are women typically less likely than men to know where they can go to get laboratory testing?		
Do the laws (either customary or formal) create any restrictions to women's access to public spaces and facilities?		
Do women have less access to finances, information, and transport than do men?		

QUESTION	YES	NO
Gender differentials in the use of laboratory testing for animals		
Is there any documentation of differences in the extent to which male livestock herders or managers compared to female herders or managers get their livestock tested?		
(IF YES): • Are male herders more likely than female herders to access laboratories to test their livestock? • Are female herders more likely than male herders to access laboratories to test their livestock?		
Do female herders have less access to transport and finances to transport their animals to a laboratory for testing than do male herders?		
Do gender norms prohibit animal health lab technicians of a certain gender from accessing herders of a different gender?		
Are animal health laboratory technicians more likely to be male than female?		
Are animal health laboratory technicians more likely to be female than male?		
Gender-specific occupations and roles that may influence risk and exposure		
Are frontline health workers predominantly from one gender?		
Is one gender more likely than another to be responsible for trading livestock?		
Is one gender more likely than another to be responsible for taking care of domestic livestock?		
Is one gender more likely than another primarily responsible for preparation of animal-based food?		
Is one gender more likely than another primarily responsible for hunting for meat?		

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GEN-LAB 03: Illustrative questions to add to laboratory surveys to assess gender-friendliness of facility

NOTE:

These questions can be added to any laboratory stocktaking or needs assessment, including those undertaken before constructing or rehabilitating a laboratory;

Not all questions need to always be included; each program can choose which questions to include depending on priority, need, finances, and other context-relevant constraints and opportunities.

These questions can be edited and formatted to be part of a quantitative survey or formatted and arranged to be part of qualitative data collection (focus groups or individual interviews).

IDEAL RESPONDENT: the head or a senior staff person of the laboratory being surveyed

Questions to assess gender differences in laboratory staffing (for existing laboratories that are to be rehabilitated)

- 1 What is the gender of the head of this laboratory?
- 2 For each service offered by this laboratory, what is the gender of the person responsible for the service? (Ask for all services offered, such as: pathology, bacteriology, hematology, parasitology, biochemistry, virology, etc.)
- 3 How many staff are in this laboratory, by type of specialization? (Ask for totals, and disaggregated by sex, for positions such as: FETP and similarly trained staff, doctors, pharmacists, laboratory technicians, laboratory aides, secretaries, administrative personnel, storekeeper for medicines offered at the laboratory, maintenance engineers, data managers, accountants, etc.)
- 4 Have there been any promotions in this laboratory in the last year? IF YES: how many? How many women were promoted? How many men were promoted?
- 5 What do you think are the barriers that prevent women from attaining decision-making positions in this laboratory? (open-ended question OR can be coded based on gender norms established using GEN-LAB 02)
- 6 Are there gender differences in salary in this laboratory for personnel of different genders in the same post and the same qualifications? IF YES:
 - a Why do you think this is the case? (Open-ended question)
 - b Do men get higher salaries on average or women, for the same post and same qualifications?
- 7 What are the reasons for staff departures in this laboratory? (Ask, differentiated by sex of staff, for reasons such as: availability of better alternative jobs in other laboratories, higher salary elsewhere, fired due to poor performance, personal reasons such as moved to another area, perceived and actual sex discrimination, sexual harassment, health reasons, pregnancy or childbirth, spouse's opposition, etc.)
- 8 In the last year how many people have left this laboratory for any of these reasons? (Ask for men and women separately)
- 9 How many staff have participated in any technical training in the last year? (Document by sex of staff participating)
- 10 Do hours of work differ by sex of staff? (IF YES:
 - a What are the hours of work for women?
 - b What are the hours of work for men?

Questions to assess availability of testing facilities specifically for women (existing laboratory or planned for a future laboratory to be constructed)

- 1 What clinical services does/will your laboratory offer? (Include in the list of services included as potential responses for this question obstetric-gynecological testing and other laboratory services and testing for reproductive tract infections)
- 2 How many staff are trained in ob-gyn and reproductive tract infections? How many male staff? how many female staff?

Questions to assess gender differences in access to the laboratory (existing laboratory or to facilitate planning for a future laboratory to be constructed)

- 1 According to you, what are some key constraints that limit the population's access to this laboratory? (Ask separately for men and women, reasons can include: cost, distance to the laboratory, norms that prevent access, need to seek permission, need to be accompanied by someone, stigma associated with testing, stigma associated with the particular laboratory, other reasons)
- 2 Does your lab offer cost subsidies for any testing? If yes, to which categories of patients? (In categories, include: women and pregnant women)
- 3 Ask to see the register or other documentation of testing in the last (month, 6 months – whatever time period is considered appropriate). Make a list of:
 - a Total number of patients using the laboratory, by sex;
 - b Tests conducted, by sex;
 - c Number of subsidized patients, by sex.

Questions to assess gender-friendliness of physical facilities (for existing laboratories that are to be rehabilitated)

- 1 How many toilets does this laboratory facility have?
- 2 How many toilets only for women?
- 3 How many toilets only for men?
- 4 How many of the existing toilets are functional? (Note separately for toilets for men and toilets for women)
(If social norms mandate or prefer separate spaces for men and women)
- 5 Does this laboratory have separate testing rooms for men and women?
- 6 Does this laboratory have separate entrances for men and women?
- 7 Are there separate hours of service dedicated to serve women?

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GEN-LAB 04: Considerations for prioritizing integration of gender in laboratory functions and facilities

It is possible that all identified gender gaps in laboratory functions and facilities cannot be addressed simultaneously. This could be due to time constraints, or limited human, budgetary, institutional or infrastructural resources. Below are some rules of thumbs for prioritizing action, if needed.

WHAT:

Mandate documentation of sex and age for samples, laboratory test results and reporting of results for priority notifiable diseases for which sex and gender biases are most likely to occur. This could include:

- ☒ Diseases for which there have been frequent outbreaks and it is known that infection rates, disease outcomes, treatment during the epidemic, and/or consequences of an outbreak vary by sex and/or age;
- ☒ Diseases or symptoms for which the literature strongly suggests sex and/or age differentials in infection rates, disease outcomes and/or treatment for particular diseases;
- ☒ New and emerging diseases or symptoms for which patterns by sex and/or age are as yet unknown.

Mandate documentation of “whether pregnant: yes/no” for samples from women 15-49 years of age, the laboratory test results and reporting of results of these samples for priority notifiable diseases where pregnancy is known to increase risks for the woman and/or the fetus. This could include:

- ☒ Symptoms, events or unusual findings that are first identified among pregnant women;
- ☒ Diseases for which there have been frequent outbreaks and it is known that infection rates could be higher and/or disease outcomes be worse for the woman and/or her fetus or newborn;
- ☒ Diseases or symptoms for which the literature lists pregnancy as a risk factor;
- ☒ New and emerging diseases or symptoms for which the role of pregnancy in exacerbating or mitigating risk is as yet unknown.

GENDER BIAS At the minimum:

- ☒ Ensure that pathogens known to be particularly harmful for pregnant women, such as maternal rubella, are included in the list of priority notifiable diseases;
- ☒ Ensure that samples of zoonotic pathogens related to care of livestock include information on the sex of the person taking care of the livestock in question;
- ☒ Assess the gender-specific barriers to access and use laboratories using other tools in this Module and address them as feasible;
- ☒ Brainstorm with the team and experts in your country on other ways in which identified gender biases specific to your country context could impact the use of laboratory services by a gender, and how to address this gender disadvantage.

GEN-LAB 05: Guidance to develop a plan of action to address data disaggregation across the laboratory system

ACTION ITEM	GUIDANCE
Use results of tools for Level 02 and GEN-LAB 04 to determine protocols for data disaggregation	<ul style="list-style-type: none"> ▶ Select which notifiable diseases to prioritize to mandate disaggregation by sex; ▶ Select which notifiable diseases to prioritize to mandate disaggregation by age (and how to define); ▶ Select which notifiable diseases to prioritize to mandate disaggregation for samples from women 15-49 years by pregnancy status; ▶ Determine how to standardize recording of sex, age and pregnancy status for samples, test results, and reporting across the country for each notifiable disease; ▶ Modify all laboratory forms used to incorporate recording of sex, age and pregnancy status, using standardized definitions determined, and for prioritized notifiable diseases; ▶ Select areas in which to pilot the above modifications and mandates.
Standardize processes as needed, based on information from the SOP protocols (GEN-LAB 01)	<ul style="list-style-type: none"> ▶ Send information to all laboratories on using the standardized definition of sex, age and pregnancy status as determined through the action above; ▶ Hold workshops with laboratories at different levels to modify or develop new SOPs that are appropriately standardized across laboratories in one level of the health system, and across the health system overall, in recording and reporting of sex, age and pregnancy status; ▶ Develop monitoring indicators to monitor progress across laboratories in modification of SOPs.
Improve synergy between laboratories at different levels in standardizing disaggregation of data	<ul style="list-style-type: none"> ▶ Improve and systematize communication between different labs to enable better knowledge sharing on best practices, understanding trends, etc. that are sex and gender responsive. For example: ▶ Include in MOUs integration of prioritized sex and gender aspects at the level of the labs for which MOUs are being developed; ▶ Engage local-level labs in dialogue with district- and regional-level labs when MOU documents (or other structural processes) are being defined to ensure consensus, information, and synergy across MOUs; ▶ Establish routine meetings to strengthen communication between laboratory focal points - particularly between laboratories that transmit specimens and those that receive them - at facilities at different levels;
Systematize integration of gender into laboratory testing	<ul style="list-style-type: none"> ▶ Establish alerts for priority infections that carry disproportionate risks or have a disproportionate impact on a particular gender, if existing priority notifiable infections do not include these; ▶ Ensure that existing laboratory early warning alert systems and testing protocols include those for identified infections that have disproportionate gendered effects; ▶ In the case of diseases that have a high risk of vertical transmission and/or poor maternal outcomes if contracted by pregnant women, provide rapid and easily-usable testing kits and tools via field laboratories, such as “combo” antenatal testing kits for common maternal and vertically transmitted infections (see GEN-LAB 08 for examples); ▶ Conduct routine record reviews of laboratory registers, particularly at the community and district levels, for confirmed priority infections and health conditions/diseases that may signal gender-differentiated patterns of risk, exposure, outcomes, or health-seeking behavior.

Source: Developed based on information in (WHO Regional Office for Africa 2019b)

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GEN-LAB 06: Modifications to IDSR case-based laboratory reporting form to integrate select sex and gender indicators

Note: **Part I** modifications include variables # 7-9; **Part II** modifications include variables # 3-6

IDSR CASE-BASED LABORATORY REPORTING FORM		
Part I: Referring health worker to complete this form and a copy sent to the laboratory with the specimen		
	VARIABLES	ANSWERS
1	Date of specimen collection (day/month/year)	
2	Suspected Disease or Condition	
3	Specimen type *	
4	Specimen unique identifier **	
5	Patient Name (s)	
6	Sex (M= Male F= Female)	
7	Age (..... Years/Months/...Days)	
8	Pregnancy status:	
9	Occupation:	
10	Date Specimen sent to laboratory (day/month/year)	
11	Phone and email address of clinician	
12	Laboratory Name and location	
Part II. Laboratory to complete this section and return the form to district and clinician		
1	Laboratory Name and location	
2	Date laboratory received specimen (dd/mm/yyyy)	
3	Sex (M= Male F= Female)	
4	Age (..... Years/Months/...Days).	
5	Pregnancy status:	
6	Occupation:	
7	Specimen condition: (Adequate/Not adequate)	
8	Type of test(s) performed	
9	Final Laboratory Result(s)	
10	Date (dd/mm/yyyy) laboratory sent results to district	
11	Date Results sent to the clinician (dd/mm/yyyy)	
12	Date district received laboratory results (dd/mm/yyyy)	

* Blood, Plasma, Serum, Aspirate, CSF, Pus, Saliva, Biopsy, Stool, Urethral/Vaginal discharge, Urine, Sputum, food/water samples

** Same as the patient's identifier in the IDSR immediate case-based reporting form

Source: Adapted from (WHO Regional Office for Africa 2019b), Annex 2G

GEN-LAB 07: Integration of gender into core lab functions by health system level

LEVEL	COLLECT	CONFIRM	REPORT
Local health posts and facilities	<p>Use standard case definitions to label collected specimens by sex, age, and pregnancy status</p> <p>When assisting First Contact Laboratories in specimen collection, ensure that priority infections that have gender-specific and gender-differentiated impacts are also included within approved guidelines</p> <p>Document specimens with clinical history and ensure documentation includes sex, age, and pregnancy status</p> <p>Transport specimens to First Contact Laboratory and Referral Laboratory per approved guidelines accompanied by case-based laboratory reporting forms modified to include sex, age, and pregnancy status</p>	<p>Use standardized case definitions, including for sex, age, and pregnancy status to initiate or request appropriate testing for disease confirmation</p> <p>Handle specimens within approved SOPs and guidelines that have been modified to integrate gender in all processes such as testing and confirmation, referral, personnel training and recruitment, accreditation, etc.</p>	<p>Record details of specimen collection and transport that is disaggregated by sex, age, and pregnancy status</p> <p>Receive test results and provide feedback that incorporates sex, age, and pregnancy status-specific testing results</p>

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LEVEL	COLLECT	CONFIRM	REPORT
District or Province level	<p>Communicate collection policies and procedures to providers that have been modified to be female-friendly as culturally required (such as specific hours for testing women and sex-segregated bathrooms)</p> <p>Request additional specimen collection materials as needed, especially for tests of reproductive tract areas, and for additional sex, age, and pregnancy status-disaggregated outbreak investigation</p> <p>Arrange for specimen transport to First Contact Laboratory and Referral Laboratory per approved guidelines, accompanied by case-based laboratory reporting forms modified to include sex, age, and pregnancy status</p>	<p>Perform laboratory studies for sex, age, and/or pregnancy status-specific diagnosis as appropriate and available</p> <p>Store samples, labeled by sex, age and pregnancy status, for transportation in specified conditions as per guidelines</p> <p>Carry out routine analysis of laboratory results that is sex, age, and pregnancy status-disaggregated</p> <p>Routinely examine the laboratory analysis for changes in sex, age, and pregnancy status-disaggregated trends</p>	<p>Record, store and back up laboratory results and details of laboratory testing including all tests done and timeliness of analysis, ensuring that all results are sex, age, and pregnancy-status disaggregated</p> <p>Provide feedback of results to clinical staff and patients, using sex, age, and pregnancy status-disaggregated data</p> <p>Ensure regular receipt of laboratory results from National level that are sex, age and pregnancy status-disaggregated</p> <p>Update line-lists with sex-, age and pregnancy status-disaggregated laboratory results and follow-up on any missing results or missing data with testing laboratory</p> <p>Ensure that line list registers also incorporate sex, age, and pregnancy status</p> <p>Report sex, age, and pregnancy status-disaggregated results and timeliness details to next level</p> <p>Report observed sex, age, and pregnancy status-specific changes in trends during routine analysis of laboratory results to the national level</p> <p>Use summary information for outbreak investigation including analyses based on sex, age and pregnancy status</p>

LEVEL	COLLECT	CONFIRM	REPORT
National referral labs, including those that act as First Contact labs	<p>Set specimen collection guidelines, policies and procedures with the national authorities that integrate sex, age, and pregnancy status</p> <p>Distribute appropriate specimen collection and transportation kits for epidemic-prone diseases, including agile testing kits such as composite self-administered prenatal testing kits for women and girls in communities</p> <p>Request additional specimens with particular sex, age, or pregnancy characteristics to be collected by laboratory or providers as needed</p> <p>Store specimens within approved conditions for further referral and analysis or additional research or investigation.</p>	<p>Set confirmation policies and procedures with the national authorities that integrate disaggregation of test results by sex, age, and pregnancy status</p> <p>Perform laboratory studies for confirmation as appropriate and label samples and results by sex, age, and pregnancy status; these include microscopy, culture, antimicrobial susceptibility testing, serotyping, serological investigation, molecular detections and identification, genomic sequencing</p> <p>Store representative isolates from the outbreak as needed, ensuring labeling of patient by sex, age, and pregnancy status</p>	<p>Record, store and back up sex, age, and pregnancy status-disaggregated laboratory results, details of all laboratory testing, and timeliness of analysis of test results</p> <p>Report sex, age, and pregnancy status-disaggregated results to Regional and District Health Teams and all relevant stakeholders at the national, regional and district levels for onward dissemination</p> <p>Report case-based and summary data according to the agreed protocol that is modified as necessary to ensure labeling of all data by sex, age, and pregnancy status</p> <p>Report sex, age and pregnancy status-disaggregated laboratory results from screening sentinel populations at target sites</p> <p>Carry out routine analysis of laboratory data and results and examine for sex, age, and pregnancy-specific changes in trends</p>
Global reference	<p>Set specimen collection guidelines, policies and procedures that emphasize ensuring gender equitable collection, and labeling of all specimens by sex, age, and pregnancy status. Share all policies with the national authorities</p> <p>Request for additional specimens with particular sex, age, or pregnancy characteristics to be collected, as needed.</p>	<p>Perform additional analysis on referred specimens or isolates as appropriate, labeling all specimens and results by sex, age, and pregnancy status</p>	<p>Record, store and back up sex, age, and pregnancy status-disaggregated laboratory results, details of all laboratory testing, and timeliness of analysis</p> <p>Report sex, age and pregnancy status-disaggregated laboratory results to National Reference Laboratory or National Laboratory</p>

Source: Adapted from (WHO Regional Office for Africa 2019b) Annex 1E

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GEN-LAB 08: Case studies for use of rapid testing to facilitate access to women and girls

CASE STUDY #1: Laboratory screening tests in antenatal care (ANC) services in Senegal

- ▶ Standard array of laboratory testing for ANC of pregnant women includes hemoglobin concentration, HIV status, glycemie (blood sugar) status, blood group and Rhesus factor, Emmel test, proteinuria and syphilis.
- ▶ Only 38% of pregnant women had 0-2 of these tests available to them using the regular testing process and lab technology (that is: a pregnant woman visits the clinic, a midwife orders and collects blood and urine samples, a laboratory conducts the tests, and clinical diagnosis is confirmed, and care plan developed based on test results).
- ▶ It was found that using all-in-one rapid testing kits available at community health centers that test for Prevention of Mother-to-Child Transmission (PMTCT) using HIV/Syphilis DUO tests, hemoglobin, blood sugar, among others, increased uptake of testing by pregnant women to 94% primarily due to the need for limited trips to the clinic, reduced costs, and fast results. Such testing also reduced testing burden on already limited infrastructure, among other benefits.
- ▶ Point-of-care laboratory testing where possible for pregnant and breastfeeding women was also useful in early diagnoses and timely clinical management, particularly in the control of HIV and tuberculosis infections.

Source: (Ondoa 2019)

CASE STUDY #2: Multiple-disease integrated testing for cervical cancer in women in Lesotho

- ▶ Cervical cancer caused by Human Papilloma Virus (HPV) is the most common female cancer and most common cause of cancer death in Lesotho. Most women have never had screening for cervical cancer and often present with advanced disease.
- ▶ Current clinical and laboratory screening methods include pap smears and visual inspection with ascetic acid. A high precision screening test is required to mitigate public health burden of disease.
- ▶ Supported by UNITAID, HPV Nucleic Acid Testing was piloted at two sites in Lesotho leveraging on early infant diagnosis (EID) and rapid point-of-care (POC) platforms (via Gene eXpert4 technique).
- ▶ Health care workers were trained through clinical and on-site trainings meetings on the benefits of diagnostic integration of POC (EID and HPV); women were sensitized on multi-diagnostic opportunities at POC.
- ▶ Reduced resulting time-to-diagnosis to 0-3 days (potential same day EID diagnosis) was observed compared to an average 61 days turnaround time with the standard procedure. Women were able to self-collect an HPV sample to run on the POC test; the HPV test and viral load were taken on same day.
- ▶ POC tests are performed by dedicated nurse assistants at high volume sites having Gene eXpert4.
- ▶ This multi-disease integration of a point of care testing platform has been feasible and acceptable to health care providers in Lesotho and has improved diagnostics for women and their families.
- ▶ POC EID and HPV testing has improved early infant diagnosis and cervical cancer screening in Lesotho; plans are underway to transition EID fully to POC platforms (and ease lab-based machines for general population viral-load testing).

Source: (Mahoanyane 2019)

GEN-LAB 09: Illustrative measures to increase women's and girls' access to laboratory testing

NOTE: This tool is intended for contexts where there is a female disadvantage in laboratory testing. However, measures can be modified to also be applicable to cases where men are less likely than women to use laboratory testing facilities for priority notifiable diseases.

LEVEL OF INTERVENTION	SUGGESTED MEASURES
Facility-based	<ul style="list-style-type: none"> ▶ Offer on-site or external testing - especially for priority infections - at both inpatient and outpatient clinics, contingent to availability of trained personnel and resources; ▶ Improve gender equality in personnel at all levels (use GEN-HR tools as needed); ▶ Identify and train as needed allied female health personnel such as nurses or midwives to augment laboratory testing at community centers; ▶ Train all personnel on culturally-appropriate ways in which to approach women and girls for laboratory testing; ▶ Ensure functional, sex-segregated toilets at the facility; ▶ Modify spaces as needed to take into account cultural preferences or mandates, such as separate entrances for women and men, dedicated hours for women, rooms for nursing mothers, etc.
Community-based	<ul style="list-style-type: none"> ▶ Where women are reluctant to come to a central laboratory, offer testing at day care centers, workplaces, community health centers, and other community locations where women tend to congregate; ▶ Deploy agile testing methods such as rapid testing kits, consolidated testing (e.g., HIV/Syphilis DUO – See GEN-LAB 08 for case studies); ▶ Mobilize community health teams for targeted outreach for women and girls to encourage testing for priority infections, standard testing (such as antenatal testing), self-testing options, community testing fairs, etc.
Individual capacity-building	<ul style="list-style-type: none"> ▶ Incorporate in annual workplans informational campaigns that emphasize the importance of routine testing per standards of care and raise awareness of the gender differences in priority diseases and the importance for women and girls, in addition to men and boys, to get tested; ▶ Build awareness around disease prevention with early and routine testing, focusing on the importance for women and girls to get tested equally with men and boys.

Source: Developed based on information in (WHO Regional Office for Africa 2019b)

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GEN-LAB 10: Illustrative checklist to monitor actions to integrate gender in laboratory functioning

ACTION	
INTEGRATION OF SEX, AGE AND PREGNANCY STATUS IN LABORATORY SAMPLE LABELING, TEST RESULTS AND REPORTING OF RESULTS	
Are all biological human samples identified by sex and age?	
Are test results of all biological human samples disaggregated by sex and age?	
Do reports of test results of all biological human samples shared with higher levels of the laboratory network disaggregate findings by sex and age?	
Does recording and analysis of all biological human samples, test results, and reporting of results for infections known to exacerbate risks of pregnancy incorporate the pregnancy status of all female patients between 15-49 years of age?	
Do all other lab records (paper and/or online) provide space to record the sex of all patients?	
Do all other lab records (paper and/or online) provide space to record the age of all patients?	
Do all other lab records (paper and/or online) provide space to record the pregnancy status of all female patients between 15-49 years of age for infections known to exacerbate risks of pregnancy?	
Do forms to document collection, testing and reporting of test results for biological samples include other gender characteristics (such as occupations that are typically gendered) where determined to be necessary to establish specific risks?	
Does identification of samples and reporting of test results for livestock biological samples include the sex of the herder or manager for that livestock?	
IMPROVING GENDER FRIENDLINESS OF LABORATORY FACILITIES	
Is there an active strategy in place to ensure gender equity in recruitment of lab technicians and personnel?	
Are efforts in place to enhance gender equity in access to training for lab technicians and other relevant personnel, such as in the Field Epidemiology Training Programs (FETPs)?	
Are health workers who work with lab personnel engaged in efforts to address gender gaps in access to lab services at the community/health post/district/provincial/national (choose appropriate level depending on where the checklist is being used) level?	
Do SOPs include procedures for outreach to ensure lab access regardless of gender?	
Do SOPs include reporting procedures for priority infections that impact women and girls?	
Do SOPs specify efforts to engage with women and girls in marginalized communities to encourage laboratory testing for priority notifiable diseases equally to men and boys from these communities?	

Adapted from (WHO Regional Office for Africa 2019b)

GEN-LAB 11: Use of laboratory quality JEE indicators to monitor gender integration

JEE INDICATOR(S)	GENDER IMPLICATIONS	ACTIVITIES TO REPORT AGAINST INDICATORS	MEASUREMENT OF ACTIVITIES
D.1.1 Laboratory testing for detection of priority diseases	Testing for priority infections that have gender-specific impacts as part of routine testing procedures can improve accuracy of diagnosis, infection control measures and treatment coverage (for example, rubella for women)	Include in routine testing procedures identified priority infections that have gender-specific impacts	<ul style="list-style-type: none"> ▶ Percent of labs where routine lab testing includes priority infections that have gender-specific impacts; ▶ Percent of routine testing procedures that include priority infections with gender-specific impacts
D.1.3 Effective national diagnostic network	<ul style="list-style-type: none"> ▶ Greater gender equity in lab technicians and personnel trained in basic diagnostic techniques, including bacteriology, serology, and PCR, can improve gender balance in staffing and diminish gender gaps in population use of labs ▶ Agile outreach testing (e.g. composite prenatal testing kits) can improve gender gaps in testing coverage, especially for women with mobility constraints 	<ul style="list-style-type: none"> ▶ Pay attention to gender equity in hiring, retention and training of lab technicians and other personnel. ▶ Develop outreach and point-of-care options to improve gender gaps in lab access 	<ul style="list-style-type: none"> ▶ Sex ratio of lab techs and other personnel; ▶ Sex ratio of personnel in technical training in the last one year; ▶ Number of point-of-care diagnostics deployed per quarter; ▶ Number of outreach testing events per quarter
D.1.4 Laboratory quality system	Laboratory quality standards that are sex and gender responsive and that are consistently implemented across all appropriate levels can improve quality control and assurance in laboratory capacity	<ul style="list-style-type: none"> ▶ Modify laboratory quality standards to integrate attention to gender; ▶ Deploy and use modified quality standards in labs at all appropriate levels of the system 	<ul style="list-style-type: none"> ▶ Lab quality standards modified to integrate sex and gender (Y/N); ▶ Percent of labs at each appropriate level that use modified lab quality standards

Source for JEE indicators: (World Health Organization 2022)

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GEN-LAB 12: Illustrative integration of attention to gender in laboratory audits - The Example of the SLIPTA audit

NOTE:

- ▶ The example here uses specific audit requirements under Section 1 of the WHO Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) Audit Form, namely:
 - ☐ Requirement 1.2 (Laboratory Quality Manual)
 - ☐ Personnel Management
 - ☐ Personnel Training
 - ☐ Reporting and release of results

The scoring system remains unchanged and is thus not included in the matrix below.

Other SLIPTA audit requirements can be similarly modified to assess also integration of relevant aspects of gender in the laboratory system being audited.

- ▶ The following examples can also be used to integrate gender into other audits or assessments of laboratories.

REQUIREMENT	COMPONENT	YES	PARTIAL	NO	COMMENTS
Laboratory Quality Manual	<p>Does the current laboratory quality manual, composed of the quality management system's policies, also outline procedures to capture sex, age, and (where relevant and feasible) pregnancy status in forms used to identify samples, document test results and convey findings?</p> <p>Has the manual content on disaggregated data been communicated to, understood, and implemented by all staff?</p>				
	<p>Does the manual's description of the roles and responsibilities of the laboratory director, or laboratory manager, quality manager, and other key personnel include responsibility for ensuring compliance with disaggregation of data by sex and age, and other gender-responsive procedures?</p> <p>Is there acceptable representation across gender among technicians and personnel engaged in compliance regulation?</p>				
	Are policies and/or standard operating procedures (SOPs) for laboratory functions, technical and managerial procedures updated and reflect feasible interventions to address potential or identified gender gaps (such as defining measures for stronger gender-equitable outreach and access to labs)?				
	Is there a laboratory handbook for laboratory users that includes information on location of the lab, services offered, laboratory operating times including any dedicated testing hours by gender, instructions on completion of request forms, instruction for preparation of the patient, special cultural considerations in approaching female patients, sample collection including patient collected samples, transport, agreed turnaround times, acceptance and rejection criteria, availability of advice on sex-, age and pregnancy-specific examination and interpretation of results; and lab policy on protection of personal information, laboratory complaints procedure?				

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REQUIREMENT	COMPONENT	YES	PARTIAL	NO	COMMENTS
Personnel Management & Training	How the laboratory will: 1) define the structure of the organization (and organizational plan that pays attention to gender-equitable representation); 2) manage personnel (personnel policies that take into account gender-based concerns such as sexual harassment and gender-based discrimination); 3) maintain sex-specific personnel records?				
	How the laboratory will: 1) perform staff orientation; 2) conduct initial and refresher training; 3) provide a continuous education program; 4) identify required training relevant to job title and responsibilities; 5) keep record of training; 6) evaluate the effectiveness of training, all ensuring representation in training across gender?				
	Do orientation, education and training include raising awareness of the importance of disaggregation by sex, age and pregnancy status, and other gender concerns and biases, in laboratory functioning?				
	Are there special plans in place to ensure gender-equitable opportunity to participate in all training and education programs?				
	Is there documented evidence that all relevant policies and SOPs – including the sex and gender sensitive approaches outlined within – have been communicated to and are understood and implemented by all staff as related to their responsibilities?				
Reporting and release of results	How the laboratory will : 1) issue standardized report (define the format and medium) ; 2) review patient results; 3) communicate patient results including alert, urgent and critical results; 4) ensure release of results to authorized persons; 5) amend reports; 6) issue amended reports; 7) store patient results; 8) maintain patient results, all disaggregated by sex and age, and – where deemed necessary – by pregnancy status.				
	Are all records, reports and results disaggregated by sex and age and – where deemed necessary – by pregnancy status?				
	Are all records, reports and results disaggregated by pregnancy status and/or occupation and/or other gender characteristics for infections where this is deemed necessary?				

Source: Modifications to audit checklist in (World Health Organization 2020)

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Gender in Human Resources

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GOAL: Human resource policy is gender-equitable and all staff engaged in public health emergency preparedness and response understand the role of gender for preparedness and response and for the effective implementation of the IHR at all levels of the health system.

Why integrate gender into human resources for prevention, preparedness and response in epidemics?

To integrate gender into core capacities of health security, it is critical that the staff creating and implementing the policies, strategies, plans and activities for prevention, preparedness and response be trained in gender in epidemics. Thus, one aspect of gender integration in human resources is to ensure that staff technical training includes training on the role of gender in epidemics, and a familiarity with the tools to integrate gender in PPR activities. Gender equity in human resources themselves is important for effective and efficient PPR. First, across gender, people are resources. If a gender is underrepresented in human resources for PPR, their experiences and knowledge are not fully exploited for effective PPR. Second, because of existing gender norms, patients may prefer, or be mandated to, only interact with laboratory personnel of the same gender, or require gender-disaggregated spaces in laboratory facilities. Without these, potential patients of the disadvantaged gender may not use laboratory facilities and thus will not be counted in laboratory testing and results. This, in turn, can result in inaccurate and incomplete assessment of prevention, preparedness and response needs.

Human resources include all staff engaged in public health emergency preparedness and response, such as: nurses and midwives, physicians, public health and environmental specialists, social scientists, communication, occupational health, laboratory scientists/technicians, biostatisticians, information technology (IT) specialists, biomedical technicians, epidemiologist, and others, as well as the workforce in the animal sector, including veterinarians, animal health professionals, para-veterinarians, epidemiologists, IT specialists and others (World Health Organization 2019; 2022).

Gender Benchmark 3.1: Capacity Levels for Gender Equity of Human Resources

CAPACITY LEVEL	<p>Gender Benchmark 3.1: The country's human resources (HR) for public health emergency preparedness and response and the effective implementation of the IHR are representative across gender</p> <p>Objectives:</p> <ul style="list-style-type: none"> To ensure feasible¹ gender equity in public health emergency preparedness and response staffing at all levels.
01 NO CAPACITY	<p>No systematic assessment has been conducted of gender gaps in human resources for public health preparedness and response.</p> <p>(IF NO ASSESSMENT, START WITH ATTAINING LEVEL 02)</p>
02 LIMITED CAPACITY	<p>Systematic assessment has been conducted to identify existing gender gaps in human resources for public health preparedness and response.</p>
03 DEVELOPED CAPACITY	<p>Protocols to address gender-related gaps in human resources for public health emergency preparedness and response are developed and integrated into the country's multisectoral workforce strategy, protocols, SOPs etc.</p>
04 DEMONSTRATED CAPACITY	<p>Human resources for implementation of IHR are representative across gender at the national level.</p>
05 SUSTAINABLE CAPACITY	<p>Human resources for implementation of IHR are representative across gender at all levels of the country where they are present.</p>

¹ "Feasible" indicates taking into account existing gender gaps in capacity, as well as existing gender norms and resulting constraints that may inhibit women's career options in public health preparedness and response. Countries are encouraged to identify and address these constraints so as to increase the feasibility of gender-equitable human resources for preparedness and response over time.

Actions and Tools to Achieve Level 02 (Limited Capacity)

1 Conduct a stocktaking of current gender gaps in hiring, retention, advancement, representation, and pay.

Gender equity in staffing goes beyond measuring the sex ratio of current staff and includes identifying and addressing gender biases across the human resource spectrum: in hiring, retention, advancement, representation and pay.

Available tools: *(To view tools: Click on the name of a tool or scroll to GENHR tools)*

- ☒ **GENHR 01:** Illustrative questions for a stocktaking of gender inequity in staffing

2 Assess current human resource policies to identify gender biases in the workplace

HR policies and the work environment may, even inadvertently, create gender-specific barriers that inhibit one gender or the other, typically women, to apply to positions or to stay in a job, and thus need to be assessed. **GENHR 01** includes a menu of questions that can be used to document the potential ways in which current policies may discourage qualified women to apply and stay in a job in public health preparedness and response.

Available tools: *(To view tools: Click on the name of a tool or scroll to GENHR tools)*

- ☒ **GENHR 01 :** Illustrative questions for a stocktaking of gender inequity in staffing (Go to section on HR policies in **GENHR 01**)

3 Assess staff attitudes and beliefs about gender equity in the workplace.

Available tools: *(To view tools: Click on the name of a tool or scroll to GENHR tools)*

- ☒ **GENHR 02 :** Instrument to assess staff attitudes towards gender equity in the workplace

4 Assess staff attitudes and awareness of sexual harassment in the workplace

Available tools: *(To view tools: Click on the name of a tool or scroll to GENHR tools)*

- ☒ **GENHR 03 :** Questions to assess staff perceptions of sexual harassment and abuse

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 Ensure gender equity in human resource policies

Gender equity in human resources in the workplace means that human resource policies ensure “...that women and men have an equal chance of choosing to work in your preparedness and response project, developing the requisite skills and knowledge, being fairly paid, enjoying equal treatment and advancing in a career” (IntraHealth International Undated). The results of assessments conducted using questions in GENHR 01 and GENHR 02 can be used to do so, as follows:

- ▶ Make a list of all the identified gender gaps in human resource policies;
- ▶ Discuss with HR leadership the order in which to address identified gender gaps;
- ▶ Hire an HR specialist consultant (or use an existing one) to use the findings from the activities of Level 02 to develop an HR plan to address prioritized gaps;
- ▶ Institute a system to monitor gender-based disadvantage and efforts to address it in recruitment, retention, achievement, representation and pay.
 - Create a checklist with contextually relevant questions from GENHR 01 and GENHR 02 to monitor shifts in gender-based disadvantage and HR policies at regular intervals.

2 Integrate into HR processes regular monitoring of staff knowledge and attitudes towards sexual harassment in the workplace

Available tools: (To view tools: Click on the name of a tool or scroll to GENHR tools)

- ☒ **GENHR 03** : Questions to assess staff perceptions of sexual harassment and abuse

The same questions used in initial staff assessment can be used for repeat, regular monitoring of changes in staff knowledge and attitudes.

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are required.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are required.

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Gender Benchmark 3.2: Capacity Levels for Human Resources Training in Gender

CAPACITY LEVEL	<p>Gender Benchmark 3.2: The country's human resources for public health emergency preparedness and response and the effective implementation of the IHR are trained to understand the importance of gender for preparedness and response.</p> <p>Objectives:</p> <ul style="list-style-type: none"> To integrate an understanding of the role of gender in epidemics in staff training for human resources for health.¹
01 NO CAPACITY	The country's workforce training for public health emergency preparedness and response staffing does not pay attention to gender.
02 LIMITED CAPACITY	Systematic assessment has been conducted to identify existing gaps in training on the role of gender in preparedness and response.
03 DEVELOPED CAPACITY	Training on gender in preparedness and response is available and integrated into training for the country's workforce for public health emergency preparedness and response.
04 DEMONSTRATED CAPACITY	All staff engaged in any aspect of preparedness and response at the national level have received at least one in-depth training on gender in epidemics; Gender gaps in FETP participation are starting to narrow.
05 SUSTAINABLE CAPACITY	All staff engaged in any aspect of preparedness and response at all levels of the health system have received at least one in-depth training on gender in epidemics, and follow-up trainings have been integrated into staff training; There are no gender gaps in FETP participation at all levels of the program.

¹ Training includes in-service training, the field epidemiology training program (FETP) as well as curricula within schools of public health and other educational programs that train potential human resources for public health emergency preparedness and response.

Actions and Tools to Achieve Level 02 (Limited Capacity)

1 Assess current availability and quality of in-service gender trainings

Available tools: (To view tools: Click on the name of a tool or scroll to GENHR tools)

- ☒ **GENHR 04:** Guidance to assess availability and quality of gender training for workforce provides illustrative questions to assess (a) gender gaps in participation in training and (b) the types of training in which gender is integrated, including stand-alone or other technical trainings.

2 Assess current availability and use by current staff of gender training in public health university programs

Available tools: (To view tools: Click on the name of a tool or scroll to GENHR tools)

- ☒ **GENHR 04 :** Guidance to assess availability and quality of gender training for workforce (modified as needed to apply to public health training institutions)
- ☒ **GENHR 05 :** Illustrative questions to assess integration of gender in public health training institutions

3 Assess gender gaps in participation in FETP at all levels of the program

Available tools: (To view tools: Click on the name of a tool or scroll to GENHR tools)

- ☒ **GENHR 06 :** Illustrative Terms of Reference – Study on gender gaps in FELTP training

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 Develop training on gender in epidemics, either stand-alone and/or integrated into regular preparedness and response training

The guidance and tools to integrate gender into other core capacities, as laid out in other modules of GENPAR, can be used as training material on gender in specific capacities for epidemics. However, it is advisable to start with an introductory training on why gender in epidemics, the material for which is provided in this Module.

Available tools: (To view tools: Click on the name of a tool or scroll to GENHR tools)

- ☒ **GENHR 07 :** Material for introductory training on gender in epidemics

2 Finance and provide technical support to schools of public health to integrate gender into current epidemiology courses and/or develop new courses on gender in epidemics

3 Address identified gender gaps in FETP participation to increase gender equity in FETP training.

- ▶ Use the findings of **GENHR 05** to support scholars and other experts in schools of public health to integrate gender into current epidemiology courses and/or develop new courses on gender in epidemics.
- ▶ Strengthen new programs integrating gender by building collaborations with other schools of public health in Africa or externally that have a strong component of gender in their programming.
- ▶ Use the findings of the study resulting from the terms of reference in **GENHR 06** to develop, finance, and implement a national plan to incentivize gender-equitable nomination and participation in FETP training at all levels.

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are required.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are required.





Tools to integrate gender in human resources for preparedness and response

Tools for Gender Benchmark 3.1: Gender Equity of Human Resources

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Note: All tools can be modified to fit individual project or country requirements and context.

GENHR 01: Illustrative questions for a stocktaking of gender inequality in staffing

NOTE: Start with a record of current staffing by sex:

- ▶ Ask the respondent to provide information on current staffing for his or her department or ministry, disaggregated by gender.
- ▶ Make a copy of relevant information.
- ▶ Use the information collected to prepare the following tabulations and note where and what information is not available.
- ▶ Ministry of Health
 - ☐ Data disaggregated by sex across current positions, for example in top leadership, technical positions, managerial positions, logistics, field implementers, etc.
 - ☐ Data disaggregated by sex across current positions presented separately for: (i) national level; (ii) provincial level; (iii) district level; and, (iv) community level (if available).
 - ☐ Data disaggregated by sex, disaggregated by technical departments and position type.

Other Ministries engaged in preparation and response: same information as above.

Questions for **RECRUITMENT** and **RETENTION**:

- 1 What is the sex ratio across the recruitment pipeline, that is, in recruitment for positions at different levels of the hierarchy? *(Probe for details across positions and report as much detail as is available)*
- 2 What is the sex ratio of recruitment across levels, that is, at national, provincial, district and community levels? *(Probe for details across levels and report as much detail as is available)*
- 3 What is the sex ratio across the recruitment process, that is:
 - a Among people applying for a position?
 - b Among applicants being invited for an interview?
 - c Among interviewees advancing to the final round of a selection process?
 - d Among those hired?
- 4 Are there gender-specific proactive strategies implemented to recruit or promote into senior management positions? Can you provide examples?
- 5 In the last one year, what is the gender difference in resignation at each level of [institution's name] hierarchy? *[start with senior-most level and continue on to the junior levels; note the sex difference in resignation rate for each level before advancing to the next.]*

Note to researcher(s): use the information gathered to determine:

- ▶ Gender differences in resignation by level of hierarchy;
- ▶ Gender differences in resignation by level of implementation, that is, national, provincial, district and community;

Questions for **ADVANCEMENT**:

- 1 What is the sex ratio at each level of seniority?
 - a At national level?
 - b At provincial level?
 - c At district level?
 - d At community level?
- 2 Is there gender-equitable access to leadership and management training? If yes, how do you know? If not, why not?
- 3 Is access to career training and development opportunities gender-equitable? Is such gender-equitable access embedded into policies and procedures? Can you provide an example?

Questions for **REPRESENTATION**:

- 1 *[To the researcher(s)]:* Ask for lists of participants of meetings held in the last month by the implementing structure being assessed: what is the gender balance of participants at these events?
- 2 What is the sex ratio in senior leadership posts? *(if not already determined by the HR documentation collected at the start of the assessment)*

Questions for **PAY**:

- 1 Are consultants remunerated on a gender-equitable basis, using the same contractual criteria?
- 2 Are there transparent systems to ensure equal pay for all, regardless of gender, for the same work?
- 3 Do staff who do the same work receive the same pay, regardless of gender? That is, are systems to ensure equal pay, if they exist, enforced?

Questions for **HR POLICY**:

- 1 Are there formal protocols and reporting mechanisms in place that enable staff to make complaints and appeal for redress for any discrimination on the basis of gender?
- 2 Does the firm have childcare facilities on site? If yes, are they accessible and safe? How many staff use these services?
- 3 Do staff have paid maternity leave and benefits? If yes, for how long? Does the HR policy have a clause prohibiting dismissal for pregnant workers? If yes, is the policy respected?
- 4 Do staff have paid paternity leave and benefits? If yes, for how long?
- 5 Is staff encouraged to take advantage of maternity leave?
- 6 Is staff encouraged to take advantage of paternity leave?
- 7 Is there a childcare and dependent care leave policy?
- 8 Is there training of all staff in gender awareness and sensitization?
 - a If only available for some staff, who is not trained and why?
 - b Is repeat training available given staff turnover? How frequently?
- 9 Is there training of senior management and members of your Technical and Steering Committees toward institutionalizing gender equity in management?
 - a Is repeat training available given turnover? How frequently?

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Sources: Adapted from (Akina Mama wa Afrika 2020; ILO 2007; International Planned Parenthood Federation (IPPF) 2019; InterAction 2010)

GENHR 02: Instrument to assess staff attitudes towards gender equity in the workplace

NOTE: This instrument can also be used to review and monitor ongoing changes in staff attitudes towards gender equity in the workplace.

Instructions to the interviewer(s):

- ▶ It is preferable to hand the list of statements to the respondent so that he/she can fill it themselves. In case of respondents in the field with minimal literacy, the statements can be read out and the responses filled by the interviewer.
- ▶ Please prepare a top sheet with basic demographic and other relevant information of the respondent; this should remain confidential, and the respondent should be assured that his/her individual responses will not be connected to him/her. The information is solely for aggregate analysis. This sheet should include the following type of information:
 - ☐ Basic demographics: Age, sex, marital status, level of education;
 - ☐ When joined the participating government ministry or department;
 - ☐ Position in the participating government ministry or department;
 - ☐ Where the person is based;
 - ☐ Whether family is with the respondent in his/her place of work or in their home location;
 - ☐ Anything else the team considers pertinent.
- ▶ For scoring:
 - ☐ Add up and present scores separately for Part 1 and Part 2 below.
 - ☐ For Part 1: add up the scores - the higher the score, the more the person perceives that there is gender equity in staffing.
 - ☐ For Part 2: add up the scores - the higher the score, the more the person has a gender bias in their attitudes towards staffing.

Instructions by the interviewer to the respondent: *Please fill in the top sheet with some basic information. Then please score each statement below based on your level of agreement, as follows:*

1 = *Strongly disagree*

2 = *Disagree*

3 = *No opinion/don't know*

4 = *Agree*

5 = *Strongly agree*

STATEMENT	Score
PART 1: Respondent's perception of level of gender equality in the project	
Women and men are both represented in decision-making positions and roles	
All management/technical staff carry out field trips regardless of rank and sex	
Consultancy assignments (if they exist) are equally likely to be given to both men and women	
At headquarters, there a good gender balance in senior technical positions	
At the provincial level, there a good gender balance in management roles	
At the district level, there a good gender balance in management roles	
At the community level, there a good gender balance among staff managing implementation in the community	
The [project name] implements proactive strategies to ensure gender blind recruitment or promotion into senior technical positions	
The [project name] implements proactive strategies to ensure gender blind recruitment or promotion into senior management positions	
At headquarters, there is a good gender balance in senior management positions	
There is gender equity in access to all types of training	
The [project name] promotes teamwork, involving both men and women as equal partners	
The [project name] working environment has improved notably for women staff in the past year	
Gender issues in staffing are taken seriously and discussed openly in the project	
Women hired by our project/department think that the workplace is women-friendly	
I would be equally comfortable with a female boss as with a male one	
Men hired by our project/department think that the workplace is women-friendly	
PART 2: Respondent's own biases related to gender in the workplace	
It is better to hire men than women because men work longer hours and work harder than do women	
It is better to hire women than men because women work longer hours and work harder than do men	
In [project name] meetings tend to be dominated by male staff	
It is unfair to promote women more than men	
It is unfair to promote men more than women	
In [project name], male staff have a much easier time establishing personal and professional networks than do female staff	
I think women and men should not be paid the same amount at the same level because you can't rely on female staff – they may have to leave because of their husbands, children, or other family constraints whereas men do not do that	

Sources: Modified from (InterAction 2010; ILO 2007)

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GENHR 03: Questions to assess staff perceptions of sexual harassment and abuse

Instructions to person(s) developing a questionnaire using the questions below:

- ▶ These questions can be formatted into a quantitative questionnaire to be implemented by an interviewer, or as prompts for a qualitative assessment, or as a questionnaire to be self-administered by respondents (preferred option, if feasible).
- ▶ Please adapt, add, remove questions as needed to make the questionnaire pertinent and manageable for your project, consistent with your country's laws regarding gender-based violence and SEA/SH in the workplace.
- ▶ When developing the questionnaire for your project, please prepare a top sheet with basic demographic and other relevant information of the respondent; this should remain confidential and the respondent should be assured that his/her individual responses will not be connected to him/her. This sheet should include the following type of information:
 - ☐ Basic demographics: Age, sex, marital status, level of education;
 - ☐ When joined the participating government ministry or department;
 - ☐ Position in participating government ministry or department;
 - ☐ Where the person is based;
 - ☐ Whether family is with the respondent in his/her place of work or in their home village/city;
 - ☐ Anything else the team considers pertinent.

Questions

- 1 What do you understand by the term “sexual harassment in the workplace”? [Open-ended answer]
- 2 Do you agree or disagree with each of the following statements: [*Respond with: strongly agree, agree, no comment, disagree, strongly disagree*]:
 - a It is natural for men to comment on how their female colleagues dress at work
 - b It is acceptable for a service provider to demand sexual favors from another colleague in exchange for services
 - c It is acceptable for a service provider to demand sexual favors from a member of the recipient community in exchange for services
 - d If women want to work alongside men, they need to get used to the occasional inappropriate joke or comment
 - e People should not make comments or jokes that could be construed as sexual innuendos by their colleagues
 - f It is everyone's responsibility to create a safe working environment for all colleagues
 - g Women invite sexual innuendos by the way they dress at work

- h Women do not face sexual harassment at work because it is illegal
- i Women should accept comments as compliments and not over-react
- 3 Are you aware of a policy against sexual exploitation and abuse and sexual harassment (SEA/SH) in the workplace that applies to staff in this workplace?
 - a IF YES: Can you explain at least one provision of the policy? [*Open-ended answer*]
 - b What is the procedure to register a complaint of sexual harassment?
- 4 Do you know of any staff training on recognizing, preventing and addressing sexual harassment in the workplace that you can attend?
 - a IF YES: can you elaborate on at least one lesson or module that is included in this training that you think is valuable to create a safer and more gender-sensitive work environment in your project/ department? [*Open ended answer*]
- 5 Have you ever been to a staff training on recognizing, preventing, and addressing sexual harassment in the workplace as a member of the project?
 - a IF YES: what did you find most useful? What did you find least useful?
 - b IF NO: why not?
- 6 Do people in your work environment use inappropriate language, jokes and comments, or display images and materials that might make other staff uncomfortable?
- 7 Do people in your work environment exhibit and encourage gender-sensitive behavior, for example, intolerance of sexist language, jokes or comments?
 - a IF YES: Can you provide an example of such sensitivity?

Sources: Modified from (Akina Mama wa Afrika 2020; InterAction 2010)

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GENHR 04: Guidance to assess availability and quality of gender training for current preparedness and response workforce

The following steps can facilitate a systematic assessment of the existence and quality of past and current gender training available to the preparedness and response workforce at all levels.

Workforce training on-the-job

STEP 1: Identify person(s) responsible for organizing workforce trainings in each institution associated with the preparedness and response program for which this assessment is being conducted.

STEP 2: Conduct an interview with the person(s) identified to get the following information with which the table below can be completed:

Question to ask: *Please list all workforce training for preparedness and response conducted in this institution over the last 12 months?*

List all the trainings in the first column.

For each training mentioned, ask about and fill in the information for the remaining columns.

Name/title and of training	Was there a gender component? (Yes = 1, No = 0)	How many staff participated in the training?	How long was the training?	Is there a list of participants you can share?

STEP 3:

1 For all trainings that had a gender component and for which a list of participants is available, ask for the list of participants and summarize the following information for each training:

- ▶ Total number of participants, by sex;
 - ☐ Percent female of all participants;
- ▶ Names of institutions represented among participants (note each institution once);
 - ☐ Percent female of participants per participating institution;
- ▶ List of designations represented;
 - ☐ Percent female of participants from each designation.

STEP 4: Ask for the training terms of reference. Use all information gathered to analyze and report on the following:

- ▶ How many trainings in public health preparedness and response did the workforce undertake in the last 12 months?
- ▶ What was the focus of each of these trainings?
- ▶ Which of these trainings also incorporated attention to gender?
 - Where gender was incorporated, what was the focus? (For example, general training on gender in preparedness and response; gender in specific core capacities; gender norms and behavior in the workplace; gender norms and behavior in the communities targeted by the project; etc.)
- ▶ What was the nature of the gender disaggregation of staff that have attended these trainings?
 - Sex ratio of staff attending any trainings, regardless of subject-matter?
 - Sex ratio of staff attending trainings that incorporated gender?
 - Analyze gender differences in participation in trainings that incorporate gender and in trainings overall.
- ▶ What was the nature of the gender distribution of participants across institutions and designations?
 - Are some institutions more likely to have sent a gender-balanced team than others? Which ones? Why do you think this may have happened?
 - Are some institutions more likely to have sent women than men? Which ones? Men than women? Which ones?
 - Were women represented equally to men across designation? If not, where were the largest gender gaps (for example, among senior staff, junior staff, technical staff, non-technical staff, headquarters staff, field staff, depending on who attended)?

At what levels were there likely to be more female attendees than male?

At what levels were there likely to be more male attendees than female?

STEP 5: If feasible, hire a gender training expert as a consultant to assess the quality and impact of the gender aspects of training provided. This person can also be hired to undertake the assessments in STEPS 3 and 4.

- ▶ The consultant can conduct focus group discussions with participants of training that integrated gender and seek information on the following:
 - Was the training long enough, too long, too short? Why?
 - Was the subject matter of the training interesting, informative, and well presented by the training team/trainer?
 - What did you learn about gender in [subject matter of the training]?
 - How useful was this in your current job and why?
 - How did this training change the way you approach your work and why?
 - Should there be follow-up trainings such as this one?
 - Has there been any follow-up to support integration of what you learned into your day-to-day

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functioning? What kind of follow-up? Has it been useful?

- ☐ Any other questions the consultant can suggest.
- ▶ If pertinent and time-and-budget permitting, the consultant can also interview training organizers for each training that integrated gender to seek information on the following:
 - ☐ What was the motivation for integrating gender into [subject matter of the training in question]?
 - ☐ What is your expertise and background in gender? In gender in [subject matter of the training in question]?
 - ☐ What follow-up technical support is planned to help trainees integrate what they learned into their work?
 - ☐ What follow-up training is planned?

STEP 6: Incorporate all the information from prior steps to write an assessment of gender in workforce training (or have the consultant write up) and offer conclusions on:

- ▶ The adequacy and inadequacy of current incorporation of gender in workforce training for preparedness and response, either overall and/or for particular core capacities;
- ▶ The quality of the training that incorporates gender in preparedness and response;
- ▶ Adequacy or inadequacy of time and budget allocated to overall training and to training that integrates gender;
- ▶ The expertise of trainers for trainings that integrate gender;
- ▶ The representativeness (or lack thereof) by gender in participation in trainings, across designations, type of training, and participating institutions and implications about gender disadvantages in access to training;
- ▶ Any other conclusions that arise from the review;
- ▶ Recommendations to address gender gaps identified.

GENHR 05: Illustrative questions to assess integration of gender in public health training institutions

NOTE:

- ▶ This section focuses on public health training institutes whose students typically join the government health system.
- ▶ The questions below can be modified to fit the context as needed.
- ▶ The questions can be asked by an appropriate staff person of the preparedness and response program, or a consultant familiar with qualitative interview methods can be hired to conduct the interviews.
- ▶ The interviewer(s) need to be provided a list of schools of public health and other institutions.
- ▶ Potential respondent(s): Directors of institutions; directors of particular programs within an institution; HR directors.

Illustrative questions to assess whether gender is included in any courses/programs

- 1 Do programs/courses on epidemiology, One Health, primary health care, and other subjects that are deemed relevant to preparedness and response address gender aspects of preparedness and response?
 - a If yes, which programs and/or courses [make a list and ask for course catalogues]
 - b If no, why not? Are there plans to do so?
- 2 Do programs/courses on epidemiology, One Health, primary health care, and other subjects that are deemed relevant to preparedness and response include a specific focus on reaching the most vulnerable, including women and girls?
 - c If yes, which programs [make a list and ask for course catalogues]
 - d If no, why not? Are there plans to do so?
- 3 Is there fieldwork associated with degree programs or courses on epidemiology or other public health areas?
 - e If yes, does it include any focus on reaching vulnerable populations, especially women and girls, with health services, messaging or training, and an analysis of gender-based constraints and opportunities?
 - f If no, why not? Are there plans to do so?

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GENHR 06: Illustrative Terms of Reference – Study on gender gaps in FELTP training

Terms of Reference (ToR)

Consulting Services to conduct a Rapid Study to Investigate and Document Gender Gaps in participation in Field Epidemiology Training Program (FETP) and Field Epidemiology and Laboratory Training Program (FELTP), especially at higher levels.

[Name of Ministry].

Position: Consultancy to conduct a rapid study to investigate and document (a) reasons for gender gaps in participation in FETP and FELTP, especially at higher levels and (b) Recommendations to address identified reasons.

NOTE: This ToR is written for gender gaps in general. The language can be modified as relevant to pertain to understanding reasons for lower participation of women compared to men, or of men compared to women. (For example, the phrase “persons of the under-represented sex” can be replaced by “women” or “men” according to the situation.)

Introduction

A Field Epidemiology Training Program (FETP) is a competency-based, mentored workforce development program to improve the field epidemiology knowledge, skills, and competencies of Ministry of [NAME] workers enrolled in the program. The program blends training of the participants with service to the country. The FETP model is based on the premise that improving the epidemiologic skills of [Ministry name] staff improves the capacity of the [Ministry name] to prevent, detect, and respond to public health priority issues, and in turn can contribute to improving the health of the population. The current FETP approach includes three tiers to address the epidemiologic training needs at different levels of a country’s health system. These tiers are FETP-Frontline, FETP Intermediate, and FETP-Advanced. Each program uses the same training approach consistent with principles of adult education — no more than 25% program time in classroom workshops, interspersed with 75% of time learning “on the job” by conducting mentored [Ministry name]-relevant field activities. The table below provides a high-level comparison of competencies by FETP tier and competency domain.

Table 1. High-level comparison of competencies by FETP tier and competency domain

COMPETENCY DOMAIN	FETP-FRONTLINE	FETP-INTERMEDIATE	FETP-ADVANCED
Public Health Surveillance	Summarize surveillance data and monitor reporting from local sources	Summarize data from and evaluate surveillance systems	Summarize data from and implement improvements to surveillance systems
Field Investigation	Participate in epidemiologic field investigation	Conduct outbreak investigation using descriptive epidemiology	Conduct (lead) outbreak investigation using analytic epidemiology
Epidemiologic Methods	Summarize and interpret surveillance data	Design, conduct, analyze, and interpret data from descriptive epidemiologic studies	Design, conduct, analyze, and interpret data from analytic epidemiologic studies
Scientific Communication	Prepare timely surveillance reports for internal use	Produce epidemiologic reports for external distribution	Develop and deliver written and oral epidemiologic reports to an external audience

Program Goal - The goal of FETP is to use training to improve the [Ministry name]’s epidemiologic capacity, particularly at the district level.

Program Objectives - Through successful implementation of FETP, the [Ministry name] will achieve the following program objectives:

- ▶ Increase appreciation among public health workers for the role of data for monitoring the health of the community and for providing information for decision-making;
- ▶ Improve basic surveillance data collection and analysis, interpretation, and communication;
- ▶ Improve the quality and use of surveillance data for disease and outbreak detection;
- ▶ Improve the sharing and dissemination of health information; and
- ▶ Improve the capacity to investigate and respond to public health events of importance.

Key Elements of FETP

- ▶ The program is hosted by the [name of host institution].
- ▶ Two 1-week classroom workshops provide participants with the knowledge and tools necessary to conduct assigned job-relevant field activities.
- ▶ On-the-job field activities allow participants to apply public health surveillance skills, including creating a report with summary tables and charts of surveillance data; conducting monitoring and feedback visits at reporting sites, and investigating local cases and/or outbreaks of priority health conditions.
- ▶ Field activities are conducted with the support of a mentor, who is in regular contact with participants to provide feedback and guidance as needed for the successful completion of those activities.
- ▶ At the third (concluding) workshop, participants give oral presentations of one or more of their activities, sharing their findings with colleagues, FETP staff, and [Ministry name] officials.

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1 Background

To date, the FETP program has had lower participation of [enter less-represented gender], especially – but not only – at higher levels of training. In order to better understand and address this gender gap, the Government of [country name] intends to contract the services of a highly experienced Consultant to conduct a rapid study to investigate and document (a) reasons for gender gaps in FETP and FELTP participation, especially (but not only) at higher levels and (b) recommendations to address identified reasons.

2 Objective/Purpose of the Assignment

The objective of the TOR is to obtain the services of a qualified and experienced Consultant to conduct a rapid study to investigate and document (a) reasons for gender gaps in FETP and FELTP participation, especially (but not only) at higher levels and (b) recommendations to address identified reasons. Recommendations will be used to make [country name]’s selection of candidates for FETP and FELTP more gender-balanced. Thus, the focus of the work is:

- a Understand from those whose gender is less represented but who are eligible the constraints that inhibit them from undertaking the FETP/FELTP training.
- b Understand from providers of FETP/FELTP training and nominating institutions the constraints they visualize for the less-represented sex, as well as efforts they could take to address the constraints identified.
- c Provide recommendations for Government of [country name] to create an enabling environment and incentivize [the less represented gender] to participate in all levels of FETP/FELTP, especially advanced.

3 Scope of Work

The Consultancy will be delivered using a two-part approach.

- ▶ Desk Review: Desk review activities include scanning the literature and analyzing secondary data to provide the basis for comparing the findings of this study with others within the health and other social service sectors.
- ▶ Interviews of key informants, including potential eligible FETP/FELTP beneficiaries.

4 Duties and Responsibilities of the Consultant:

The consultant will be responsible for all aspects of the study, as described in – but not limited to – the steps below.

The consultant will identify potential, relevant respondents:

Eligible respondents:

- ▶ Determine the pool of potentially eligible persons of the under-represented sex who could apply to each level of FETP/FELTP, that is: the numbers of [the under-represented sex] at the high school/university level that is the required to be eligible to apply to each level of FETP/FELTP training;
- ▶ Persons of the under-represented sex in government organizations who are eligible to be nominated for particular levels of FETP/FELTP but have not been nominated and/or not participated;
- ▶ Persons of the under-represented sex who have participated in frontline and intermediate FETP/FELTP.

From this pool of eligible Persons of the under-represented sex, the consultant will recommend a sample that will include Persons of the under-represented sex with different levels of eligibility, from different geographic regions of the country, and at various levels of the nominating institutions.

Key person(s) in institutions associated with provision of FETP/FELTP training and selection of candidates who will be interviewed, as well as other relevant key person(s), such as:

- ▶ CDC in [country name]
- ▶ AFENET
- ▶ Local providers of frontline and intermediate FETP/FELTP
- ▶ The university that provides advanced FETP/FELTP training
- ▶ Ministries in charge of sponsoring candidates for FETP/FELTP training
- ▶ Male and female FETP/FELTP trainees or graduates
- ▶ Others to be identified by Government of [country name] and/or consultant
- ▶ (The exact institutions and/or persons associated with FETP/FELTP will need to be determined.)

The consultant will propose an appropriate study instrument for each group that should cover aspects such as – but not limited to – the following:

- ▶ *For potential candidates of the under-represented sex (those with required educational eligibility for each level but who have never applied to FETP/FELTP):* Their career goals in the field of epidemiology; their knowledge and awareness of the FETP/FELTP program; whether or not they would consider the FETP/FELTP as an important training for them and why or why not; what conditions would increase their interest and ability to participate (for each level of training); what conditions and situations would dissuade them from participating.
- ▶ *For potential trainees of the under-represented sex in government agencies eligible to be nominated for FETP/FELTP training for each level but not nominated to date:* Would they participate if nominated?
 - ☐ if yes, why they would want to participate, what constraints they would have to overcome to participate, benefits and problems they foresee in the program related to content, timing, location, structure, etc.;
 - ☐ if no, why they would not participate if nominated, what are the conditions under which they would participate.
- ▶ *For potential trainees of the under-represented sex in government agencies who were nominated for each level of FETP/FELTP but chose not to participate:* Why they did not participate; what conditions would have had to be met for them to have participated or to participate if nominated in future.
- ▶ *For trainees of the under-represented sex who have participated in frontline and intermediate FETP/FELTP:* Reasons for choosing to participate; any problems they had to overcome in order to participate; what they gained from participation; what did not work for them in terms of content, structure, timing, location, etc.; how the FETP/FELTP fits into their career plans, including how it has helped them in their current job; suggestions on how to increase participation of the under-represented sex.
- ▶ *For providers of training:* Their views on the reasons for limited participation of the under-represented sex, especially in higher levels of FETP/FELTP training; reactions to constraints identified by trainees of

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the under-represented sex and willingness to modify programs to address these constraints.

- ▶ *For government departments nominating trainees of the under-represented sex:* Explanation of the nomination process and eligibility requirements; reasons for not nominating more candidates from the under-represented sex; their understanding of why those nominated may not have participated; willingness to provide incentives, scholarships, etc. to increase the participation of potential candidates from the under-represented sex.

The consultant will be responsible for implementing the study, including:

- ▶ Provide a detailed timeline for study implementation, including all the steps of the study mentioned below;
- ▶ Propose which quantitative and/or qualitative methods are most suitable for each type of respondent, given the kind of group, access to individuals and institutions, and the information sought;
- ▶ Propose, for each type of respondent, a combination of in-person and digital or phone-based system of implementing the study taking into account the COVID situation if pertinent, and the limited time frame and budget of the study;
- ▶ Design the instruments, and implement the study;
- ▶ Clean and analyze the data;
- ▶ Produce an initial draft of a report that describes the results.

The consultant will engage with responsible [name of person(s) who will coordinate the study] for input at each of the above steps.

The consultant will then provide a final report that describes the results. This should include main findings on constraints, benefits, experiences, and recommendations from the respondents; the consultant can add her/his recommendations based on her/his understanding of the situation as well.

5 Deliverables

- ▶ Developed study instrument for each group that should cover various aspects of the study.
- ▶ An initial draft report describing the results of the study.
- ▶ A final report detailing the main findings on constraints, benefits, experiences, and recommendations from the respondents.

6 Payment Terms:

- ▶ **30%** of the total cost on presentation and acceptance of study instrument for each group; to be completed by [time frame determined for development of the study instrument].
- ▶ **50%** of the total cost on acceptance of the initial **draft report** describing the results of the study; to be completed by [time frame determined for development of the study instrument].
- ▶ **20%** of the total cost on acceptance of the **final report** detailing the main findings on constraints, benefits, experiences, and recommendations from the respondents; to be completed by [time frame determined for development of the study instrument].

7 Required Qualification and Experience

- ▶ At least a Master's degree in a social science or epidemiology-related field of study.
- ▶ Experience with quantitative and qualitative data collection, including identification of samples, designing questionnaires, conducting surveys, data cleaning and analysis.
- ▶ Experience with conducting virtual data collection using digital/phone tools.
- ▶ Familiarity with gender inequality and gender norms in [country in which study is being carried out] is preferred.
- ▶ Familiarity with FETP/FELTP programs is preferred.

8 Competencies

- ▶ Good writing skills in [country main language: English/French/Portuguese].
- ▶ Good communication skills in the field, especially to ask sensitive questions about gender-based constraints that respondents may face in being able to participate in training (e.g. for women these could be related to household responsibilities, spousal permission, etc.).
- ▶ Ability to deliver high quality products in a timely and cost-effective manner.

9 Duration of Consultancy: [Time frame determined for the study]

10 Duty Station: [To be determined by each country]

11 Reporting Requirements: [To be determined by each country]

12 Selection Criteria: [Procurement processes used for such a study]

13 Facilities to be provided by [those overseeing the study]: [whatever facilities are determined, such as office space, phone, computer, travel expenses, etc.]

GENHR 07: Material for introductory training on gender in epidemics

NOTE: This presentation is designed to be incorporated into other, regular training, or as the first presentation to be done in a specific, gender-related training. Slides can be modified, or different slides added, according to the needs and preferences of the project in question. Instructions to the presenter are in italics

SLIDE 1

Sex and gender dimensions in
infectious disease outbreak
surveillance

Country name and crest, as pertinent

TRAINER:

“Before starting our training on *[insert name of training]* we will discuss the importance of sex and gender in preparedness and response. This presentation is an introduction to the importance of sex and gender in infectious disease epidemics and its aim is to start the process of building our capacity to understand and address sex and gender in epidemics through REDISSE”

SLIDE 2

Questions covered in this presentation

- What is the difference between “sex” and “gender”?
- Why integrate sex and gender into preparedness and response?
- What is the WHO’s approach towards sex and gender in preparedness and response?
- What are the implications for your preparedness and response project?

TRAINER:

Introduce the slide: “We will discuss four questions today.”

Ask one random participant to read each question out loud

NOTE: Additional questions can be added as needed to relate these questions to the subject of the training; for example, in surveillance training an additional question could be: “What is the importance of sex and gender in surveillance?” Module 1 would provide material to answer such a question.

SLIDE 3

Q1. What is the difference between sex and gender?

TRAINER:

“Our first question is: What is the difference between sex and gender?”

Ask trainees to try to answer. Allow a maximum of 2-3 minutes for answers before proceeding. If trainees are very animated the trainer can allow a longer discussion moderated by her/him

SLIDE 4

Sex and Gender

« Sex differences » refer to the biological and physiological differences between men and women including:

- Differences in biology
 - Especially reproductive organs
- Differences in immune reactions

and that can cause gaps between men and women in:

- Infection and transmission risks
- Probability of survival/death
- Drug reactions
- Vaccine reactions
- Increased risks to pregnant women

All this influences differences in the biological and socio-economic experiences of women and men during an epidemic.

« Gender differences » refer to the roles, behaviours, activities and attributes that are socially prescribed to men and women, and that determine:

- Roles and responsibilities of women and men in the family and society
- Different health behaviours between men and women
- Gender gaps in access to resources, services, opportunities
- Gender gaps in the power to make life decisions, including one's own health

TRAINER:

Acknowledge the responses you have received

Have the trainees read, with one trainee reading each point, starting with « sex differences », followed by « gender differences » and finally the text in red at the bottom of the slide

Prompt the trainees for any thoughts; allow 2-3 minutes for open discussion or any reactions by trainees

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SLIDE 5

Q2. Why integrate sex and gender into preparedness and response?

Sex
(biological)

- Different biologies of women and men may influence their experiences of epidemics differently
- Pregnancy status can exacerbate the risks of certain diseases for pregnant women and/or the fetus (SARS, malaria, tuberculosis, Ebola)
- SO: The quality of surveillance, and of other aspects of preparedness and response, will be improved if gender, age and (if possible) pregnancy status are taken into account

Gender
(social)

- Gender biases can create inaccuracies in surveillance, even when data is disaggregated by sex
- If male contact tracers cannot reach women → women will be missed for preparedness and response activities
- If the staff at the health posts are all men and/or are not used to gathering information from women → women less likely to be counted or their information incorrect → inaccurate response activities
- If women have less access to health facilities than men → women not reached by services

TRAINER:

“These sex and gender differences can create major challenges for preparedness and response if not addressed.”

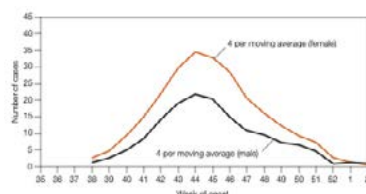
Ask the trainees to read, one trainee per point, starting with « Sex » (NOTE: invite trainees who were not involved to read in the previous slide)

« Now we will examine two examples of such dynamics in an epidemic »

SLIDE 6

Example #1: Epidemic curves disaggregated by sex : Outbreaks of Ebola Haemorrhagic Fever 2000-2001

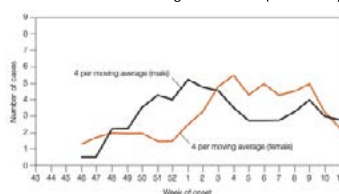
EHF outbreak in Gulu, Uganda (2000-2001)



Four-week moving average of number of cases by sex and week (n=404), Uganda, week 35, 2000 – week 2, 2001

Female cases > Male cases throughout the epidemic

EHF outbreak in the Congo and Gabon (2000-2001)



Four-week moving average of number of cases by sex and week (n=119), Gabon and Congo, week 43, 2001 – week 11, 2001

Male cases > Female cases at the start of the epidemic, but later reversed

Would not know if data were not collected and analyzed separately for men and women

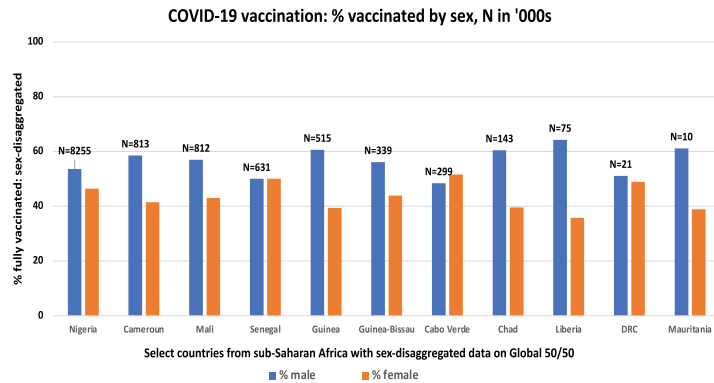
Source: Anker 2007, using unpublished data (2000-2001) from WHO Department of Communicable Disease Surveillance and Response

TRAINER:

“These are the epidemic curves for Ebola hemorrhagic fever in Uganda as well as in the Congo and Gabon. We see that the trends of the two epidemics of the same disease are varied, and differ in different ways by the sex of the cases. What is important is that it is possible to see these trends – and plan the response accordingly – only because surveillance officers had collected information on the gender of cases and had also done gender-disaggregated analysis and reporting. Knowing these patterns will allow for more targeted prevention and response activities that may not have been undertaken in the absence of this sex-disaggregated information.”

SLIDE 7

Example #2 : Gender differences in COVID-19 vaccinations in Africa



Source: Global 50/50, July 1, 2022 (<https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/>)

TRAINER:

“Here is a very different example, that of vaccination for the COVID-19 pandemic at the global level. The “N” in this graph refers to the total numbers who have been vaccinated. So, for example, Nigeria at the point at which this graph was constructed had vaccinated 8.2 million people.”

Ask participants to comment on the gender-specific patterns they see. Note down on a white board the patterns noted by participants. If not mentioned already, tell them in addition the three patterns below.

- ▶ DRC and Cabo Verde have more equitable sex ratios of vaccination than the other countries represented above even though they have vaccinated many fewer people than most of these countries.
- ▶ Nigeria has a less equitable sex ratio than Senegal even though Nigeria has vaccinated 13 times more people than has Senegal.
- ▶ Guinea-Bissau and Cabo Verde have vaccinated similar numbers of individuals but have very different sex ratios of vaccination.

Prompt the trainees for any thoughts on Slides 5 and 6; allow up to 5 minutes for open discussion or any reactions by trainees. Examples of questions to prompt discussion:

- ▶ What are your reactions to these patterns? Are these gender differences something you'd considered before when you thought about Ebola or COVID?
- ▶ Do you think it is important to do this kind of sex-disaggregated data collection and analysis in your surveillance system? Is it feasible?
- ▶ Would such data and analysis be helpful for staff like you in your work in the field? How?

Conclude with a summary of key points here: Thus, totals AND sex distribution of data must be examined together, or important details of patterns that are critical for accurate policymaking remain hidden.

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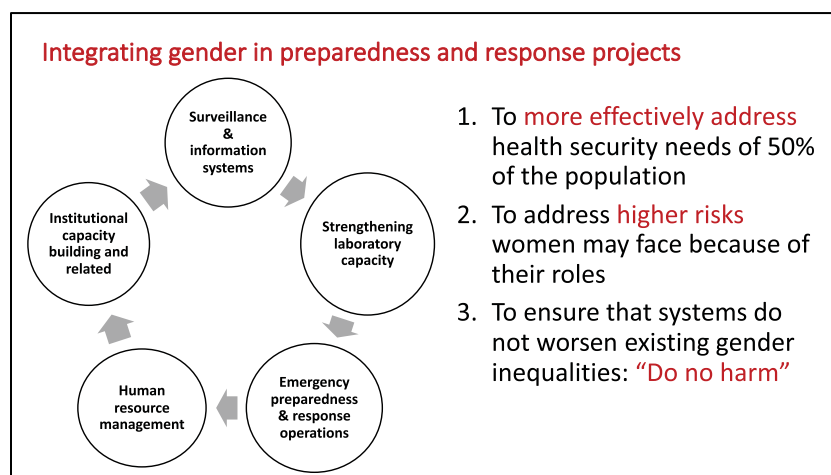
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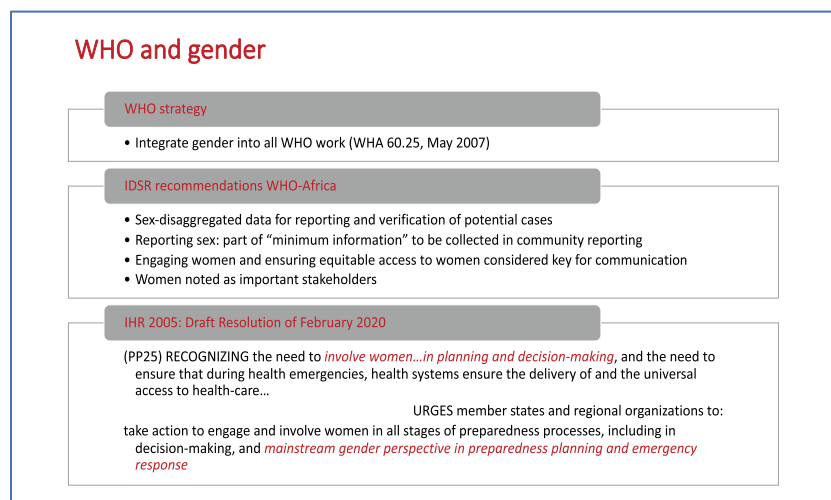
SLIDE 8



TRAINER: "These examples serve to illustrate why we need to integrate gender in preparedness and response. By integrating gender into preparedness and response, we achieve at least three important endpoints:

- First, most societies have gender-based and social-based norms that create some gender disadvantage, typically with women and girls being disadvantaged. By integrating gender, we are able to more effectively address the health security needs of those 50% of the population, that is, women and girls."
- Second, in most societies, gender differences in risk arise because of gendered roles and responsibilities. Thus, to effectively address and mitigate risks, health security projects **MUST** take gender-differentiation in risks and thus outcomes into account.
- Finally, at the very least, taking gender into account ensures that our interventions do not worsen existing gender inequalities, thus we ensure that we Do No Harm."

SLIDE 9



TRAINER: "The WHO, the key institution that provides technical guidance for preparedness and response recognizes that integrating gender is good practice that leads to better results.

WHO's strategy integrates gender into all their work.

- WHO-Africa's technical guidance for IDSR in Africa (3rd Edition) discusses collection and use of sex-disaggregated data to track infection, and better engagement of women in response systems
- Finally, a draft resolution put forth by some countries for IHR 2005 explicitly recommends a gender perspective to planning, decision-making and emergency preparedness and response"

SLIDE 10:

Gender Equality as a core capacity in the IHR		
Table 1: Gender Indicator in JEE (P1.2) and SPAR (C1.2)		
Level	P1.2. Gender equity and equality in health emergencies	Select level
Level 1	No systematic assessment of gender gaps in any of the IHR capacities has been conducted	
Level 2	Systematic assessment of gender gaps has been conducted in at least one IHR capacity	
Level 3	An action plan to address identified high priority gender gaps in at least one IHR capacity is developed and incorporated in annual workplans	
Level 4	The developed action plan(s) to address gender gaps in at least one IHR capacity is funded and being implemented, with mechanisms in place for monitoring, evaluation and reporting	
Level 5	Systematic gender analysis of IHR capacities is conducted, and action plans to address gender gaps and inequalities are developed, funded and operationalized in at least three IHR capacities, with mechanisms in place for monitoring, evaluation and reporting	
Source: (World Health Organization 2022), pp 8 and 9		

TRAINER: “Post-COVID, the WHO has further emphasized integration of gender in preparedness and response. In 2022, Gender Equality was added as a core capacity in the revised IHR, and a specific gender indicator was introduced in the 2022 revision of the JEE and SPAR.”

Ask one participant at random to read each of the levels of capacity for the indicator.

“We now come to the end of this introduction. As I noted at the start, this is an introduction to gender in emergency preparedness and response, to establish a basic understanding of the importance of sex and gender in epidemics. Tools and guidance are available to integrate sex and gender into our/your annual work plan activities under our/your preparedness and response project, and I encourage us/you to take this understanding forward and start to test ways to integrate gender to one or more core capacities we/you are trying to improve with our/your project.

“Any questions?”

Provide at least 5 minutes for final discussion, as needed. Close session.

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References

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Gender in Emergency Preparedness and Emergency Response Operations

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GOAL: Attention to gender dynamics is integrated into all aspects of public health emergency preparedness and response operations,¹³ including emergency management structures, risk and resource mapping, emergency preparedness and response planning, simulations, and after-action reviews.

Why integrate gender into emergency preparedness and emergency response operations?

Health structures form an important foundation for prevention, preparedness and response. These include: Public Health Emergency Management Committees (PHEMC), Public health Emergency Operations Centers (PHEOC), and Public Health Emergency Rapid Response Teams (PHERRT); the incident management system (IMS); and, public health emergency preparedness and response plan (PHEPR) management. Integrating attention to gender into these aspects of emergency preparedness and emergency response operations allows for actions and activities that consider how gender differentials may influence the course of a potential outbreak.



¹³ This Module provides two benchmarks, and associated tools, to integrate gender in the Emergency Preparedness and Emergency Response Operations core capacities of the IHR 2005 (World Health Organization 2019).

Gender Benchmark 4.1: Capacity Levels for Gender in Emergency Preparedness and Response Structures

CAPACITY LEVEL	<p>Gender Benchmark 4.1: Health emergency preparedness and response structures integrate gender</p> <p>Objectives:</p> <ul style="list-style-type: none"> To ensure that public health emergency preparedness and response structures have gender-balanced staff and teams. To ensure that gender is integrated into roles and responsibilities of staff in public health emergency preparedness and response structures.
01 NO CAPACITY	No consideration has been given to gender integration in developing or strengthening public health emergency preparedness and response structures.
02 LIMITED CAPACITY	Systematic assessment has been conducted to identify gender gaps in public health emergency preparedness and response structures at the national and sub-national levels.
03 DEVELOPED CAPACITY	Gender is integrated into the staffing and roles and responsibilities of public health emergency preparedness and response structures at the national level.
04 DEMONSTRATED CAPACITY	Gender is integrated into the staffing and roles and responsibilities of public health emergency preparedness and response structures at national levels, and at sub-national or intermediate levels in at least half of the areas of the country that are recognized as safely accessible.
05 SUSTAINABLE CAPACITY	Gender is integrated into the staffing and roles and responsibilities of public health emergency preparedness and response structures at all levels across all areas of the country recognized as safely accessible.

Public health emergency preparedness and response structures included here are: Public Health Emergency Operating Centers (PHEOC), Public Health Emergency Management Committees (PHEMC), and Public Health Emergency Rapid Response Teams (PHERRT).

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Actions and Tools to Achieve Level 02 (Limited Capacity)

1 An assessment has been conducted of the extent to which:

- ▶ Staffing at PHEOCs, PHEMCs, and PHERRTs is gender-inclusive, and
- ▶ Staff roles and responsibilities integrate attention to the role of gender in emergency preparedness and response

Available tools: *(To view tools: Click on the name of a tool or scroll to Annexes)*

- ▶ **GENPHEOC 01/GENPHRRT 01:** Illustrative terms of reference for a gender assessment of PHEOCs/ PHERRTs

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 PHEOCs, PHEMCs, and PHERRT staffing and roles and responsibilities are modified so as to integrate gender into their structures, functions, and roles and responsibilities at the national level

Available tools: *(To view tools: Click on the name of a tool or scroll to Annexes)*

- ▶ **GENPHEOC 02 :** Actions to integrate gender into PHEOCs
- ▶ **GENPHERRT 02 :** Actions to integrate gender into PHERRT roles and responsibilities

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are required.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are required.

Gender Benchmark 4.2: Capacity Levels for Gender in Public Health Emergency Functions

CAPACITY LEVEL	<p>Gender Benchmark 4.2: Select health emergency functions integrate gender Objectives:</p> <ul style="list-style-type: none"> • To integrate attention to gender in key management and readiness activities such as risk and resource mapping, emergency preparedness and response planning, and investigation and confirmation of suspected outbreaks • To develop simulation exercises that include attention to the role of gender in infectious disease outbreaks • To ensure that all after action reviews include a critical review of attention to gender
01 NO CAPACITY	No consideration has been given to gender integration in select health emergency management functions.
02 LIMITED CAPACITY	Systematic assessment has been conducted to identify gender gaps in select health emergency management functions at the national and sub-national levels.
03 DEVELOPED CAPACITY	Gender is integrated into select health emergency management functions at the national level.
04 DEMONSTRATED CAPACITY	Gender is integrated into select health emergency management functions at national and sub-national or intermediate levels.
05 SUSTAINABLE CAPACITY	Gender is integrated into select health emergency management functions at all levels.

ⁱSelect health emergency management functions refer to functions that are not covered in other modules of GENPAR. Thus, the functions included here exclude surveillance, laboratory, inclusion of RMNCAH in essential services, attention to GBV, and animal health.

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Actions and Tools for Level 02 (Limited Capacity)

1 Assess gaps in integrating gender in risk and resource mapping, emergency preparedness and response planning, and investigation and confirmation of suspected outbreaks

Available tools: *(To view tools: Click on the name of a tool or scroll to Annexes)*

- ▶ **GENFUNCTION 01** : Illustrative questions to assess integration of gender in select public health emergency management functions

2 Review simulation and after-action review (AAR) templates and plans to identify entry points to integrate gender

Available tools: *(To view tools: Click on the name of a tool or scroll to Tools)*

- ▶ **GENSIM 01** : Checklist to review potential entry points to integrate gender in simulation exercises
- ▶ **GENAAR 01** : Checklist to review potential entry points to integrate gender in AARs

Actions and Tools for Level 03 (Developed Capacity)

1 National-level risk and resource mapping and emergency preparedness and response planning integrate gender

Available tools: *(To view these tools from other Modules: Click on the name of a tool or return to the Table of Contents and go to the appropriate Module and its Tools)*

- ▶ Module 1 (Surveillance): **GENSURV 08**, **GENSURV 09**, **GENSURV 12**, and **GENSURV 13** provide insight into how to analyze surveillance data disaggregated by sex, age and pregnancy status to assess risk, if any of these characteristics of cases and deaths has been collected as part of routine surveillance.
- ▶ Module 3 (Human Resources): **GENHR 04** provides an illustrative assessment of training needs and availability on gender and **GENHR 07** provides an introductory training for gender in epidemics.
- ▶ Module 5 (Risk Communication): **GENRC 02** and **GENRC 03** provide insight for integrating gender in risk communication.

2 There exists at least one example of investigation and confirmation of suspected outbreaks integrating gender

Available tools: *(To view tools: Click on the name of a tool or scroll to Tools)*

- ▶ **GENFUNCTION 02** : Key actions to integrate gender in investigation and confirmation of suspected outbreaks

3 At least one national level simulation of any type has been conducted that integrates gender

Available tools: *(To view tools: Click on the name of a tool or scroll to Tools)*

- ▶ **GENSIM 02** : Guidance to integrate gender in key steps and stages of a simulation exercise
- ▶ **GENSIM 03** : Examples of gender integration in simulation scenarios and injects

4 At least one after-action review (AAR) has been undertaken and assesses attention to gender

Available tools: (To view tools: Click on the name of a tool or scroll to Tools)

- ▶ **GENAAR 02** : Guidance to integrate gender in key steps and stages of an AAR
- ▶ **GENAAR 03** : Examples of gender integration in trigger questions of AAR pillars

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are required.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are required.



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Tools for gender in public health emergency preparedness and response operations

Tools for Gender Benchmark 4.1

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Tools for Gender Benchmark 4.2

Tools to integrate gender into preparedness and response functions

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Tools to integrate gender into simulation exercises

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Tools to integrate gender into After Action Reviews

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GENPHEOC 01/GENPHERRT 01: Illustrative terms of reference for a gender assessment of PHEOCs/PHERRTs

Terms of Reference

Consulting Services to conduct an assessment of the integration of gender into the Public Health Emergency Operating Centers (PHEOC) and/or Public Health Emergency Rapid Response Teams (PHERRT) at all levels

[This TOR is written with the assumption that there is a PHEOC or PHERRT in place; the TOR can be revised to be pertinent for an assessment intended to feed into the development of a new PHEOC/PHERRT so as to integrate gender into the characteristics and functioning of these public health emergency management structures.]

1 Introduction

Gender inequality can interact with sex-differentiated risks of infection to result in different disease outcomes from an outbreak for men and women, boys and girls. In particular, the societal division of labor between men and women can place women at higher risk while at the same time constraining their access to services for and information about infectious disease outbreaks. Almost every task – whether it be in the household, labor market, farm, or livestock – is gendered in most societies. Each type of task carries different risks of infection and different implications for access to services and resources. For example, where women are primarily restricted to managing home and children and do not venture into the public space, they may have less exposure and thus less risk, but at the same time are likely to have less access to information, risk communication, community engagement and other aspects of preparedness and response. In another example, if men are responsible for wage work, they may have higher exposure to pathogens but also have greater access to sources of mass information, finances to seek care, and mobility to access services when needed.

The IDSR Technical Guidelines (3rd Edition) call for certain basic structures of preparedness and response to be in place, namely, a Public Health Emergency Operating Center (PHEOC) at least at the national level, Public Health Emergency Management Committees (PHEMC), and Public Health Emergency Rapid Response Teams (PHERRT), that use an incident management system (IMS) and develop a public health emergency preparedness and response plan (PHEPR) to address health emergency events.

Given the impact of gender on exposure, risk, infection, treatment and disease outcomes, the PHEMC, PHEOC, PHERRT and management and other plans that flow from these need to be structured in a way that allows gender-specific verification, confirmation and risk assessment, and, consequently, preparedness and response that takes into account whether, which, and how gender differentials may influence the course of a potential outbreak. This term of reference concerns an assessment of the extent to which gender is/can be integrated in PHEOCs and PHERRTs in [country name].

2 Background

[Country name] currently has [number of] PHEOCs and [number of] PHERRTs in [names of regions, sub-regions, national level]. However, these were developed without particular concern to:

- a the gender distribution of staff and experts, and
- b the integration of gender into the rules, responsibilities, and other agenda.

This gender assessment will provide information to address these gaps and strengthen these public health emer-

agency management structures.

3 Objective/Purpose of the Assignment

The purposes of this assignment are:

- a To undertake an assessment of the extent to which PHEOCs and PHERRTs have gender equity in their staffing;
- b To undertake an assessment of the extent to which the roles and responsibilities of these structures take into account the ways in which gender can modify exposure, risks, infection, treatment, and recovery from infectious disease epidemics;
- c To provide recommendations on strengthening the PHEOCs/PHERRTs by integrating gender into their structure and their functioning.

4 Scope of Work [to be amended as needed by the country program]

The Consultancy will be delivered using a two-part approach.

- ▶ Desk Review: Desk review activities include reviewing the charter or other documents that established the PHEOC/PHERRT for any gender-related language; obtaining a list of staff and their responsibilities; other documentation about the structure and roles and responsibilities of the institution to analyze attention to gender;
- ▶ Interviews of key informants.

5 Duties and Responsibilities of the Consultant

The consultant will be responsible for all aspects of the gender assessment, as described in – but not limited to – the steps below.

The consultant will identify and summarize relevant documents such as those listed in the section above.

The consultant will identify potential relevant key respondents for interviews. These could include [modify as appropriate]:

- ▶ The directors and staff of PHEOCs/PHERRTs;
- ▶ Ministry of health and other ministry departments that work with the PHEOCs/PHERRTs;
- ▶ At least one representative of the Ministry of [whichever ministry focuses on gender];
- ▶ Others as contextually relevant.

The consultant will select locations from which to select key respondents for interviews: This will entail that there are respondents from the national level PHEOC/PHERRT and, depending on the number of regional and

sub-regional structures, at least some representation from each region that has such a structure.

The consultant will propose appropriate study instruments that provide information such as, but not limited to, the following:

For PHEOCs:

- ▶ The structure of the team:
 - Is it multisectoral, consistent with the One Health approach?
 - Does the team include representatives from Ministries of the social sectors such as Gender/Women, education, and reproductive health?
- ▶ How does the PHEOC facilitate partner coordination and who are the identified response partners?
 - How many of the PHEOC's response partners include those most likely to work with vulnerable populations, including women? List their names.
 - Are there partners who work in areas such as broader health services, especially reproductive and sexual health and family planning; and also, gender-based violence and other sectors important for post-epidemic recovery such as education and jobs?
- ▶ How does the PHEOC facilitate communication between public health and emergency management personnel?
 - For example, do communication channels include those between PHEOC personnel, those in social ministries and other actors that monitor health and other potential effects of outbreaks?
- ▶ To what extent does the information system developed by the PHEOC integrate gender?
 - Is data on at least sex and pregnancy status – if not other gender aspects of individuals – collected?
 - Are analyses and reports sex- and pregnancy-status disaggregated?
 - Is the possibility of gender biases in data collection acknowledged and attempts made to mitigate it?
- ▶ To what extent and how is gender integrated in the PHEOC's task of monitoring events and developing plans and procedures?
 - Is all data used to track events sex- and pregnancy-disaggregated?
 - Are changes tracked in access to essential services during an outbreak, especially those that serve vulnerable populations, including women?
 - Has the PHEOC developed relationships with organizations (governmental and others) providing services for survivors of gender-based violence (GBV) so that they can be included to track any increases in GBV during an outbreak?
 - Do operational plans and procedures identify and try to address gendered patterns in epidemics?
- ▶ Do all information flows from the PHEOC incorporate trends, patterns and analysis by sex to ensure appropriate action targeted to the right populations?
- ▶ Have PHEOC members undergone any training on gender in epidemics in the last year? The last 2 years? (List name and duration of trainings)
- ▶ Do activities and training (including simulation exercises) during the inactive phase of the PHEOC continue to pay attention to gender? Provide examples.

For PHERRTs:

- ▶ Do community-level responsibilities such as verification of cases, sample collection, follow-ups, etc. take gender into account in the information that is collected?

- ☐ Do data include sex, age and (as feasible) pregnancy status?
- ☐ Are all cases and deaths disaggregated by these variables?
- ☐ Are gender norms taken into account in selection of field workers accessing populations across gender?
- ▶ To what extent is data collection, analysis, developing plans and strategies, writing investigation reports, monitoring and evaluation (M&E), and similar activities undertaken by the PHERRT disaggregated by sex, age and (as feasible) pregnancy status?
- ▶ To what extent do activities designed for infection prevention and control measures integrate gender? For example:
 - ☐ Are there consultations with in-country gender experts to identify key gender differentials in risks, exposure and disease outcomes that are likely to arise because of socially differentiated gender roles and responsibilities?
 - ☐ Do activities pay attention to identified gender differentials in mechanisms for, and implementation of, infection prevention and control measures?
 - ☐ Does the PHERRT coordinate activities with the Ministry of Health to ensure maintenance of essential services?
 - ☐ Does the PHERRT coordinate activities with providers of services to address the needs of survivors of GBV during an outbreak?
 - ☐ What measures are established to mitigate GBV in any quarantine protocols to be implemented?
- ▶ How does the PHERRT's risk communication system ensure that messaging and media are based on analysis of gender in risk communication, and that appropriate spokespersons are chosen so as to reach populations across gender?

The consultant will be responsible for implementing the study, including:

- ▶ Provide a detailed timeline for study implementation, including all the steps of the assessment mentioned above;
- ▶ Propose which quantitative and/or qualitative methods are most suitable;
- ▶ Identify and obtain consent and participation of key respondents;
- ▶ Propose a combination of in-person and digital or phone-based system of implementing the study taking into account any health or other ongoing emergencies, and any time, budgetary or human resource limitations;
- ▶ Design the instruments;
- ▶ Implement the study;
- ▶ Produce an initial draft of a report that describes the results and provides recommendations for improving the integration of gender in PHEOCs and/or PHERRTs, including a plan to increase representation across gender in staffing.

The consultant will engage with responsible [name of government unit or other person(s) who will coordinate the study] for suggestions and input at each of the above steps.

6 Deliverables

- ▶ Developed study instruments;

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- ▶ A list of key informants interviewed;
- ▶ An initial draft report describing the results of the study;
- ▶ A final report detailing:
 - The main findings on how to integrate gender into staffing and procedures of PHEOCs and/or PHERRTs in the country;
 - Recommendations for next steps at the national level, regional levels and sub-regional levels.

7 Payment Terms:

[to be added as per the country's system]

8 Required Qualification and Experience

- ▶ At least a Master's degree in a social science, gender, or epidemiology-related field of study
- ▶ Experience with quantitative and qualitative data collection, including identification of samples, designing questionnaires, conducting surveys, report writing
- ▶ Experience with conducting virtual data collection using digital/phone tools
- ▶ Familiarity with gender inequality and public health emergency management structures in [country name] is preferred
- ▶ Familiarity with regional languages and cultures is preferred.

9 Competencies

- ▶ Good writing skills in [country main language];
- ▶ Good communication skills, especially to ask sensitive questions on integrating gender;
- ▶ Ability to deliver high quality products in a timely and economical fashion.

10 Duration of Consultancy: [To be determined]

11 Duty Station: [To be determined by each country]

12 Reporting Requirements: [government department or other person(s) overseeing the assessment]

13 Selection Criteria: [Procurement processes used for such an assessment]

14 Facilities to be provided by [government department or person(s) overseeing the study]: [whatever facilities are determined, such as office space, phone, computer, travel expenses, etc.]

GENPHEOC 02: Actions to integrate gender into PHEOCs (active and inactive)

IDSR-RECOMMENDED PHEOC STRUCTURE AND FUNCTIONS	MODIFICATIONS TO CREATE GENDER RESPONSIVE STRUCTURE AND FUNCTIONS
<i>INTEGRATION OF SEX AND GENDER IN AN ACTIVE CENTER</i>	
Create a multisectoral team within a One Health approach	► In addition to others relevant to the One Health approach, ensure representatives from Ministries of the social sectors such as Gender/ Women, education, and reproductive health.
Facilitate coordination with multiple response partners	► Use this coordination role to ensure inclusion of governmental, donor, non-governmental, and other response partners such as those working in the following areas: broader health services, especially reproductive and sexual health and family planning; GBV; education; and jobs.
Improve communication between public health and emergency management personnel	► Improve communication also between these personnel and personnel in social ministries and other actors that monitor health and other potential effects of outbreaks.
Develop an information system to support informed decision-making	► Ensure that the information system collects, analyzes and reports on data that are sex- and pregnancy-status disaggregated and – where possible – also free of gender biases in collection (see Module 1 on Surveillance for several tools and guidance).
Monitor events using various sources of data	► Ensure that data from surveillance is sex- and pregnancy-disaggregated (see Module 1 on Surveillance for several tools and guidance); ► Include data from divisions of other health services to track gender variations in access to essential services, especially those that serve vulnerable populations; ► Forge connections pre-epidemic with organizations (governmental and others) providing services for survivors of gender-based violence (GBV) and use their information to track any increase in GBV during an epidemic (GEN-GBV-03 provides guidance on joint GBV-epidemic preparedness).
Develop plans and procedures for operations	► Use collected data and partnerships to identify and include plans and procedures to address gendered aspects of operations.
Help ensure the flow of information vertically and horizontally to relevant departments, ministries, partners	► Integrate any gender-differentiated patterns in the core information that is shared (such as reportable events, risky behaviors, etc.) so that information flows include any trends and patterns by gender to ensure appropriate action targeted to the right populations.

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IDSR-RECOMMENDED PHEOC STRUCTURE AND FUNCTIONS	MODIFICATIONS TO CREATE GENDER RESPONSIVE STRUCTURE AND FUNCTIONS
Develop trained human resources	<ul style="list-style-type: none"> ▶ Ensure adequate representation of women. ▶ Ensure that all personnel have basic gender training (GENHR 07 provides material) and seek resources for more advanced gender training as required based on roles and responsibilities.
INTEGRATION OF SEX AND GENDER WHEN A CENTER IS INACTIVE	
Continue routine liaison with relevant sections or departments to continue maintaining plans and procedures	<ul style="list-style-type: none"> ▶ Include social sector ministries that were critical during the last outbreak, such as: Women, reproductive health, immunization, other routine health services, education, etc. ▶ Ensure that plans and procedures continue to provide space for relevant gender-specific planning or procedures for future outbreaks.
Conduct training and simulation exercises	<ul style="list-style-type: none"> ▶ Include refresher gender training, incorporating elements from prior outbreaks and lessons learned therein. ▶ Include various gender-specific scenarios in simulation exercises (see GENSIM 02, GENSIM 03 and GENSIM 04).
Conduct routine and event-based surveillance activities	<ul style="list-style-type: none"> ▶ Use the tools in Module 1 (Surveillance) to maintain collection, analysis and reporting of data disaggregated by sex, age and pregnancy status in all surveillance. ▶ Use the tools in Module 1 (Surveillance) to continue to monitor potential gender biases in surveillance data collection.
Maintain a systematic database of resources available	<ul style="list-style-type: none"> ▶ Include in the database personnel and organizations within and outside the national government that address gendered impacts of epidemics such as GBV, education, livelihoods, etc.

Source: (WHO Regional Office for Africa 2019c)

GENPHERRT 02: Actions to integrate gender into PHERRT roles and responsibilities

ROLES AND RESPONSIBILITIES LISTED IN IDSR (3 RD EDITION)	EXAMPLES OF PERTINENT GENDER ASPECTS
Responsibilities that require visiting individuals: verification, sample collection, follow-ups, etc.	<ul style="list-style-type: none"> ▶ Maintain a record of the sex of individuals visited and monitor it regularly so as to ensure equal attention to women and men; ▶ If social norms require it, ensure that female team members visit women and male team members visit men¹; ▶ Ensure that resultant notes are disaggregated by sex, age, and – if possible – pregnancy status for women of reproductive age.
Responsibilities related to data collection, analysis, developing plans and strategies, writing investigation reports, monitoring and evaluation (M&E), and similar activities	<ul style="list-style-type: none"> ▶ Ensure disaggregation by sex, age, and – if possible – pregnancy status for women of reproductive age in: ▶ all data gathered by the RRT; ▶ all surveillance and laboratory data being used; ▶ All analyses, reporting, and M&E.
Activities related to laying out mechanisms for, and implementing, infection prevention and control measures	<ul style="list-style-type: none"> ▶ Include consultation with in-country gender experts to identify key gender differentials in risks, exposure and disease outcomes that are likely to arise because of socially differentiated gender roles and responsibilities; ▶ Include attention to identified gender differentials in mechanisms for, and implementation of, infection prevention and control measures; ▶ Coordinate with Ministry of Health to ensure maintenance of essential services;² ▶ Coordinate with providers of services to address the needs of survivors of GBV;² ▶ Include measures to mitigate GBV in any quarantine protocols to be implemented.²
Establishment of a Risk Communication System	<ul style="list-style-type: none"> ▶ Ensure that messaging and media used for risk communication are based on analysis of gender in risk communication, and that appropriate spokespersons are chosen, so as to ensure reach to both women and men.²

Notes:

1 GENSURV 02 in the Surveillance Module provides a checklist that can help identify which social gender norms are contextually appropriate

2 See Module 5, Module 7 and Module 8 for tools and guidance for gender in risk communication, maintenance of essential services, and GBV, respectively.

Source: (WHO Regional Office for Africa 2019c)

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GENFUNCTION 01: Illustrative questions to assess integration of gender in select management functions

Note: these questions can be modified for use in quantitative and/or qualitative assessments

Illustrative questions for gender in risk and resource mapping

- 1 Is the recording of populations identified as being at risk disaggregated by sex? *(Yes/No)*
- 2 Is the recording of populations identified as being at risk disaggregated by age? *(Yes/No; if yes, ask what definition of age groups is used)*
- 3 Is the recording of women between the ages of 15-49 years who have been identified as being at risk disaggregated by pregnancy status? *(Yes/No; if yes, ask what type of disaggregation is used: "whether pregnant, yes/no" or other?)*
- 4 Is women's role as potential resources during an outbreak recognized in risk and resource mapping? *(Yes/No)*

If Yes: probe for how women are tapped as potential resources, for example:

- ▶ Are women identified as being among community-based focal persons or resource persons?
- ▶ Are women's groups engaged as partners in risk communication, community engagement, and other community-based aspects of preparedness and response?
- ▶ Are female herders and livestock owners and carers who have been trained in animal health aspects of outbreaks identified as potential community-based communicators?
- ▶ Other.

Illustrative questions for emergency preparedness planning

- 1 Do risk assessments conducted as part of emergency preparedness planning incorporate gender differences in risks so that the resultant plan can address these differences? *(Yes/No)*
- 2 Do estimates of the population at risk for epidemic-prone infectious diseases provided in plans disaggregate patterns by sex? By age? By pregnancy status for women of reproductive age? *(Yes/No for each)*
- 3 Are data used for planning disaggregated if the risk assessment indicates that risks vary by these parameters? *(Yes/No; if No, ask why estimates are not disaggregated even if the risk assessment suggests they should be)*
- 4 Do training needs and plans identified as part of the emergency preparedness planning include training on gender and epidemics? *(Yes/No; if Yes probe for examples of training; if No, ask why not)*
- 5 Are risk communication procedures and plans structured so as to segment audiences, messages, and

media used by different genders? (Yes/No; if Yes, ask for some examples)

Illustrative questions for outbreak investigation and confirmation

- 1 When deciding on the area in which an investigation will take place, does the essential engagement with affected communities to understand local cultures, customs and routines include understanding gender-specific roles and responsibilities? (Yes/No)
- 2 Do teams for outbreak investigation and confirmation include persons across gender? (Yes/No; if Yes, ask about the size of teams, and numbers of people by gender in each team; If No, ask why)
- 3 Do case investigation forms include space to note sex of each case? Age? Pregnancy status for cases that are women 15-49 years of age? (Yes/No for each of these)
- 4 Do clinical history and epidemiology forms include space to note sex of each case? Age? Pregnancy status for cases that are women 15-49 years of age? (Yes/No for each of these)
- 5 Do laboratory results of identified cases report the sex of each case? Age? Pregnancy status for cases that are women 15-49 years of age? (Yes/No for each of these)
- 6 Do isolation protocols – in case isolation is to be instituted – include protocols to avoid gender-based violence or sexual harassment in institutional isolation situations? (Yes/No; if Yes, ask for examples of such protocols. if No, ask if the respondent thinks this is important to do, why or why not)

Are sex, age, and pregnancy status included in:

- Analysis and interpretation of data about an outbreak? (Yes/No, separately for inclusion of sex, age and pregnancy status)
- All situation reports (SitReps) prepared for the outbreak? (Yes/No, separately for inclusion of sex, age, and pregnancy status)

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GENSIM 01: Checklist for potential entry points to integrate gender in simulation exercises

POTENTIAL ENTRY POINT	GENDER INTEGRATION CHECK	Y	N
Background context	Does the context provided as background to the exercise include a description of gender norms, roles and responsibilities that can differentially influence men's and women's risks, exposure, access to services, or outcomes?		
Partnership and commitments	Do potential partners include the Ministry of Gender?		
	Do potential partners include ministries dealing with human capital, such as education and jobs?		
	Do potential partners include civil society and/or other experts on gender, including gender-based violence?		
Purpose, scope and objectives	Does the defined purpose include evaluating and/or validating whether mechanisms of preparedness and response take into account gender-specific needs of preparedness and response?		
	Does the scope include integrating gender in preparedness and response mechanisms?		
	Are there gender-specific objectives?		
Scenario	Is the scenario built incorporating gender differences in risks, exposure, infection and outcomes?		
Operations and functions tested ¹	Are all data related to operations and functions tested disaggregated by sex (Examples include: sex-disaggregated analysis and interpretation; sex-disaggregated reporting; contact listing by sex)? By age? By pregnancy status where appropriate, if feasible?		
	Do operations and functions designed for the simulation integrate gender (Examples include: mixed-gender teams for contact tracing if culturally preferred; audiences segmented by sex for risk communication, etc.)?		
Key reference documents	Do key documents provided to simulation participants include those that detail gender norms and guidance on integrating gender in preparedness?		
Methodology	Does the overview of the methodology provided to simulation participants include a description of integrating sex and gender into the simulation?		
Teams	Do the various teams reflect an acceptable ² level of diversity across gender (that is, the exercise management team, support team, observers)?		
Project monitoring, evaluation and reporting	Does the overview of the report's main elements include integration of gender (Examples include sex-disaggregation of all data, attention to gender-specific risks, etc.)?		
	Does the list of participants include the sex of each participant? (to evaluate the gender diversity in participation)		
Scenarios	Are scenarios created to include gender differences in risks, exposure, behaviors, infection, access and use of treatment, and/or outcomes?		
Injects	Do at least half of all injects integrate gender?		

Notes:

¹This entry point is relevant only in case of a field/full-scale exercise, and is not relevant for a table top exercise

²"Acceptable" can be determined based on the feasibility of gender representativeness in teams based on the level of capacity and training across gender, as well as the current staffing of institutions from which teams are drawn.

Source: Potential entry points are drawn from sections in Template FSX-01 in (WHO 2017), section 7.5

GENAAR 01: Checklist to review potential entry points to integrate gender in AARs

AAR PILLAR	GENDER INTEGRATION CHECK	Y	N
Case management	Does AAR include an assessment of how effectively gender dimensions of access, treatment, or risks of death from disease were handled?		
Infection prevention and control (IPC)	Did the AAR of this pillar take into account how gender aspects of the following were incorporated and addressed:		
	Gender differences in IPC beliefs, behaviors, and access to messaging and other resources?		
	Any gaps in effectiveness of IPC measures in accessing men and women equally effectively?		
	Inclusion of actors or institutions with gender expertise as part of IPC?		
	Measures to ensure that IPC actions do not unexpectedly exacerbate gender-based violence of any kind?		
	Extent to which staff across gender and position in IPC had access to well-fitted personal protective equipment?		
Coordination	Did the AAR assess whether each aspect of coordination integrated gender?		
Logistics	Did the AAR for logistics include attention to whether logistical plans included maintaining supply chains for essential health services for women and children during the outbreak?		
Surveillance	Did the AAR of surveillance incorporate the extent to which data collection, recording, analysis and reporting was disaggregated by sex, age and (if feasible) pregnancy status?		
	Did the AAR of surveillance investigate any gender-specific barriers experienced during contact tracing and how these were resolved?		
Laboratory	Did the AAR of laboratory data include the extent to which these samples and results were disaggregated by sex, age and (if feasible) pregnancy status?		
	Did the AAR of laboratory functioning include an assessment of attention paid by laboratories to ensure gender-equitable access to their services?		
Vector surveillance and control	Did the AAR of vector surveillance and control incorporate the extent to which this pillar included the engagement of female livestock owners or caretakers?		
Communication and community engagement	Did the AAR of communication and community engagement take into account how the following gender aspects were incorporated and addressed:		
	Audience segmentation in developing risk communication that segmented by gender?		
	Engagement of female leaders as part of community engagement?		
	Explicit inclusion of women in trust-building exercises?		
	Explicit attention to structuring community feedback to encourage feedback across gender?		
	Sex-disaggregation of all analyses of the effectiveness in reach of communication messaging?		

Source: AAR pillars are drawn from (WHO 2019), annex 8

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GENFUNCTION 02: Checklist of actions to integrate gender in investigation and confirmation of suspected outbreaks

NOTE: Use this Tool to: Understand and put in place key actions that will allow you to integrate gender into the process of investigation and confirmation of suspected outbreaks following the steps laid out in the IDSR (3rd Edition) Technical Guidelines; and, Determine which key steps currently do not integrate attention to gender and take action to modify them accordingly.

KEY ACTIONS AND CHECKLIST TO INTEGRATE ATTENTION TO GENDER IN INVESTIGATION AND CONFIRMATION OF SUSPECTED OUTBREAKS	Y	N	ACTIONS TO TAKE IF ANY RESPONSE IS “NO”
STEP 1: Engage with the affected communities to understand local cultures, customs and routines when deciding on the area in which an investigation will take place			
► Definitions of “local cultures and customs” used to guide initial investigation in a community include local gender norms			► Revise all community descriptions to include local gender norms, roles and responsibilities (information can typically be accessed from key informants and/or literature); ► Reform the community engagement team to include people across gender; ► Seek out key informants or community leaders to identify female community members and include them as part of the community assessment.
► Description of “routines” to be taken into account in organizing initial investigation include gender-specific responsibilities in home, community, livestock, and agricultural practices			
► The team for community engagement includes people across gender			
► With the help of community leaders, as appropriate to the context, trusted female community members have been included among those selected to assist with community engagement in the investigation			
STEP 2: Develop case investigation forms			
► Case investigation forms collect information on sex			► Develop or modify case investigation forms to record information sex, age, and – where relevant – whether pregnant for cases that are women 15-49 years of age
► Case investigation forms collect information on age			
► Case investigation forms collect information on whether pregnant (for women between 15-49 years of age			
STEP 3: Review clinical history and epidemiology of identified patients above the determined threshold			
► The clinical history and epidemiology data, and its analysis, takes into account each patient’s sex			► Request from the sources of clinical history and epidemiology all available data on sex, age, and – where relevant – whether pregnant (for cases of women 15-49 years of age). ► If the source(s) did not collect this information, revise forms so that future clinical history and epidemiology collects and incorporates this information in reports.
► Clinical history and epidemiology include the age of identified patients above the determined threshold, in age groups as relevant for the context			
► Clinical history and epidemiology includes the pregnancy status (whether pregnant) of identified female patients between 15-49 years of age who are above the determined threshold			

KEY ACTIONS AND CHECKLIST TO INTEGRATE ATTENTION TO GENDER IN INVESTIGATION AND CONFIRMATION OF SUSPECTED OUTBREAKS	Y	N	ACTIONS TO TAKE IF ANY RESPONSE IS “NO”
STEP 4: Review laboratory results			
▶ Laboratory results include results disaggregated by sex			▶ Request from source(s) of laboratory results all additional information on sex, age, and – where relevant – whether pregnant for cases that are women 15-49 years of age. ▶ If the source(s) did not collect this information, revise forms so that future laboratory results forms collect and report this information.
▶ Laboratory results include age-disaggregated findings			
▶ Laboratory results include findings disaggregated by pregnancy status for female patients 15-49 years of age			
STEP 5: Isolate cases if necessary			
▶ Isolation and quarantine protocols take precautions to avoid gender-based violence			▶ Review GEN-GBV 02 for an assessment tool for attention to women’s safety under quarantine ▶ Take possible actions given the context to provide separate, functional toilets for women or use a different isolation center ▶ Purchase feminine hygiene products to keep in isolation centers
▶ In any institutional isolation for families, there are separate, functional toilets for women			
▶ In any institutional isolation, feminine hygiene materials are provided for women			
STEP 6: Search for and record information on additional suspected cases and deaths			
▶ Information recorded on additional suspected cases allows for disaggregation of cases by sex			Develop or modify forms to record information on additional suspected cases and deaths to include space to record sex, age, and – where relevant – whether pregnant for cases or deaths that are women 15-49 years of age.
▶ Information recorded on additional suspected cases allows for disaggregation of cases by age			
▶ Information recorded on additional suspected cases allows for disaggregation of female cases between the ages of 15-49 years by pregnancy status (whether pregnant)			
▶ Information recorded on additional deaths allows for disaggregation of cases by sex			
▶ Information recorded on additional deaths allows for disaggregation of cases by age			
▶ Information recorded on additional deaths allows for disaggregation of female cases between the ages of 15-49 years by pregnancy status (whether pregnant)			

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KEY ACTIONS AND CHECKLIST TO INTEGRATE ATTENTION TO GENDER IN INVESTIGATION AND CONFIRMATION OF SUSPECTED OUTBREAKS	Y	N	ACTIONS TO TAKE IF ANY RESPONSE IS “NO”
STEP 7: Analyze and interpret data about the outbreak			
► Methods of analysis and interpretation about the outbreak allow for sex-disaggregation ¹⁴			► Modify methods to allow for disaggregation of analysis and interpretation by sex, age and (where relevant) pregnancy status ► If data on sex, age and pregnancy status were not collected, put in place systems that will ensure the collection of these characteristics for all cases and deaths in the future
► Methods of analysis and interpretation about the outbreak allow for age-disaggregation			
► Methods of analysis and interpretation about the outbreak allow for disaggregation by pregnancy status (whether pregnant) for women 15-49 years of age			
STEP 8: Prepare situation reports (SitRep), transmission trees and other documentation to report on the investigation and its conclusions			
► SitReps include sex-disaggregated data and analysis OR explanations of why such disaggregation is not possible or appropriate			► Conduct additional analyses as needed to ensure that SitReps, transmission trees and all other documentation disaggregates findings by sex, age, and (where relevant) pregnancy status. ► Integrate gender-specific patterns and conclusions in the reports ► If data do not exist in this investigation for full disaggregation, ensure that forms etc. are modified so that subsequent investigations incorporate disaggregated analysis.
► SitReps include age-disaggregated data and analysis OR explanations of why such disaggregation is not possible or appropriate			
► SitReps include pregnancy-disaggregated data and analysis for women 15-49 years of age OR explanations of why such disaggregation is not possible or appropriate			
► Sex, age and pregnancy status are included in transmission trees			
► Conclusions include discussion of whether and what types of sex-, age- or pregnancy-specific patterns exist			
► Conclusions identify gender norms or gender-specific behaviors that may have increased risks or acted as protective behaviors, where relevant.			

Source: adapted from (WHO Regional Office for Africa 2019c)

¹⁴ See GENSURV 09 in Surveillance Module for examples of sex-disaggregated analyses

GENSIM 02: Integration of gender in key steps and stages of a simulation exercise

STEP/STAGE OF A SIMULATION EXERCISE	HOW TO INTEGRATE GENDER
DEVELOPING	
Defining purpose, scope, objectives	<p>Incorporate attention to gender in the initial definition of the purpose, scope and objectives, for example:</p> <ul style="list-style-type: none"> ▶ Regardless of which function of preparedness and response forms the purpose of a simulation, include in the objectives ensuring that the actions or operations being tested reach and address the needs of the most vulnerable, especially rural women and girls; ▶ Add sub-objectives such as: ▶ Ensuring maintenance of reproductive and maternal health during an active epidemic as part of essential services; ▶ Monitoring GBV, and collaborating with partners in preventing and responding to reports of GBV during isolation or quarantine; ▶ Other additional gender-specific aspects of emergency preparedness and response that are relevant for the main objective of the exercise.
PLANNING	
Exercise needs assessment	<ul style="list-style-type: none"> ▶ In the Risk Assessment, highlight the risks to the most vulnerable populations, including gender-differentiated risks, and the need to reach them adequately and in a timely fashion with preparedness and response measures; ▶ Use the needs assessment to also assess whether the system, plans and/or training level in place is adequate and appropriate to reach the most vulnerable, across gender.
Building the exercise management team	<ul style="list-style-type: none"> ▶ Include expertise on gender in the exercise management team.
Selecting exercise participants	<ul style="list-style-type: none"> ▶ Ensure equal gender representation among exercise participants.
Defining the evaluation strategy and methodology	<ul style="list-style-type: none"> ▶ Develop indicators to evaluate attention to relevant gender dimensions of the problem or disease that is the focus of the simulation; ▶ Define sex- and age-disaggregated indicators where feasible; ▶ Include indicators to gauge success in reaching pregnant women if the simulation focuses on a disease in which pregnancy may be a risk factor for worse outcomes (for example, Ebola Viral Disease).
Media, public relations, and communication strategy	<p>Ensure that all media and related strategies incorporate relevant gender dimensions in order to highlight the importance of integrating gender into preparedness and response; and to prevent any cultural clashes or misunderstandings in the community during a full-fledged field simulation.</p>

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STEP/STAGE OF A SIMULATION EXERCISE	HOW TO INTEGRATE GENDER
MATERIAL DEVELOPMENT	
Context research	Ensure that the context research includes research on gender norms and gender-specific roles, responsibilities, access to finances and other aspects of daily life that can create gender differences in risk, patterns of disease, and/or access to care for the disease(s) included in the simulation.
Develop evaluation material	Integrate sex- and age-disaggregated indicators for the evaluation, as well as indicators to disaggregate by pregnancy status for women 15-49 years, if feasible.
Backstory, scenario, or master scenario	Include specific gender-related events or situations in the back story or master scenario. Examples are provided in GENSIM 04.
Write injects	Ensure at least some injects address gender-related issues or concerns. Examples are provided in GENSIM 04.
CONDUCTING THE SIMULATION EXERCISE	
Capture outcomes	Ensure that outcomes to be captured are disaggregated by age, sex, and (if feasible) pregnancy status, where relevant. (See Module 1 for examples of sex- and age-specific outcomes.)
Capture the discussions during the exercise	Ensure (by including gender dimensions in the scenarios and injects, and by prompting participants as needed) that discussions include analyses of efforts to address gender dimensions.
POST-EXERCISE	
All debriefing and reports	Include experiences, lessons learned, gaps etc. related to the gender aspects of the simulation in all debriefing and reports.

Source: Adapted from steps in a simulation exercise in (WHO 2017)

GENSIM 04: Examples of gender-specific simulation scenarios and injects¹⁵

As the National Surveillance Director at the Ministry of Health of [NAME OF COUNTRY], you are receiving a call from the Regional Health Director for [NAME OF REGION], which is adjacent to the capital, reporting haemorrhagic cases.

The RRT reports seven (7) probable cases of a haemorrhagic syndrome, of which two (2) are deceased at [NAME OF HOSPITAL], in two (2) different districts of [NAME OF REGION]. Five (5) of the cases thus far are women. Both deaths are to women. No case is confirmed for anything other than the haemorrhagic virus. Blood tests have been sent for five (5) of the seven (7) cases, of which four (4) are male and one (1) is a female case. No confirmation has been received until now. One of the deceased is a female healthcare worker.

The RRT reports that prevention and control measures in [NAME OF HOSPITAL] are deficient because of lack of equipment and training, there are no facilities for pregnant and lactating women, and many healthcare workers are refusing to come to work.

The RRT reports also one (1) female case of haemorrhagic fever admitted to [NAME OF HOSPITAL] in [NAME OF REGION] four (4) months ago. Ebola Virus Disease was confirmed by the reference laboratory. 37 contacts were identified and followed, of which twelve (12) were men and the remaining twenty-five (25) were women. All of them had developed symptoms 12 days after their last exposure. The [NAME OF REGION] has already created institutional isolation areas and the thirty-seven (37) contacts have been housed there.

After discussion with the Health Minister [SIMULATED], you decide to convene the Emergency Operating Centre (EOC) at 08:00 for the following day [SIMULATED WITH THE COLLABORATION OF THE NATIONAL SURVEILLANCE DIRECTOR].

At 08:00 the following day, the radio is reporting an epidemic in [NAME OF HOSPITAL] in [NAME OF REGION] [INJECT 02 – PRESENTED AS AUDIO]. The coverage is alarming, emphasizing the deaths to pregnant women, confirming Ebola, and blaming the hospital and Ministry of Health for negligence. It is requesting the closure of the hospital on the grounds of negligence.

At the same time at the [NAME OF HOSPITAL], one case remains hospitalized. The family is alarmed and requests a meeting with the chief doctor. One of the patient's brothers has begun a fever that morning. The family has been listening to the radio and are convinced it is Ebola.

Examples of gender-specific injects for an epidemic of Ebola Virus Disease

- Inject #1: There is a report that one of the men housed in the isolation center attempted to sexually assault one of the women.
- Inject #2: The [NAME OF HOSPITAL] in [NAME OF REGION] reveals that 10 of the 25 female contacts are pregnant and are now infected with Ebola. This poses great danger to their pregnancies.
- Inject #3: Extra efforts will need to be identified to ensure that maternity wards remain open in district-level health centers in [NAME OF REGION]

Source: Adapted from examples in (WHO 2017)

¹⁵ Example of a narrative for a field/full-scale exercise that integrates gender (modify the elements needed to convert to a table-top exercise, while maintaining gender elements)

GENAAR 02: Guidance to integrate gender into key steps and stages of an AAR

STEP	INTEGRATING GENDER
1.Design	<ul style="list-style-type: none"> ▶ For any objective, scope and format selected for an AAR: ▶ Include in the AAR team at least one person with expertise in gender and health; ▶ Include in the concept note how the review will include identification of, and attention to, gender gaps in the action(s) being reviewed; ▶ Include in key stakeholders Ministries of Women or Gender (as the case may be), as well as women leaders outside of the government who can give input on gender aspects of the action(s) being reviewed; ▶ Include facilitators who have some experience with gender analysis; ▶ Ensure gender-equitable selection of interviewers; ▶ If interviewing community members, select a venue that is accessible, comfortable and appropriate for all regardless of gender.
2.Prepare	<ul style="list-style-type: none"> ▶ In background information: include the project's attempts to ensure gender-equitable reach given gender norms (attempts can include: sex-disaggregated data; engagement of gender experts; integration of gender in designing and implementing the response, etc.) ▶ In trigger questions: assess how gender gaps and/or gender norms were taken into account in designing and implementing the action(s); ▶ Include the importance of identifying and addressing gender gaps in facilitator and interviewer briefings.
3.Conduct	<ul style="list-style-type: none"> ▶ Include a gender analysis in the AAR, for example identifying strengths, challenges, and capacities to identify and address gender gaps.
4.Results	<ul style="list-style-type: none"> ▶ Include a section on gender in all AAR debriefing and in the final report that covers analysis across all technical pillars.
5.Follow-up	<ul style="list-style-type: none"> ▶ Ensure analysis of successes and constraints in addressing gender dimensions is included in progress documented and any database or documentation of lessons learned.

Source: Adapted from

GENAAR 03: Examples of gender integration in trigger questions of AAR pillars

NOTE: Suggested gender-specific questions can either be integrated into the set of trigger questions for each Pillar of an AAR (as structured here), or the team can add a separate "Gender Pillar" and use these as trigger questions specifically for that pillar. This decision is at the discretion of the team and country undertaking the AAR.

PILLAR	EXAMPLES OF GENDER-SPECIFIC TRIGGER QUESTIONS
Case management	<ul style="list-style-type: none"> ▶ How did case management take into account norms or circumstances that may create gender differences in access, treatment, or risks of death from disease? ▶ What special care was taken to transport and refer pregnant patients between health care facilities?
Infection prevention and control	<ul style="list-style-type: none"> ▶ How did infection prevention and control measures implemented during the infectious disease outbreak take into account norms or circumstances that may create gender differences in prevention and control beliefs, behaviors, and access to messaging and other resources? ▶ Were infection prevention and control measures implemented during the outbreak equally effective in preventing and controlling infection among people of each gender, in the community and/or a health care setting? Why or why not? ▶ Which actors or institutions with gender expertise were included in coordination efforts in the implementation of infection prevention and control measures in communities and health care facilities, in livestock activities, and for water, sanitation and hygiene activities in the home and the community? ▶ How did the team ensure that infection prevention and control measures would not increase the risks of gender-based violence? For example, how was this ensured in any quarantine or isolation measures implemented? ▶ Did all staff of each gender have equal access to all necessary, appropriate, and well-fitted personal protective equipment?
Coordination	<ul style="list-style-type: none"> ▶ Were existing contingency or response plans for this outbreak effective in identifying actions and communication appropriate to reach people of each gender, given gender differences in access to services, communication media, literacy levels, socio-economic vulnerability, etc.? ▶ How did information products developed incorporate gender-differentiated content when needed? ▶ Was a joint interagency, multisectoral response plan developed that included agencies working with women and/or addressing gender inequality? How did this contribute to enhancing the response?
Logistics	<ul style="list-style-type: none"> ▶ How were supply chains for essential health services for women and children ensured while stepping up supply chains for the outbreak? These could include reproductive health and menstrual hygiene supplies, child and infant nutrition supplies, etc.
Surveillance	<ul style="list-style-type: none"> ▶ How were gender differences in risks, exposure and outcomes used in epidemiological data analysis to improve the design, implementation and management of the action(s) undertaken? ▶ How was information from surveillance and early warning systems shared with partners who work with vulnerable populations, including women and girls, to ensure quick attention and response to these vulnerable populations? ▶ What were the gender-specific barriers to effective contact tracing (if any)?

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PILLAR	EXAMPLES OF GENDER-SPECIFIC TRIGGER QUESTIONS
Laboratory	<ul style="list-style-type: none"> ▶ How were sex- and age-differentials in sample analyses results recorded? How were these used to enhance a response to the event? ▶ How was patient access to laboratories monitored during the emergency, specially access for women and girls in remote or otherwise vulnerable populations or geographic areas affected by the outbreak?
Vector surveillance and control	<ul style="list-style-type: none"> ▶ How were women owners of livestock engaged in vector surveillance and control (where applicable)? ▶ How did this engagement enhance vector control, or lack of engagement hamper vector control?
Communication and community engagement	<ul style="list-style-type: none"> ▶ Is there a national risk communication strategy based on audience segmentation that incorporates gender differences in access to media, response to messaging, and literacy? ▶ Did community engagement measures harness the strengths of female leaders in communities? If not, why not? ▶ Were communication messages able to reach the most vulnerable, including women and girls, in affected communities? If not, why not? How do we know? ▶ How effective was public communication in building trust with people of each gender in affected communities? What were the gender differences, if any, in building trust? ▶ How was community feedback structured to encourage people of each gender equally to provide feedback?

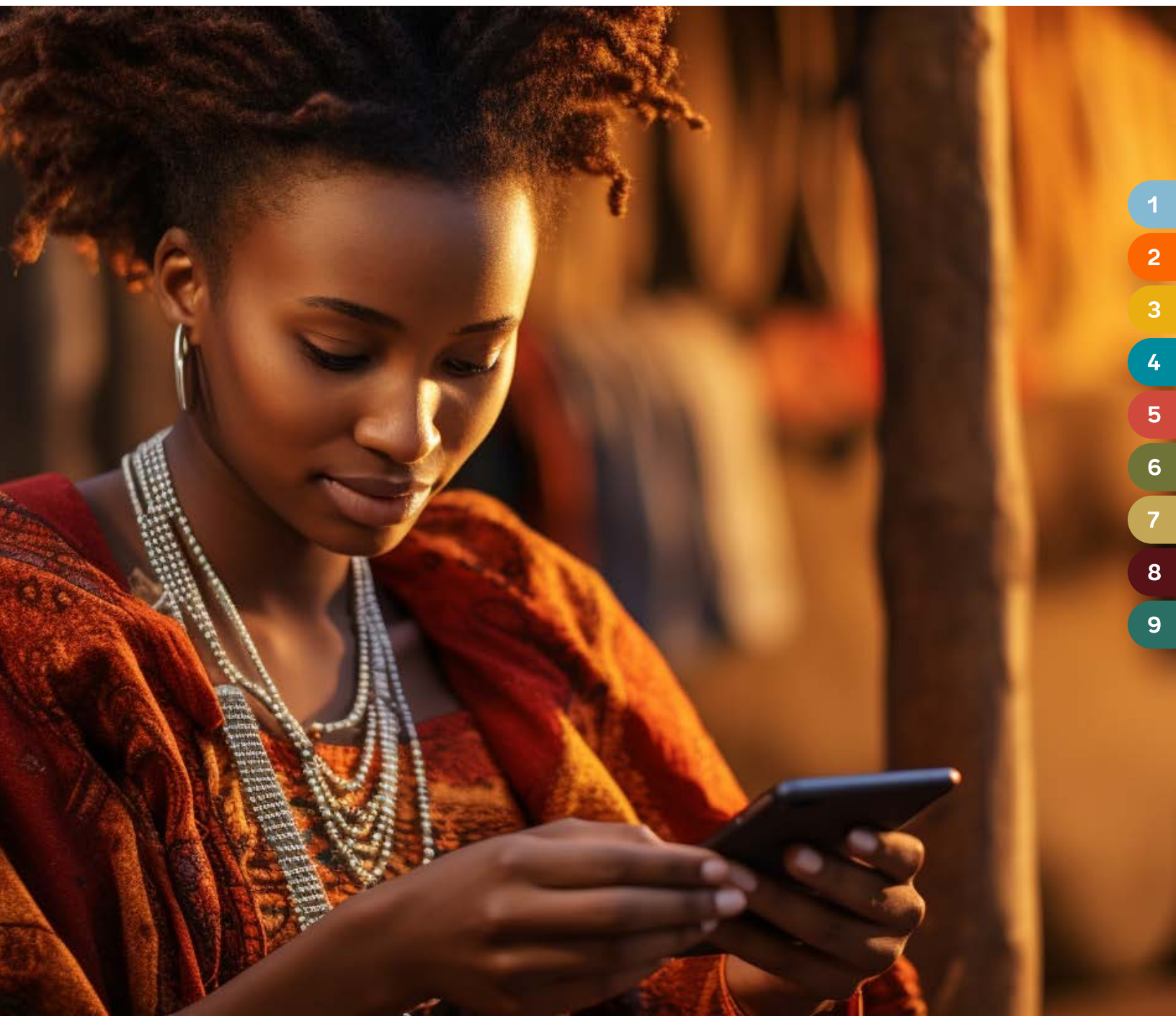
Source: Adapted from (WHO 2019)

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WHO Regional Office for Africa. 2019c. "Integrated Disease Surveillance and Response Technical Guidelines, Booklet Three: Sections 4, 5, 6 and 7." Brazzaville.



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Gender in risk communication

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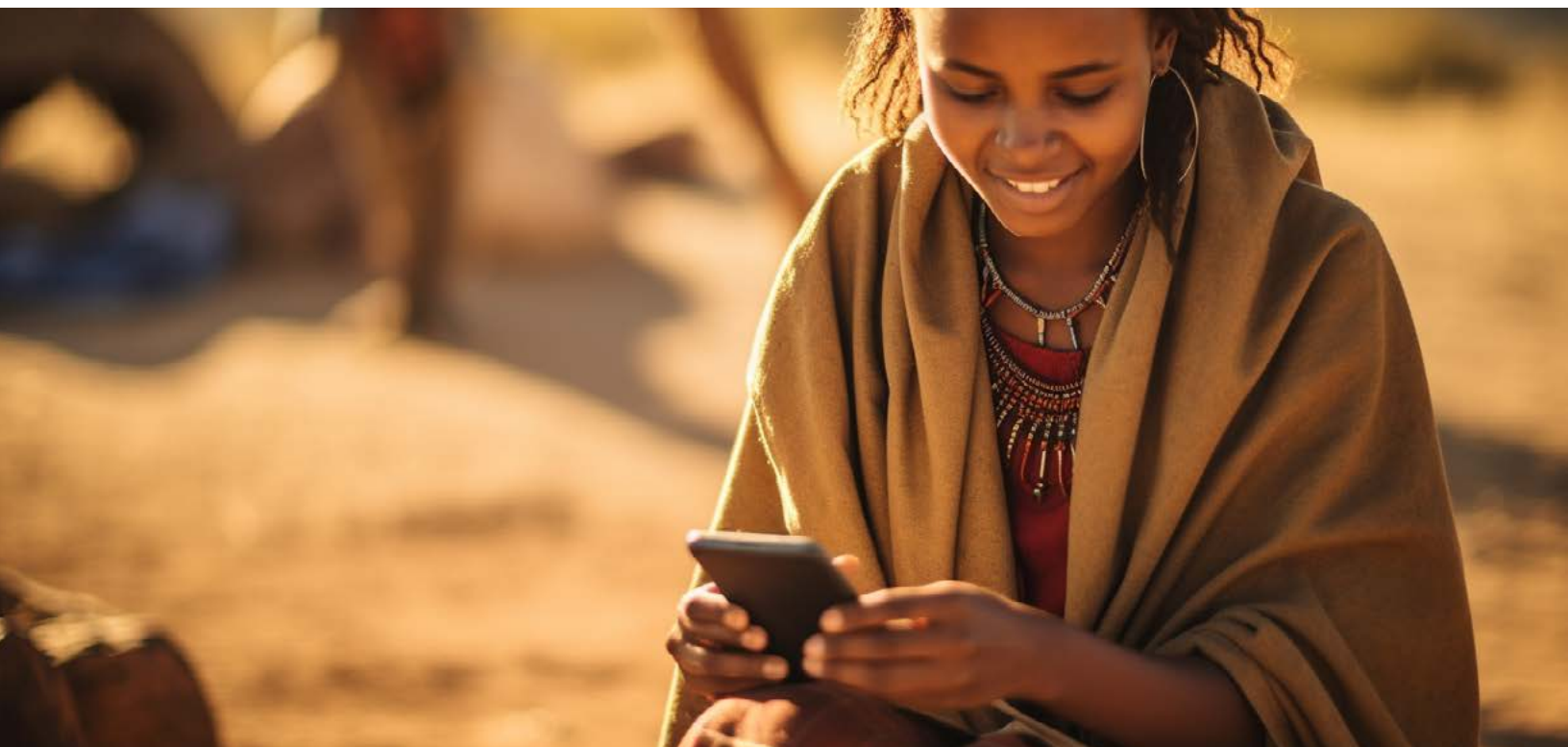
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GOAL: A risk communication strategy that fully and effectively segments media, messaging and messengers by gender¹⁶ and is able to equally effectively reach all genders with information, education and communication on prevention, preparedness and treatment for priority infectious disease epidemics.

Why integrate gender in risk communication?

Attention to gender differentials in developing risk communication is essential because risk communication cannot be effective with a one-size-fits-all approach. Access and response to different media, messaging and messengers is likely to vary by gender (as well as other characteristics). Thus, development of effective communication needs to “segment” the target audience so as to reach each segment – here, segmented by gender – equally effectively (Enarson 2009).



¹⁶ “Audience segmentation” for risk communication should ideally also take into account factors in addition to gender, such as age, literacy, cultural beliefs, language, region of residence, etc. However, here we focus specifically on gender, though many of these guidelines can be modified to use for audience segmentation based on other characteristics.

Gender Benchmark 5.1: Capacity Levels for Gender in Risk Communication (RC)¹⁷

CAPACITY LEVEL	<p>Gender Benchmark 5.1: The risk communication strategy is gender-sensitive</p> <p>Objectives:</p> <ul style="list-style-type: none"> To create and implement a risk communication strategy that takes into account gender-differentiated access to media and messengers, and gender-specific understanding and appreciation of messaging.
01 NO CAPACITY	The risk communication strategy does not take into account gender differences in communication needs, access, and constraints.
02 LIMITED CAPACITY	Systematic assessment has been conducted to identify how to create a risk communication strategy for gender-specific audiences.
03 DEVELOPED CAPACITY	Activities to create or modify the risk communication strategy to segment audiences by gender are developed, budgeted, and piloted.
04 DEMONSTRATED CAPACITY	A post-pilot national-level risk communication strategy that demonstrates audience segmentation by gender is operational.
05 SUSTAINABLE CAPACITY	Gender is integrated fully in risk communication at all levels across the country, with mechanisms in place for integrating attention to gender in supervision, monitoring, evaluation, and reporting.

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¹⁷ The Gender Benchmark for Risk Communication concerns integration of gender into a risk communication strategy. It does not concern other technical and logistical aspects of developing and implementing risk communication overall; rather, it assumes that there is a team in place that has expertise in developing and implementing risk communication. The Gender Benchmark is applicable to either the development of a new risk communication strategy that integrates gender or to modifying an existing gender-neutral risk communication strategy to take gender into account.

Actions and Tools to Achieve Level 02 (Limited Capacity)

Available tools : *(To access tool, click on the link or go to GENRC Tools)*

- ▶ **GENRC 01** : Draft terms of reference for a risk communication gender needs assessment

The language and scope of the draft terms of reference provided can be modified by each country depending on context, needs, and budgetary and other resource availability and constraints.

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 ***Integrate gender in risk communication strategy and approach, and in the development of communication messages, messengers and media.***

Available tools: *(To access tool, click on the link or go to GENRC Tools)*

- ▶ **GENRC 02** : Actions to integrate gender in risk communication
- ▶ **GENRC 03** : Gender in IHR Core Capacity Monitoring Questionnaire for Risk Communication

2 ***Prioritize and pilot risk communication activities.***

Available tools: *(To access tool, click on the link or go to GENRC Tools)*

- ▶ **GENRC 04** : Considerations to prioritize gender integration in risk communication
- ▶ **GENRC 05** : Key steps to pilot prioritized actions to integrate gender in risk communication

GENRC 04 provides some rules of thumbs for prioritizing action to integrate gender into risk communication in a step-wise manner if all identified gaps cannot be simultaneously addressed.

3 ***Evaluate the pilot and revise the risk communication strategy accordingly***

Available tools: *(To access tool, click on the link or go to GENRC Tools)*

- ▶ **GENRC 02** : Actions to integrate gender in risk communication
- ▶ **GENRC 03** : Gender in IHR Core Capacity Monitoring Questionnaire for Risk Communication

GENRC 02 and GENRC 03 can be modified to create a checklist and indicators for monitoring and evaluating piloted (and scaled-up) risk communication that integrates gender.

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are needed.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are needed.



Tools to integrate gender in risk communication

GENRC 01 Draft terms of reference for a risk communication gender needs assessment	146
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GENRC 03: Gender in IHR Core Capacity Monitoring Questionnaire.....	151
GENRC 04: Considerations to prioritize gender integration in risk communication	152
GENRC 05: Key steps to pilot prioritized actions to integrate gender in risk communication	153

Note: All tools can be modified to fit project and country requirements and context.

GENRC 01 Draft terms of reference for a risk communication gender needs assessment

Terms of Reference

Consulting Services to conduct a gender assessment of the *[Name of Ministry or other lead institution]*'s Risk Communication Strategy for Infectious Disease Epidemic Prevention, Preparedness and Response

1 Introduction

Risk communication is a core competency of the International Health Regulations (IHR) 2005, as well as one of 5 strategies within the global Pandemic Influenza Preparedness (PIP) Framework. The World Health Organization (WHO) defines risk communication as “...the real-time exchange of information, advice and opinions between experts or officials and people who face a threat (from a hazard) to their survival, health or economic or social wellbeing. The purpose of risk communication is to enable people at risk to make informed decisions to mitigate the effects of a threat (hazard) – such as a disease outbreak – and take protective and preventive measures.”¹⁸

Gender dynamics can differentially affect both, the risks faced by people and also people's access to, and adoption of risk communication messaging. Gender-specific societal division of labor can place women at higher risk while at the same time constraining their access to services and information in the case of an infectious disease outbreak. Women may have mobility and literacy limitations that result in a lower access to information and risk communication. Cultural beliefs may also be gender-specific, and may act in ways to influence how one gender or another internalizes risk communication messages and adopts healthy behaviors as a result. As primary caretakers, and those responsible for water and food management for households, women can be a tremendous resource in healthy behaviors that can prevent epidemics. Thus it is important to ensure that risk communication messages effectively reach all genders, and in ways that each gender can understand, believe, and incorporate.

2 Background

The Government of *[country name]* through the Ministry of *[Ministry name]* has received funding from *[name of donor]* to support development of risk communication as part of the country's health emergency prevention, preparedness and response program (HEPPR). The Project's Development Object (PDO) is to *[list the PDO]*.

3 Objective/Purpose of the Assignment

The purposes of this assignment are:

- a To undertake an assessment across different regions of the country to identify key gender differences, norms, and dynamics that can influence the reach, understanding and uptake of risk communication messages across gender;
- b To provide recommendations to the HEPPR program on creating/modifying their risk communication strategy, plan, messages, media and messengers used so as to effectively reach populations across gender, especially the most vulnerable.

4 Scope of Work *[to be amended as needed]*

The Consultancy will be delivered using a two-part approach.

- ▶ Desk Review: Desk review activities include scanning the literature and analyzing secondary data that exists to identify gender aspects of risk communication, as well as to analyze the effectiveness of risk communication activities in reaching populations across gender.
- ▶ Interviews of key informants.

5 Duties and Responsibilities of the Consultant

The consultant will be responsible for all aspects of the gender assessment of risk communication, as described in – but not limited to – the steps below.

The consultant will identify and summarize relevant literature, such as:

- ▶ Literature on key gender norms influencing public health, especially disease prevention behavior, and how they vary by region and sub-region;
- ▶ Any country-specific and global literature and evidence on integrating gender into risk communication for prevention, preparedness and response to epidemics.

The consultant will identify potential relevant key respondents for interviews.

These could include *[modify as appropriate]*:

- ▶ Gender specialists with experience in risk communication and/or infectious disease epidemics and/or public health;
- ▶ Those responsible for developing risk communication messaging for the Ministry of Health;
- ▶ Other risk communication professionals in the public, private, academia and non-profit sectors at national and regional levels;
- ▶ Representatives of media used for public health communication such as television channels, radio, internet, social media, paper media etc.;
- ▶ A selection of respondents from public or non-profit sectors in remote areas, or that work with particularly vulnerable populations on appropriate risk communication strategies for their populations;
- ▶ Others as contextually relevant.

The consultant will select locations from which to select key respondents for interviews: This will ensure that there are respondents from each major region, urban and rural areas both, and – as far as possible – representing the main socio-cultural groupings that are known to have different gender norms.

The consultant will propose appropriate study instruments for each group that should cover aspects such as – but not limited to – the following:

- ▶ What type of media do women prefer and have access to?
- ▶ What type of media do men prefer and use?
- ▶ Which gender has more control over which type of media, such as television, radio, internet, social media, telephone, etc.?
- ▶ Do people of different genders engage differentially with informal channels of communication? (for example,

women may be more likely than men to access informal channels of communication such as women's groups and informal networks)

- ▶ What are the levels of education by gender?
- ▶ A gender assessment of any existing risk communication messaging, such as:
 - Is messaging developed based on evidence on differing needs, knowledge, beliefs, superstitions, behaviors, constraints and strengths of each gender?
 - Is messaging based on gender differences in tolerance of risk?
 - Does messaging take into account sex- and age-specific cultural beliefs and behaviors?
 - How are people of each gender portrayed in the message? (for example, is the messaging reinforcing gender stereotypes and roles?)
 - Do messages emphasize joint responsibility of both men and women in protecting themselves, their families and their communities in case of an outbreak?
 - Who is engaged in developing risk communication messages? Is there representation from each gender at all levels, from policy level to the community level?
- ▶ Respondent recommendations on how best to integrate attention to gender differences in the above aspects to create messages that can reach across gender.
- ▶ Respondent recommendations on gender-appropriate messengers, including:
 - Suggestions for trusted sources of information for women so that the strategy does not rely on men to relay information to women in their household;
 - If using word-of-mouth communication, how to include leaders of each gender, for example not just a chief but also the chief's wife; male and female religious leaders; midwives; etc. so that people of each gender are reached;
 - Ensuring that messengers selected are considered trustworthy by people of different genders.

The consultant will be responsible for implementing the study, including:

- ▶ Provide a detailed timeline for study implementation;
- ▶ Propose suitable quantitative and/or qualitative methods;
- ▶ Identify and obtain consent and participation of key respondents;
- ▶ Propose a combination of in-person and digital or phone-based system of implementing the study taking into account any health or other ongoing emergencies, and any time, budgetary or human resource limitations;
- ▶ Design the instruments;
- ▶ Implement the study;
- ▶ Produce an initial draft of a report.

The consultant will engage with responsible [*name of government unit or other person(s) who will coordinate the study*] for suggestions and input at each of the above steps.

6 Deliverables

- ▶ Final study instruments that should cover all aspects of risk communication as illustrated in #5 above;
- ▶ A list of key informants interviewed;
- ▶ An initial draft report describing the results of the study;
- ▶ A final report detailing the main findings on actions to integrate gender into risk communication for prevention, preparedness and response and recommendations for next steps.

7 Payment Terms:

[to be added as per the country's system]

8 Required Qualification and Experience

- ▶ At least a Master's degree in a social science, communications, gender, or epidemiology-related field of study;
- ▶ Experience with quantitative and qualitative data collection, including identification of samples, designing questionnaires, conducting surveys, report writing;
- ▶ Experience with conducting virtual data collection using digital/phone tools;
- ▶ Familiarity with gender inequality and gender norms in [country] is preferred;
- ▶ Familiarity with risk communication is preferred;
- ▶ Familiarity with regional languages and cultures is preferred.

9 Competencies

- ▶ Good writing skills in [country main language];
- ▶ Good communication skills in the field, especially to ask sensitive questions about gender-based aspects of risk communication and message adoption;
- ▶ Ability to deliver high quality products in a timely and economical fashion.

10 Duration of Consultancy: *[To be determined]*

11 Duty Station: *[To be determined]*

12 Reporting Requirements: *[government department or other person(s) overseeing the assessment]*

13 Selection Criteria: *[procurement Processes used for such an assessment]*

14 Facilities to be provided by *[government department or person(s) overseeing the study]*

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GENRC 02: Actions to integrate gender in risk communication

SUGGESTED ACTION	DONE
GENDER INTEGRATION IN RISK COMMUNICATION TEAM, STRATEGY AND PLAN	
The risk communication team at each level (national, provincial, community) includes at least one person with some expertise on gender in risk communication	
The risk communication plan identifies gender differences relevant to the development of messaging, choice of messenger(s), selection of media, and timing for airing messages on mass media, based on findings from a risk communication gender assessment	
The selection of partners in risk communication development and/or roll-out includes groups working with women and girls, especially at the community level	
GENDER INTEGRATION IN DESIGN OF RISK COMMUNICATION ACTIVITIES	
<p>All risk communication activities are informed by gender differences that could influence effectiveness of communication with different gender groups. Specifically:</p> <ul style="list-style-type: none"> A. Message development incorporates wording, language, tone and content that take into account pertinent identified gender differences B. Types of media selected to disseminate risk communication messaging include media that is used and trusted by populations across gender C. The voices of authority used in the messaging (for example, a doctor, a teacher, a village elder, etc.) are selected to include sources that are used and trusted by populations across gender 	
The risk communication team has ensured that messaging does not perpetuate gender stereotypes	
GENDER INTEGRATION IN RISK COMMUNICATIONS IMPLEMENTATION, MONITORING AND EVALUATION	
Pre-tests of messages specifically plan for a gender- and age-balance in respondents from different communities participating in the pretest	
Post-test finalization of messages, media and messengers takes into account gender-specific findings of the pre-test	
Implementation team includes staff across gender as feasible and culturally appropriate	
Indicators to monitor and evaluate risk communication results include indicators to assess effectiveness of the strategy and activities to reach populations across gender	
All supervisory and other reports disaggregate analyses and recommendations by gender	

GENRC 03: Gender in IHR Core Capacity Monitoring Questionnaire for Risk Communication

NOTE: This Annex uses the Questionnaire verbatim, with suggested modifications to integrate gender *in italics*

- 1 Have risk communication partners and stakeholders been identified *in a gender-equitable manner*?
- 2 Has a risk communication plan^A *responsive to gender differences in knowledge, beliefs, behavior, access to information and media and other key aspects of risk communication* been developed?
- 3 Has the *gender-responsive* risk communication plan been implemented or tested through actual emergency or simulation exercise and updated in the last 12 months?
- 4 Are policies, SOPs or guidelines developed on the clearance^B and release of information during a public health emergency *to ensure that information can effectively reach the population across gender, especially the most vulnerable*?
- 5 Are regularly updated information sources *that take into account gender differences in experiences of infectious disease epidemics* accessible to media and the public for information dissemination?^C
- 6 Are there accessible and relevant IEC (Information, Education and Communications) materials tailored to the *overall and gender-differentiated* needs of the population?^D
- 7 In the last three national or international public health (PH) emergencies, have populations and partners been informed of a real or potential risk within 24 hours following confirmation *in ways that ensure reach of information to the population across gender*?
- 8 Has an evaluation of the public health communication *that includes gender-differentiated indicators* been conducted after emergencies, for timeliness, transparency^E and appropriateness of communications?
- 9 Have results of *gender-differentiated* evaluations of risk communications efforts during a public health emergency been shared with the global community?

Notes:

- A. Plan includes gender-specific inventory of communication partners, focal points, stakeholders and their capacities in the country
- B. Procedures are in place for clearance by scientific, technical and communications staff, and gender experts before information is released during public health events
- C. This may include website/webpage (national level), community meetings, radio broadcasts nationally as appropriate etc.
- D. The views and perceptions of individuals, partners and communities affected by public health emergencies should be systematically taken into account; this includes women and girls, and other vulnerable, minority, disadvantaged or other at-risk populations.
- E. Transparency here implies openness, communication and accountability, i.e. all information about public health risk is open and freely available in a form that can be accessed equally easily by individuals across gender.

GENRC 04: Considerations to prioritize gender integration in risk communication

WHAT: Integrate audience segmentation by gender in development of messages and choice of media and messengers for diseases with sex and gender differences. This could include:

- ☒ Diseases for which there have been frequent outbreaks and it is known that infection and transmission rates, disease outcomes, treatment during the epidemic, and/or consequences of an outbreak vary by gender, pregnancy status, and/or age;
- ☒ Symptoms, events or unusual findings that are first identified among pregnant women;
- ☒ Diseases or symptoms for which the literature strongly suggests gender, age and/or pregnancy status differentials in infection and/or transmission rates, disease outcomes and/or treatment;
- ☒ Diseases or symptoms for which either experience and/or literature has found a gender difference in willingness, access and use of prevention or treatment;
- ☒ New and emerging diseases or symptoms for which patterns by gender, age and/or pregnancy status are as yet unknown.

WHERE: It may not be possible to integrate gender simultaneously into all messaging at all levels of society or across regions, urban/rural areas and/or language groups. In this situation, start with integrating gender for areas and populations of greatest need and vulnerability. Use the following hints to identify these groups:

- ▶ Make a list of regions, sub-regional areas, language and ethnic groups that the risk communication gender assessment conducted for Capacity Level 02 has identified as most likely to have gender dynamics that influence the reach and adoption of risk communication messaging;
- ▶ Assess and document for each identified group the financial, human, media-related and other resources required to produce and disseminate gender-specific risk communication;
- ▶ Create a plan detailing a timeline and process to develop and disseminate gender-integrated risk communication to identified groups.

GENRC 05: Key steps to pilot prioritized actions to integrate gender in risk communication

STEPS	ACTION	HOW TO OPERATIONALIZE EACH STEP
#1	Select pilot messages and areas/populations	<ul style="list-style-type: none"> ▶ Use GENRC 04 to review priority areas selected to be piloted; ▶ Select relevant population groups for pilot testing; ▶ Get validation and buy-in with key partners such as media sources most used in selected pilot areas and by selected groups.
#2	Pre-test gender-integrated messages and media choices with a focus group	<ul style="list-style-type: none"> ▶ Select focus group members representative of the pilot areas and/or population groups; ▶ Conduct pre-test(s).
#3	Revise after pre-test	Use pre-test results to revise content, structure and language of messaging and media as needed.
#4	Pilot the pre-tested gender-integrated risk communication messaging	<ul style="list-style-type: none"> ▶ Select one or more pilot area(s) using the following types of criteria: <ul style="list-style-type: none"> ▶ Is there a potential pilot site that is easily accessible so that the pilot project is can be most easily supervised? ▶ Whether the pilot is to be conducted in all regions with critical gender dynamics or a sub-selection (Decide based on budget, time, staff capacity and geographical area)? ▶ Should you choose an urban area versus a rural area; an area with high literacy versus low literacy; or ensure representation of both ends of the spectrum? ▶ Will the launch of the pilot project have to take into account the season (e.g., seasonal nature of typical outbreaks in the region, access to data collection and transmission, etc.)? ▶ Create messaging and train risk communication personnel as needed on gender in risk communication ▶ Conduct the pilot for at least 6 months ▶ Collect, summarize, report and analyze data to evaluate the pilot.
#5	Modify based on piloting results	Use the results of the pilot project to modify the content, structure, language, choice of media, choice of messengers, as needed.
#6	Scale up	<ul style="list-style-type: none"> ▶ Organize workshops at national and regional levels to validate modified gender-integrated risk communication ▶ Organize a launch of the gender-integrated risk communication strategy and messaging ▶ Begin scale up either in stages or all at once, depending on the size, capacity and budgetary constraints of the country.

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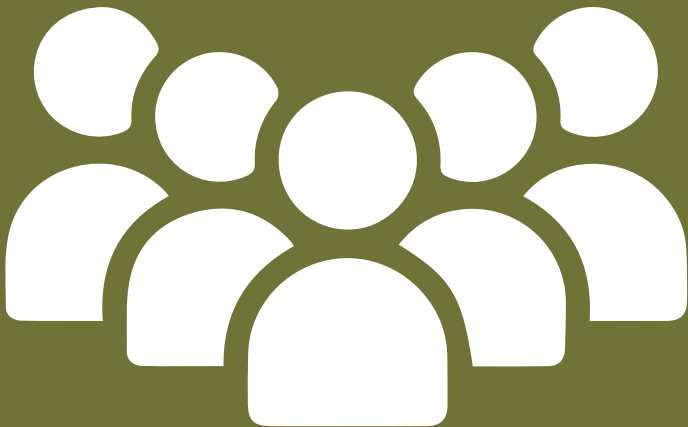
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Gender in Community Engagement

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What is “integrating gender in community engagement” and why is it important? 156

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GOAL: The community engagement strategy, plans, and activities take into account gender norms, responsibilities and differentials such that community members across gender are active participants in all aspects of community engagement for prevention, preparedness and response to epidemics.

What is “integrating gender in community engagement” and why is it important?

The community level is the foundation of a country’s response to preventing and managing epidemics and their aftermath. However, everyone is not equal in communities, and societal conditions and norms create several types of disadvantages and vulnerability within and across communities. Gender is one such parameter of vulnerability. Thus, if attention is not paid to gender differentials and norms, community engagement strategies, plans and activities may not meet the needs of community members of the most vulnerable gender. Consequently, any efforts to reach the most vulnerable with information and services related to epidemics can be inefficient and incomplete. Thus, it is important to:

- ☒ Incorporate different strategies to engage people across gender in a community;
- ☒ Engage key women and community-based women’s organizations;
- ☒ Tap into women’s expertise as community-level leaders, healers, health care workers, and managers of livestock.



Gender Benchmark 6.1: Capacity Levels for Gender in Community Engagement¹⁹

CAPACITY LEVEL	<p>Gender Benchmark 6.1: Gender is integrated into all aspects of community engagement for public health emergency preparedness and response.</p> <p>Objectives:</p> <ul style="list-style-type: none"> To integrate gender into mechanisms for community engagement in public health emergencies. To ensure that community engagement activities, processes, and stakeholders are gender-equitable and reach all genders in the community. To include progress in reaching all genders in community engagement monitoring and evaluation.
01 NO CAPACITY	Community engagement is gender blind.
02 LIMITED CAPACITY	An understanding of gender gaps and gender dynamics is integrated into community needs strategies, staffing, activities, and monitoring & evaluation.
03 DEVELOPED CAPACITY	Attention to gender is integrated into all community engagement actions that are developed, budgeted, and piloted.
04 DEMONSTRATED CAPACITY	A post-pilot national-level community engagement strategy that integrates attention to gender is operational in at least half the areas of the country that are recognized as safely accessible
05 SUSTAINABLE CAPACITY	A post-pilot national-level community engagement strategy that integrates attention to gender is operational in all the areas of the country that are recognized as safely accessible

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¹⁹ The Gender Benchmark for community engagement concerns integration of gender into all aspects of community engagement. It assumes that there is a team in place that has expertise in developing and implementing community engagement overall. The Gender Benchmark for community engagement is applicable to either the development of a new community engagement strategy that integrates attention to gender norms, gaps, and dynamics or to modifying an existing gender-neutral community engagement strategy to take gender into account.

Actions and Tools to Achieve Level 02 (Limited Capacity)

1 Include gender-specific issues and concerns in community needs assessments.

Available tools: *(To view tools: Click on the name of a tool or scroll to GEN-CE Tools)*

- ▶ **GEN-CE 01** : Community gender needs assessment – Community resource persons
- ▶ **GEN-CE 02** : Community gender needs assessment – Community members
- ▶ **GEN-CE 03** : Community gender needs assessment – Community leaders

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 Integrate gender into the development and operationalization of all aspects of community engagement.

Available tools: *(To view tools: Click on the name of a tool or scroll to GEN-CE Tools)*

- ▶ **GEN-CE 04** : Key steps to integrate gender in designing community engagement
- ▶ **GEN-CE 05** : Case studies of gender in community engagement for prevention, preparedness and response to epidemics

2 Monitor integration of gender in community engagement

Available tools: *(To view tools: Click on the name of a tool or scroll to GEN-CE Tools)*

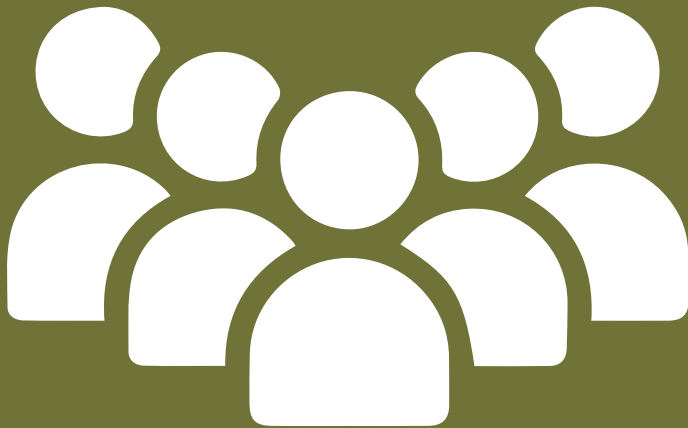
- ▶ **GEN-CE 06** : Illustrative checklist to monitor integration of gender in community engagement

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are needed.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are needed.



Tools to integrate gender in community engagement

GEN-CE 01: Community gender needs assessment – Community resource persons	160
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Note: All tools can be modified to fit project and country requirements and context.

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GEN-CE 01: Community gender needs assessment – Community resource persons

NOTE:

- ▶ Questions can be used as probes for qualitative or questions for quantitative studies
- ▶ Community resource persons include community doctors, midwives, nurses, community health workers and others who can serve as resource persons for preparedness and response

General background:

- 1 What is your role in health care for women and girls in the community?
- 2 What is your role in health care for men and boys in the community?
- 3 Are there particular challenges you face when accessing women and girls with health information?
- 4 Are there particular challenges you face when accessing men and boys with health information?
- 5 From your knowledge, have women or women's groups been involved in designing or delivering community engagement and information services related to emergency preparedness and response in this community?
 - a If yes, how and to what extent?
 - b What other groups have been involved?
- 6 Do you think you have received adequate training, information and resources to-date to serve as a community health resource person, especially to reach women and girls?

In the last infectious disease outbreak in your area:

- c Did you get any warning or information about the risks and hazards to expect and how to prepare for them?
 - a If yes, what was the information, whom did it come from and how, and was it useful?
 - b If no, what information would be most useful to you to prepare for any emergency that may occur in the future, and what would be the best way to get it to you? (*Probe for: kinds of media, written or oral, etc.*)
- 7 What was your role as a community health resource in warning your community about possible risks?
- 8 How did you transmit information to women? How did you transmit information to men? Were the language, media, and sources different in the way you transmitted the warnings and information to men as compared to women?
- 9 What were some key risks and concerns for women and girls, especially for pregnant women? What barriers did they face in getting their risks heard and attended to? What role did you play in addressing these challenges?
- 10 How was access to essential services affected? Especially reproductive, maternal and child health services?

Last question: "We would like to interview community leaders, members, and organizations working in the community. Who are some people we should talk to? Please tell us about both men and women to whom we should reach out."

GEN-CE 02: Community gender needs assessment – Community members

NOTE:

- ▶ Questions below can be used as probes for qualitative or questions for quantitative studies
- ▶ Focus groups must be segregated by sex. Consider segregating groups also by other characteristics (like age, marital status, ethnic group)

- 1 What are the issues of greatest concern in this community among women? How about among men?
- 2 Where do women in this community typically congregate for social or other purposes?
- 3 Where do men in this community typically congregate for social or other purposes?
- 4 Where do men get information about health or other services?
- 5 Where do women get information about health or other services?
- 6 To your knowledge, what services exist to serve the community in case of a health emergency? Does everyone know about these services? (*Probe: do women and girls know? Do men know?*) Are these services as accessible to women as to men?
- 7 From your knowledge, have women or women's groups been involved in designing or delivering community engagement services related to emergency preparedness and response in this community? If yes, how and to what extent? What other groups have been involved?
- 8 How often do the health post, district, and other health staff reach out for community members to voice their concerns or make suggestions about community-level plans for epidemic preparedness and response?
- 9 Overall, how receptive are health officials at health post and higher levels to feedback from different members of the community? From women and women's groups? From men and men's groups?
- 10 Overall, how do you think services for community members, especially women and girls, and those from disadvantaged or vulnerable groups, can be improved in case of any future infectious disease epidemic?
- 11 What resources or services would need to be in place in the community, in your view, for your community to recover better than in the past from another infectious disease outbreak? How could gender-equitable access to such resources and services be ensured?

In the last infectious disease outbreak in your area:

- 1 Did you get any warning or information about the risks and hazards to expect and how to prepare for them? If yes, what was the information, whom did it come from and how, and was it useful? (*Probe for why or why not it was useful*)
- 2 What were some key risks and concerns for women and girls, especially for pregnant women? What barriers did they face in getting their risks heard and attended to? What about men and boys in the community?
- 3 How was your access to essential services affected? Especially reproductive, maternal and child health services?

Source: Adapted from (Women's Refugee Commission 2021)

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GEN-CE 03: Community gender needs assessment – Community leaders

NOTE:

- ▶ **Questions below can be used as for qualitative or questions for quantitative studies**
- ▶ **Community leaders include traditional and religious leaders, respected male and female seniors in the community, representatives of community-based youth, women's and other organizations, and others whom the community considers as a "leader" in public health efforts**

- 1 What is your role in this community?
- 2 (Where relevant) What is your role in helping your community prepare for, and protect itself, against infectious disease outbreaks?
- 3 Who, or which groups in your community may be most at risk when an infectious disease outbreak strikes? (Probe: women? Girls? Other?)
- 4 What resources and capacities currently exist within the community for the community to respond to a crisis? (Probe for community networks etc.)
- 5 Are there particular challenges you face in accessing women and girls with information and other resources in an infectious disease outbreak? What would you need to be able to address any challenges?
- 6 What about accessing men and boys?
- 7 What training(s) have you received, if any, to build your current capacity to help your community prepare for or respond to infectious disease outbreaks?
- 8 From your knowledge, have women or women's groups been involved in designing or delivering community engagement and information services for emergency preparedness and response in this community? If yes, how and to what extent? What other groups have been involved?

In the last infectious disease outbreak in your area:

- 9 Did you get any information about the risks and hazards to expect and how to prepare the community? If yes, what was the information, whom did it come from and how, and was it useful?
- 10 What was your role as a community leader in warning your community about possible risks and how to protect themselves? How did you transmit information to women? How did you transmit information to men? Were the language, media, and sources different in the way you transmitted the warnings and information to men as compared to women?
- 11 What were some key risks and concerns of women and girls, especially for pregnant women? What barriers did they face in getting their risks heard and attended to?
- 12 Were regular health services disrupted for your community, such as immunization or basic primary health care? If yes, what services were disrupted, and how did that affect the community? Who or which group was most affected? (Probe for reproductive, maternal, child health or other services for women)
- 13 What attempts were made to continue providing regular health services during the last outbreak? (Probe for reproductive, maternal, child health or other services for women)
- 14 How could the community have better prepared before the emergency for the challenges it faced during the outbreak?

GEN-CE 04: Key steps to integrate gender in community engagement

Integrate gender in community engagement goals for the project

- ▶ Include the Ministry of Gender or its equivalent in consultations or other activities undertaken to set community engagement goal(s);
- ▶ Include attention to gender in community engagement goal(s);
- ▶ Include a focus on ensuring participation, inclusion, empowerment and ownership of community engagement activities among vulnerable groups, especially women and girls

Integrate gender in community engagement plan

- ▶ Use GENSURV 02 to assess gender norms that need to be taken into account in the design of a community engagement plan;
- ▶ Engage community leaders of each gender in:
 - ▶ defining community needs, constraints and opportunities;
 - ▶ supervision and monitoring of roll-out of prevention, preparation and response activities.

Ensure gender-equitable staffing as far as is feasible

- ▶ Conduct a rapid assessment to identify gender distribution of existing community level staff.
- ▶ Hire requisite community-level workers of the less-represented gender to supplement existing staff.

Ensure all staff members are knowledgeable or trained in relevant gender norms and dynamics of community engagement

- ▶ Ensure that training on community engagement training for all staff includes:
 - ▶ How to establish and maintain positive community relationships across gender and with different gender-based community groups (like women's groups);
 - ▶ How to undertake a community assessment (use GEN-CE 01, GEN-CE 02 and GEN-CE 03);
 - ▶ How to identify and work with community leaders and groups across gender;
- How to identify and address gender-specific community needs resources and other constraints.

Ensure that community entry is gender-sensitive

- ▶ Familiarize community engagement teams with community gender and social norms so that community entry is contextually appropriate (GENSURV-02 checklist can be used)
- ▶ Ensure representation across gender in the team that establishes initial contact with a community

Take gender into account in identification of key stakeholders

- ▶ Ensure that any mapping of stakeholders includes women and girls, such as:
 - ▶ Prominent women such as wives of traditional leaders, female religious leaders, women community leaders, female health workers, and other female functionaries in the community;
 - ▶ Local government agencies working on gender equality and/or with women and girls, especially from vulnerable sub-groups;
 - ▶ International, national, regional or other non-profit agencies working in the area with a gender and health focus;
 - ▶ Women's groups, youth groups and other formal and informal community networks that work with women and/or focus on gender inequalities;
 - ▶ Formal or informal women business-owners.

Sources: Adapted from (Family Planning 2020 et al. 2020; WHO Regional Office for Africa 2019c; Women's Refugee Commission 2021; UNICEF 2020a; WHO Western Pacific Region 2021)

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GEN-CE 05: Case studies of gender in community engagement – focus on epidemics

CASE STUDY #1: Women at the center in the intersection of community engagement and risk communication during the COVID-19 pandemic

In the Yumbe district of Uganda, in the Bidibidi settlement for refugees and displaced persons, women have been trained by UN Women and the Women International Peace Center as peace mediators to resolve community disputes and challenges. When COVID-19 entered the community, they were additionally trained on COVID-19 prevention measures. During the subsequent lockdown, these female community members used water and food collection points to sensitize women about distancing, masking and hand-washing; went house-to-house to sensitize all family members about COVID-19 protection measures; and ensured that every household had a hand-washing point, clean racks to store utensils, and access to toilets (UN Women 2020).

CASE STUDY #2: CLEME (Community Led Ebola Management and Eradication) Program, Sierra Leone

The CLEME program, led by the non-profit ACF International, was a participatory program that aimed to trigger behavior change in communities to strengthen community response and resilience to the 2014-16 Ebola Hemorrhagic Fever (EHF) outbreak, and to prevent further resurgence. It was implemented in the districts of Moyamba and Kambia. CLEME was designed as a process with 5 phases: community selection; community self-assessment of an outbreak and risks; designing a community action plan with the community; community support group creation and training; and follow up with continued community dialogue, monitoring, and visits by ACF staff. The CLEME methodology was based on the premise that social mobilization activities need to be tailored to each community's capacity and needs and, within communities, to any different needs and constraints of different sub-groups. An evaluation by ACF found evidence of behavior change in the fight against EHF, including construction and use of community-based isolation spaces and hand-washing spaces, aided by a sense of ownership by the community.

Gender was one of the core aspects of the approach. All tools, in particular the structures and processes of the community support groups, and the design and implementation of the community action plan, identified and reflected the differing needs of women and girls, boys, and men. Ensuring a gender-balanced team to lead the participatory community engagement was also considered key (ACF International 2015).

CASE STUDY #3: The role of women's community networking groups in combatting COVID-19 in India

A public sector program based on community networks throughout the southern Indian state of Kerala, “Kudumbashree” is a network of neighborhood groups comprised of women from poor households across villages, linking with governance structures at higher levels of administration. When India declared a national shut-down due to the COVID-19 pandemic in March 2020, this women-led community network was able to provide multiple community-based services, including:

- ▶ Spreading awareness and accurate information on prevention and protection;
- ▶ Preparing and home-delivering food to poor and quarantined families;
- ▶ Collaborating with mental health professionals as volunteers to provide temporary shelter and counseling to distressed women, especially those in quarantine in situations of domestic violence;
- ▶ Supporting elderly women to access primary health centers and other services.

Key in Kudumbashree's success was the longstanding emphasis on decentralized, democratic, women-led leadership and participatory dialogue, learning and action.

Sources: Several sources cited in (Loewenson et al. 2020)

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GEN-CE 06: Illustrative checklist to monitor integration of gender in community engagement

Action		Date completed	Person(s) responsible
The community engagement goal includes attention to gender			
Gender-specific community needs assessment (complete when all actions below are complete)			
Male stakeholders and community leaders identified			
Female stakeholders and community leaders identified			
Key resources relevant for preparedness and response identified			
Gender differences in access to key resources identified			
Ethnic, religious, tribal or other community groupings identified			
Gender-specific capacities identified as potential resources			
Gender-specific prevention needs and risks identified			
Gender-specific community action plan (complete when processes below are undertaken)			
People of each gender participated in developing the action plan			
Key activities designed to reach the vulnerable, including by gender			
Key activities address gender-specific barriers to engagement			
M&E indicators measure relevant gender differences			
Implementation strategies incorporate gender differences in needs, risks, access and skills			
Gender-specific stakeholder engagement (complete when all groups below are represented)			
Women's organizations such as self-help groups			
Women leaders			
Non-profits or other organizations that work with women			
Representation from ethnic, religious and other groupings			
Male leaders			
Gender integration in community engagement activities across core capacities (complete when all community engagement activities in a core capacity pay attention to gender-equitable community engagement, participation and decision-making, as well as gender-equity in community access to information, services, training, etc.)			
Surveillance for human health			
Surveillance for animal health			
Laboratory services and functions for human health			
Laboratory services and functions for animal health			
Human resources at the community level			
Emergency preparedness and response			
Risk communication			
Maintenance of essential services			
Attention to risks of GBV during an outbreak			

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Maintenance of RMNCAH services as an “essential service”

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Why focus on RMNCAH in maintenance of essential services during an outbreak? 170

Gender Benchmark 7.1: Capacity Levels for Maintenance of RMNCAH As An Essential Service 171

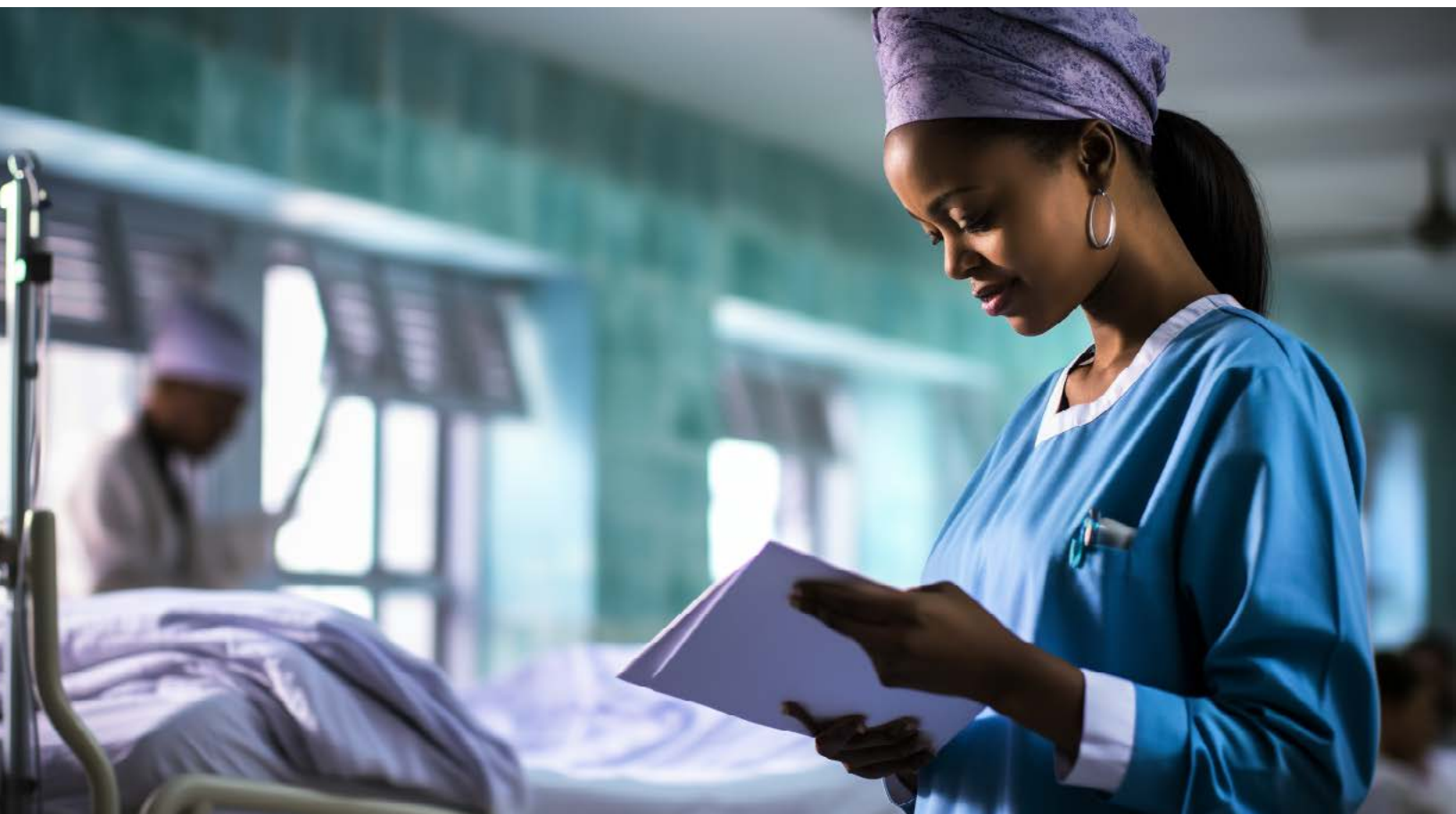
TOOLS 173

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GOAL: Availability, staffing, access, and delivery of reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services are maintained as part of “essential services” during an infectious disease outbreak.

Why focus on RMNCAH in maintenance of essential services during an outbreak?

While populations regardless of gender may lose access to essential services during an epidemic RMNCAH services are especially likely to need attention. There are several reasons for this: these services may be withdrawn as funds get diverted to manage the outbreak; an outbreak makes it harder to provide routine health services; an outbreak may make it harder than usual for women to access essential services because of lack of transport, cost, etc.; or women are denied services because of fear of infection. Lack of access to RMNCAH services can, in turn, increase women’s risks for other notifiable priority diseases.



Gender Benchmark 7.1: Capacity Levels for Maintenance of RMNCAH As An Essential Service

CAPACITY LEVEL	<p>Gender Benchmark 7.1: Joint preparedness is established to ensure that RMNCAH services are maintained as “essential services” during any infectious disease outbreak</p> <p>Objectives:</p> <ul style="list-style-type: none"> To establish joint preparedness of RMNCAH and health emergencies so as to ensure maintenance of RMNCAH services as essential services during an outbreak.
01 NO CAPACITY	Outbreak preparedness does not incorporate steps to ensure that RMNCAH services are maintained as essential services during an outbreak.
02 LIMITED CAPACITY	Systematic assessment has been conducted during a non-emergency time period to identify steps necessary to achieve joint preparedness for outbreaks and RMNCAH as essential services.
03 DEVELOPED CAPACITY	Activities to develop and/or strengthen joint preparedness are developed, budgeted, and piloted.
04 DEMONSTRATED CAPACITY	A post-pilot joint preparedness strategy is operational for all identified joint preparedness actions in multiple areas of the country that are recognized as safely accessible.
05 SUSTAINABLE CAPACITY	A post-pilot joint preparedness strategy is operational for all identified joint preparedness actions in all parts of the country that are recognized as safely accessible.

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Tools to integrate RMNCAH as essential services during an active outbreak

Available tools (across Levels)

(To view tools: Click on the name of a tool or scroll to GENSVS Tools)

These tools can be used to assess the status of joint preparedness (Level 02), to plan and budget actions to establish and/or improve joint preparedness (Level 03), and to monitor the status of joint preparedness activities (Levels 03, 04 and 05).

GEN-SVS-01 : Checklist to assess status of joint preparedness for outbreak

prevention preparedness and response (PPR) and RMNCAH essential services.....174

GEN-SVS-02 : Key gender considerations in designing maintenance of essential services.....177

GEN-SVS-03 : Sample gender-sensitive indicators to monitor maintenance of essential services 179

Note: All tools can be modified to fit project and country requirements and context.

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GEN-SVS-01: Checklist to assess status of joint preparedness for outbreak prevention preparedness and response (PPR) and RMNCAH essential services

NOTE: Users can revise the language to reflect the division of responsibilities between Ministries as pertinent to each country

TYPE OF ACTION	ACTIVITY		ADDITIONAL COMMENTS
Ensure attention to RMNCAH services	RMNCAH services are included in essential health services		
	Coordination bodies or units are established for maintenance of essential services		
	Coordination bodies or units established for maintenance of essential services include at least one focal point knowledgeable about RMNCAH service provision		
Recommended approach to joint preparedness	Human, financial, and other capacities of departments for PPR and RMNCAH have been mapped		
	Joint preparedness plans are tailored to the mapped capacity of PPR and RMNCAH Departments		
	Ministry of Health (MOH) staff have identified available tools to use to monitor the status of joint preparedness		
	Data have been used to estimate the number of women of reproductive age, adolescents, and children whose health needs will need to be met in an outbreak		
	Data have been used to estimate the number of pregnant women whose health needs will need to be met in an outbreak		
Structuring joint preparedness	Relevant MOH Departments and other partners have been identified as collaborators		
	Ministries responsible for women and children are included as collaborators		
	Functions and resources of collaborating parties have been mapped		
	Leads of MOH divisions responsible for RMNCAH and Ministry of Health leads on PPR have met at least once in the last 12 months to discuss joint preparedness needs related to RMNCAH in case of an outbreak		
	Lists of key collaborating partners are updated annually		

TYPE OF ACTION	ACTIVITY		ADDITIONAL COMMENTS
Joint planning	Maintenance of RMNCAH as an essential service has been integrated into emergency health Action Plans, policies, strategies, and legislation at national and subnational levels		
	PPR-related assessments of risks, vulnerabilities, and capacities across national, subnational and community levels include the status of RMNCAH services		
	MOH departments responsible for RMNCAH services have developed emergency protocols to maintain continuity of RMNCAH services during an outbreak		
	Workplans of PPR-related departments in the Ministry of Health include joint action plans and/or terms of references (TORs) to prepare for maintenance of RMNCAH services as part of essential services		
	Protocols and processes for the delivery of RMNCAH services are established at all levels in a manner that is consistent with outbreak preparedness and response protocols		
	Plans and protocols are based on a joint assessment that has identified barriers and facilitators to collecting timely, actionable data on maintenance of RMNCAH services		
	RMNCAH Department(s) and Department(s) responsible for PPR have an agreement to include the identification of pregnant women (at minimum: whether pregnant yes/no) on all morbidity, mortality, surveillance, laboratory, and other forms for outbreaks		
Joint supply chain actions	RMNCAH supplies, such as medicines, diagnostics, contraception, menstrual hygiene supplies, and delivery kits have been mapped to resources required to maintain them during an active outbreak		
	RMNCAH supplies required for maintenance of services during an outbreak are included in supply-chain preparedness and in continuity-of-operations plans for essential supply chain functions		
	Guidance on quarantine and sheltering during an outbreak addresses RMNCAH-specific needs, such as supplies and instructions for infant feeding, medicines, diagnostics, contraception, menstrual hygiene, delivery kits, and other supplies		

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TYPE OF ACTION	ACTIVITY		ADDITIONAL COMMENTS
Joint staffing actions	Providers of RMNCAH services are included in planning for and developing surge capacity		
	A focal point for the maintenance of RMNCAH services during an outbreak is identified within the country's lead health security team(s)		
	A focal point to coordinate with the Department(s)/Ministry(ies) leading on PPR during an outbreak is identified within the RMNCAH Department(s) in the MOH		
	Basic information on RMNCAH and related services has been integrated into health security staff training		
	Health emergency staff training at all levels includes at least one session annually on joint RMNCAH-outbreak preparedness		
	There is a roster of health emergency staff in relevant Ministries who have been trained about the effect of emergencies on RMNCAH services and clients		
	The health emergency lead(s) have confirmed that the RMNCAH Directorate has identified staff to be trained in basic outbreak preparedness measures		
Joint facility-level actions	Protocols have been established on required staff safety measures that can be activated during an active outbreak		
	Safety measure protocols for infection prevention and control (IPC) and PPE are in place in all facilities that provide RMNCAH services		
	Mechanisms to isolate patients as needed during an active epidemic have been established, especially in maternity and neonatal wards		
	Protocols have been established for management of appointments, patient flow and visitors during an active outbreak, especially at RMNCAH service provision centers		
	Facility staff have been trained in appropriate screening and triage of all those entering a maternity, neonatal or related facility or ward during an active outbreak		

Sources: Adapted from (AMCHP 2021; Family Planning 2020 et al. 2020; WHO 2017)

GEN-SVS-02: Key gender considerations in designing maintenance of essential services

ACTION	MAINTENANCE OF ESSENTIAL SERVICE	GENDER CONSIDERATIONS
Identify essential services	<ul style="list-style-type: none"> ► Identify services as “essential” based on criteria such as: ► Disease burden ► Core services for vulnerable populations 	<ul style="list-style-type: none"> ► Consider gender-based disadvantage in defining disease burden ► Include core health services for women, girls, adolescents, and children, such as RMNCAH services
Establish or modify governance and coordination mechanisms	Designate a focal point for essential services as part of the Incident Management Team (IMT)	Ensure the IMT focal point is familiar with RMNCAH
	Ensure coordination and communication channels between different stakeholders	Include decision-makers from Ministry of Women/Gender and departments providing core health services for women, girls, adolescents, and children
	Develop protocols to deliver essential services during an active health emergency	Ensure that protocols incorporate measures to address gender gaps in access to essential services during an active health emergency
	Adjust financing to maintain essential services as needed	Ensure that adjustments include financing to maintain adequate RMNCAH services (see GEN-SVS-01) and to monitor and address gender gaps in core health services for all key health outcomes

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ACTION	MAINTENANCE OF ESSENTIAL SERVICE	GENDER CONSIDERATIONS
Optimize service delivery	Conduct a mapping of health facilities that provide services designated as “essential”	Include an assessment of gender differences in accessing these essential services during an active outbreak
	Reorient and modify facility protocols (primary care support, outpatient support, admission, discharge, referral etc.) to take into account risks of an outbreak	<ul style="list-style-type: none"> ▶ Ensure that protocols define clear pathways to protect access across gender ▶ Include referral to services for survivors of gender-based violence
	Ensure adequate supplies of personal protective equipment (PPE) to providers of essential services	Provide PPE in sizes that are appropriate across gender of female providers
	Establish mechanisms for isolation of patients using regular health services as needed depending on the nature of the outbreak	Ensure that isolation mechanisms address risks of gender-based violence (see GEN-GBV 02)
	Map and adequately source all medicinal and other materials required to maintain regular, essential health services during an outbreak and establish regular inventory management to monitor and address shortages	Ensure that all management of supply chain includes supplies for RMNCAH including menstrual hygiene supplies, for patients as well as female providers
	Assess and implement as deemed suitable other measures to encourage use of essential services during an outbreak, such as limiting or temporarily suspending user fees, modifying hours of operation, etc.	Ensure attention to gender differences in affordability of user fees, in suitability of operating hours and other aspects of use of essential services during an outbreak
	Use digital platforms (telemedicine, digital information portals, electronic prescriptions, etc.)	Assess how to incorporate digital platforms so as not to exacerbate a gender digital divide
Ensure adequate trained workforce to maintain essential services	Identify additional workforce capacity that can be quickly mobilized to ensure maintenance of essential service provision during an outbreak	<ul style="list-style-type: none"> ▶ Ensure a gender balance in identified additional workers ▶ Include expertise and experience in RMNCAH and gender
Strengthen communication to ensure continuing use of essential services	Incorporate and disseminate information on the importance and safety of continuing to use essential services during an outbreak in risk communication and community engagement (RCCE) strategies and activities	<ul style="list-style-type: none"> ▶ Ensure information about RMNCAH and gender-equitable access to core services during an outbreak ▶ Ensure RCCE strategies are designed to reach populations across gender (see GEN-RC 02 and GEN-RC 03) ▶ Ensure the active engagement of key women leaders and women’s groups (see GEN-CE 04 and GEN-CE 05)

Sources: Modified from (Resolve to Save Lives 2020; WHO 2020)

GEN-SVS-03: Sample gender-sensitive indicators to monitor maintenance of essential services

SEX-SPECIFIC INDICATORS TO MONITOR ESSENTIAL HEALTH SERVICES DURING AN OUTBREAK

- ▶ Total number of outpatient attendance or primary care visits, by sex and age
- ▶ Total number of pregnant women in outpatient attendance or primary care visits
- ▶ Total number of hospital discharges, by sex and age
- ▶ Proportion of pregnant women in hospital discharged in the last XX months
- ▶ Sex ratio of hospital-based deaths, by cause of death (where available)
- ▶ Number of inpatient admissions for cardiovascular and cerebrovascular-related symptoms, by sex and age
- ▶ Sex ratio of confirmed malaria cases treated with therapies usually used in the country in question
- ▶ Percentage of confirmed malaria cases to pregnant women treated with therapies usually used in the country in question
- ▶ Number of new and relapsed TB cases notified, by sex and age
- ▶ Sex ratio of adults living with HIV currently receiving antiretroviral therapy who are affected by treatment disruptions
- ▶ Percentage of pregnant women living with HIV currently receiving antiretroviral therapy who are affected by treatment disruptions
- ▶ Number of persons with severe mental health conditions using mental health services, by sex and age
- ▶ Suicide rate, by sex and age
- ▶ Number of new cancer diagnoses, by sex and age
- ▶ Number of patients needing palliative care because of the outbreak or other causes, by sex, age and (for women ages 15-49 years) pregnancy status

Indicators to monitor RMNCAH services during an outbreak

- ▶ Number of women and girls receiving modern contraceptives (oral or injectable)
- ▶ Number of women presenting to a facility with pregnancy complications, by age group
- ▶ Number of pregnant women with at least one ante-natal (ANC) visit
- ▶ Percent of pregnant women registered at a health facility who report for at least one ANC visit
- ▶ Number of facility births, by age of mother
- ▶ Percent of facility births that are by cesarean section, by age of mother
- ▶ Number of women receiving timely post-natal care
- ▶ Percent of women registered at a health facility as having recently delivered receiving timely PNC
- ▶ Number of women screened for cervical cancer

Sex-specific indicators to monitor child health services during an outbreak

- ▶ Incidence of low birth weight (<2500 gm) among newborns, by sex of newborn
- ▶ Number of newborns admitted to a neonatal intensive care unit, by sex of newborn
- ▶ Immunization coverage rate for each vaccine included in the national vaccination schedule, by child's sex and age at immunization for each vaccine
- ▶ Number of children 0-59 months of age screened for wasting or stunting, by sex and age
- ▶ Number of children 0-59 months of age identified as severely wasted and/or stunted treated, by sex and age
- ▶ Number of children 0-59 years of age who received an age-appropriate dose of vitamin A, by sex and age

Sex-specific indicators to monitor health workers

- ▶ Number of health workers, disaggregated by occupational group, by sex
- ▶ Number of health workers for RMNCAH service provision, by sex
- ▶ Number of health workers who fall sick of the disease for which there is an outbreak, by sex
- ▶ Number of health workers with no access to appropriate PPE, by sex

Sources: Modified from (Resolve to Save Lives 2020; WHO 2020)

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GOAL: Public health emergency prevention, preparedness and response activities mitigate potential detrimental impacts of a public health emergency on gender-based violence (GBV).

Why address GBV within epidemic preparedness and response?

Addressing societal gender-based violence is not within the mandate of public health emergency preparedness and response. However, the repercussions of an epidemic for behavior and resources, as well as epidemic control measures themselves, can increase the risk of GBV, particularly that faced by women. Thus, public health emergency preparedness and response programs can and should take actions to assess and ensure – to the best of their ability and in partnership with GBV experts in their project areas — that their decisions and activities are cognizant of the risks of GBV in their target population, and that they minimize any increase in GBV risks triggered by epidemic control measures themselves.



Gender Benchmark 8.1: Capacity Levels for GBV in Public Health Emergencies

CAPACITY LEVEL	<p>Gender Benchmark 8.1: Public health emergency prevention, preparedness and response activities are organized to minimize additional GBV risks during an active outbreak.</p> <p>Objectives:</p> <ul style="list-style-type: none"> To develop joint preparedness for infectious disease outbreaks and GBV.
01 NO CAPACITY	There is no preparation for risks of GBV from activities associated with public health emergency prevention, preparedness and response.
02 LIMITED CAPACITY	Systematic assessment has been conducted during a non-emergency time period to identify steps necessary to achieve joint preparedness for outbreaks and potential surge of GBV during an outbreak.
03 DEVELOPED CAPACITY	Activities to mitigate additional risk of GBV during an epidemic have been developed, budgeted, and piloted.
04 DEMONSTRATED CAPACITY	Post-pilot actions to minimize risks of GBV associated with outbreaks are in place in at least half the areas of the country that are recognized as safely accessible.
05 SUSTAINABLE CAPACITY	Post-pilot actions to minimize risks of GBV associated with outbreaks are in place in all parts of the country that are recognized as safely accessible.

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Actions and Tools to Achieve Level 02 (Limited Capacity)

1 The potential for joint preparedness has been assessed

Available tools: *(To view tools: Click on the name of a tool or scroll to Tools)*

- ▶ **GEN-GBV 01** : Sample checklist to assess attention to risks of GBV as part of epidemic preparedness

2 The conditions necessary to lower risks of GBV in situations of institutional isolation have been assessed

Available tools: *(To view tools: Click on the name of a tool or scroll to Tools)*

- ▶ **GEN-GBV 02** : Assessment tool for ideal minimum safety standards for women and girls in group quarantine sites during an epidemic

Actions and Tools to Achieve Level 03 (Developed Capacity)

1 Activities to develop and/or strengthen joint preparedness are developed, budgeted and piloted

2 Required actions to minimize risks of GBV in locations for institutional isolation are developed, budgeted and piloted

Available tools: *(To view tools: Click on the name of a tool or scroll to Tools)*

- ▶ **GEN-GBV 03** : Illustrative measures for joint GBV-epidemic preparedness and response

Tools to Achieve Level 04 (Demonstrated Capacity)

No additional tools are needed.

Tools to Achieve Level 05 (Sustainable Capacity)

No additional tools are needed



Tools for GBV in public health preparedness and response

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GEN-GBV 02: Sample checklist to monitor attention to risks of GBV as part of epidemic preparedness.....	187
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Note: All tools can be modified to fit project and country requirements and context.

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GEN-GBV 01: Illustrative measures for joint GBV-epidemic preparedness and response

Strengthen internal project structures to be cognizant of GBV mechanisms and services in-country

- ▶ Establish a working relationship with any national-level mechanisms used for addressing GBV;
- ▶ Recruit a GBV coordinator or focal point;
- ▶ Request GBV providers for locations of existing safe shelters for survivors of domestic violence
- ▶ Ensure that all health preparedness staff are aware of these shelters in their areas;
- ▶ DO NOT convert safe shelters for survivors of domestic violence into additional capacity for outbreak preparedness and response.

Coordinate with GBV experts in the country for essential awareness and information

- ▶ Incorporate in workplans regular working sessions of PPR staff and GBV service providers so that:
 - ▶ Staff are aware of local GBV prevention and response service provision
 - ▶ Staff can obtain information on available GBV services during an outbreak.
- ▶ Work with GBV specialists to integrate age-appropriate awareness-raising messages on GBV (risks and referral mechanisms) into risk communication messaging for outbreaks;
- ▶ Strengthen response to GBV as part of first-response systems.

Integrate GBV surge preparedness in preparedness and response activities, training, and structures

- ▶ Post visual representations of up-to-date referral pathways for GBV survivors in clear locations throughout health facilities at all levels;
- ▶ Modify health facilities to ensure they are safe for women and girls;
- ▶ Train all health security staff and coordinators on risks of a GBV surge during an outbreak;
- ▶ Train PPR staff to understand their responsibilities and resources available to them in case of a GBV surge during an epidemic;
- ▶ Train staff to identify and refer to appropriate services women seen at disease screening, testing, and treatment sites who are deemed to be at risk of violence;
- ▶ Ensure that all staff are trained to safely and ethically support a survivor and refer her to the appropriate services in the event of a disclosure of violence during outbreak activities;
- ▶ Train EBS) hotline responders in a basic protocol to respond to callers who disclose that they are at risk of or experiencing GBV, and to refer such callers to appropriate services;
- ▶ Organize consultations with GBV providers in the country to identify other actions that could be taken to prepare for a GBV surge during an outbreak.

Recognize and address the potential of quarantine, shelter-in-place and other isolation measures to increase the risks of GBV

- ▶ Ensure that health providers are trained to identify women at risk of domestic violence and to take these risks into account when recommending home quarantine or shelter-in-place;
- ▶ Ensure that staff managing group shelter, isolation and quarantine sites have undergone training on an appropriate Code of Ethics and Professional Conduct;¹
- ▶ Ensure that there are female staff in all group shelter, quarantine and isolation sites to minimize the risk of violence to women from providers at such shelters;
- ▶ Ensure that group shelter, quarantine and isolation sites safe for women and girls.

¹ See, for example, WHO's Code of Ethics and Professional Conduct (<https://www.who.int/about/ethics/ethical-principles>); each country or project may have and use their own Code of Ethics and Professional Conduct instead or together with that developed by WHO.

GEN-GBV 02: Sample checklist to monitor attention to risks of GBV as part of epidemic preparedness

PROJECT ASPECT	ASSESSMENT ACTIONS	Y	N	PERSON RESPONSIBLE
Internal project structures and activities	▶ EMC committees and sub-committees include a GBV expert?			
	▶ Does the project team include a GBV expert?			
	▶ Have existing shelters and other resources for GBV survivors that can be accessed during an outbreak been mapped?			
	▶ Do health facilities engaged in outbreak preparedness and response display visual representations in clear on up-to-date information on GBV referral pathways?			
	▶ Have health facilities been assessed to ensure that they are safe for women (for example, sex-separated toilets, female staff, adequate lighting, etc.)?			
	▶ Does project risk communication include age-appropriate awareness-raising messages on GBV risks and referrals?			
	▶ Do first-response systems include adequate response to surges in GBV during an active outbreak?			
Staff training	▶ Have project staff received basic training to understand the importance of a potential GBV surge during an outbreak?			
	▶ Have project staff received basic training on available referral pathways for GBV survivors during an active epidemic?			
	▶ Have project staff been trained on how to safely and ethically support a survivor and refer her to the appropriate person(s) or services in the event of a disclosure of violence during a preparedness and response activity?			
	▶ Does at least 1 simulation of any type (tabletop, field, etc.) include injects on surges in GBV during an active outbreak?			
	▶ Have EBS hotline responders been trained on a basic protocol for callers who disclose that they are at risk of or experiencing GBV, and to refer such callers to appropriate services?			

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PROJECT ASPECT	ASSESSMENT ACTIONS	Y	N	PERSON RESPONSIBLE
Coordination with GBV experts	▶ Does the public health emergency management leadership collaborate with national-level experts on GBV prevention and response during an outbreak?			
	▶ Do PHEOCs and PHERRTs coordinate with GBV experts in-country?			
	▶ Do PHEOCs and/or PHERRTs include GBV resources in their emergency preparedness and response databases?			
	▶ Do health emergency staff across administrative levels liaise regularly with GBV prevention and response service providers?			

Sources: Adapted from (Inter-Agency Standing Committee [IASC] 2020; Peterman et al. 2020)

GEN-GBV 03: Assessment tool for ideal minimum safety standards for women and girls in group quarantine sites during an epidemic

SECTION 1: BACKGROUND			
Date of assessment		Name of assessor	
State/Province		Town/Village	
District		Street/Number	
SECTION 2: MINIMUM STANDARDS FOR SAFETY IN ACCESS			
2.1 Is the location easily accessible for women and girls? (Defined as close enough to walk, or with easily available transport)	► Yes ► No		
2.2 How far is the furthest village/town whose residents are assigned to shelter or quarantine in this location?	► Less than 1 km ► 1 – 5 km ► More than 5 km		
2.3 Is it safe for women and girls to walk to the location from their village/town (Defined as no danger of assault of any type)	► Yes ► No		
2.4 Is transport from the village/town to the location safe for women and girls? (Defined as no risk of assault in the transport)	► Yes ► No		
2.5 Is transport from the surrounding village/town to the location affordable for most women and girls?	► Yes ► No		
2.6 Can the space be accessed and used by women and girls with disabilities?	► Yes ► No		
2.7 Does the space have a separate, lockable entrance?	► Yes ► No		
2.8 Is the space far from any potential hazards for women's safety against sexual violence (e.g., security checkpoints, bars, etc.)	► Yes ► No		
2.9 Has the team spoken with women and girls to get their perspective on safety when accessing this space?	► Yes ► No		

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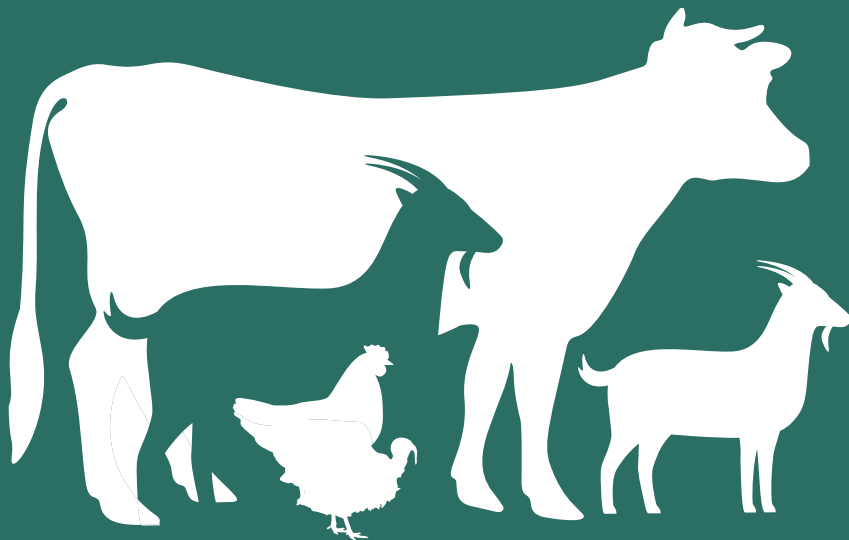
SECTION 3: MINIMUM STANDARDS FOR SAFETY INSIDE THE LOCATION	
3.1 Is the space women-only, women-and-children only, or also for families?	► Women-only ► Women-and-children only ► Families
3.2 Is the space closed to single (un-married or without a partner) men?	► Yes ► No
3.3 Does the space have adequate lighting? (Defined as no dark corners or spaces)	► Yes ► No
3.4 Does the space have fully-operational sex-disaggregated bathrooms (<i>functional latrines, bathing areas, sinks, etc.</i>)?	► Yes ► No
3.5 Is the women's latrine safely accessible? (Defined as easy to get to, well-lit, lockable)	► Yes ► No
3.6 Are there separate, lockable rooms for women and girls if needed?	► Yes ► No
3.7 How many full-time female staff members are at the site?	► 0 ► 1 only ► More than 1
3.8 Has the team spoken with women and girls to get their perspective on safety inside this space?	► Yes ► No
SECTION 4: GO/NO-GO DECISION VIS-À-VIS SAFETY FOR WOMEN AND GIRLS	
4.1 Can the space be used safely as a group isolation, quarantine, or shelter in place location for women and girls?	► Yes ► No
4.2 [If no] Can the space be used as a safe group isolation or shelter location with additional procurement and/or rehabilitation?	► Yes ► No
4.3 [If yes] What additional work on the space is required?	
4.4 Can the likely expense be supported in the program budget?	► Yes ► No
4.5 If not, can provisions be made to acquire supplemental funds for the additional work?	► Yes ► No

Source: Adapted from Annex 2, (International Rescue Committee 2018)

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Introduction

This Module will:

- (i) Assist project implementers and government livestock experts to understand the importance of men's and women's roles and responsibilities in livestock for preventing, detecting, responding, and recovering from zoonoses;
- (ii) Enable implementers and government livestock experts to identify gender-specific constraints in the livestock sector affecting the One Health approach;
- (iii) Provide examples of activities, approaches, and actions to inform the development of a project gender action plan (GAP) for animal health or support the identification of concrete gender actions; and,
- (iv) Guide implementers on integrating gender in Monitoring & Evaluation (M&E).

Developing a Gender Action Plan for Animal Health in One Health

Three Steps to A Gender Action Plan (GAP) for Livestock Health in One Health

STEPS	HOW?
Step 1: Define gender-specific roles, responsibilities, and constraints	<ul style="list-style-type: none"> ▶ Identify existing studies, research papers, project assessment, and data (such as that collected or compiled by International Livestock Research Institute (ILRI), local research centers, universities, NGOs, etc.); ▶ Conduct qualitative evaluations or assessments.
Step 2: Develop a Gender Action Plan	<ul style="list-style-type: none"> ▶ Identify gender actions based on roles, responsibilities, and constraints identified through Steps 1 and 2; ▶ Develop a Theory of Change to describe how selected gender actions will address key identified gender gaps.
Step 3: Monitor progress and results	<ul style="list-style-type: none"> ▶ Develop gender informed indicators to track progress; ▶ Integrate some of the gender informed indicators in the project Results Framework.

Step 1: Define gender-specific roles, responsibilities, and constraints

Figure 9.1 lists key factors affecting men and women roles and responsibilities in the livestock sector. Roles and responsibilities in livestock matter as:

- ▶ Women play an important role in the livestock sector and may be differently affected— compared to men—by animal health risks. For example, they face greater exposure to zoonotic diseases and foodborne zoonoses when managing animals, milking, or handling raw animal products such as milk, meat, or eggs. Frequent daily contact with poultry and small ruminants exposes women to higher specific health and safety risks, such as avian influenza, tuberculosis, and brucellosis, among other zoonotic diseases. They are therefore more exposed to health and safety risks related to poultry raising, such as the Highly Pathogenic Avian Influenza (HPAI) (FAO 2013).
- ▶ A knowledge of gender-specific roles and responsibilities enables those developing programs and training to identify who is in the best position to observe clinical signs to signal animal health problems (World Bank, Food and Agriculture Organization, and International Fund for Agricultural Development 2009).

Figure 9 1 Gender Differences in Roles and Responsibilities in Animal Health

Customary rules	<ul style="list-style-type: none"> • Some tasks may be viewed as a male or female responsibility. • In much of Sub-Saharan Africa, milking dairy animals has traditionally been women's responsibility, whilst the commercialization and the slaughter of dairy animals has traditionally been undertaken mainly by men
Age	<ul style="list-style-type: none"> • Children of different ages carry out different livestock-related tasks such as grazing and dairying.
Type of livestock	<ul style="list-style-type: none"> • Women tend to own small ruminants, bees, hogs, and poultry, and men typically own cattle and buffaloes. • Women may prioritize livestock that contributes more to household food than to household income.
Age of livestock	<ul style="list-style-type: none"> • Women may be responsible for young stock and men for adult stock.
Livestock production type	<ul style="list-style-type: none"> • Livelihood: Small livestock holdings typically intended as a source of household livelihood are frequently managed by women. • Commercialization: women are less present in commercialization as when women's livestock production reaches a larger size and a more profitable commercialization stage it is frequently taken over by men. • Pastoralism: Men leave home to graze large livestock (camels and cows) at distant communal sites, leaving women alone with small children managing small stocks.
Household headship	<ul style="list-style-type: none"> • Women heads of households responsible for all livestock and household work • Limited time for female heads of household for proper livestock management, trainings, engagement with community animal health workers, etc
Country emergencies (conflicts, floods, drought)	<ul style="list-style-type: none"> • Women's responsibilities for all kinds of livestock can increase. • Droughts increase women's and girls' workloads as they have to travel further to find animal feed. • Increased work pressure and responsibilities for women.

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Gender-specific constraints at different stages of livestock value chains affect women, men, and households' capacity to engage in preventing, detecting, responding, and recovering from livestock infectious diseases. For example, compared to men, women are likely to have:

- ▶ limited access to animal health services (e.g., vaccines, deworming) due to economic, social and cultural reasons as well as lack of mobility and time;
- ▶ lack of animal health advice relevant to specific production needs;
- ▶ lack of resources to pay for private veterinary services;
- ▶ lack of decision-making power on investment in an animal;
- ▶ limited knowledge about zoonotic diseases despite being first identifiers of diseases in children and animals.

Available tools

- ▶ **GENANIM 01** : Operationalizing Step 1 of a Gender Action Plan – Example of Brucellosis in Benin.
- ▶ **GENANIM 02** : Examples of Gendered Constraints in Livestock Sector Activities related to Zoonoses.
- ▶ **GENANIM 03** : Checklist for Assessing Potential Gender Barriers to Vaccination
- ▶ **GENANIM 04** : Illustrative Questionnaires for Assessing Constraints to Women's Participation in Trainings
- ▶ **GENANIM 05** : Terms of Reference for a Qualitative Evaluation of Gender Roles, Responsibilities and Constraints in Animal Health for Project X.

Step 2: Develop a Gender Action Plan

A GAP identifies gender-responsive activities, approaches, and actions to prevent, protect from, and/or respond to animal health risks, based on identification of gender roles, responsibilities, and constraints. **While activities and approaches may focus mainly on women as women are typically disadvantaged in most contexts, ideally, they will also involve men and respond to their roles, challenges, and needs.** An effective project GAP also requires:

- 1 starting with a Theory of Change;
- 2 integrating gender actions within implementation manuals (defining when these actions take place, how, and who is responsible);
- 3 including gender actions within a program's Annual Work Plan with a clear budget allocation and targets (when applicable) for gender actions;
- 4 developing gender indicators in results chains to be able to track progress;
- 5 including gender capacity-building activities in capacity building plans;
- 6 integrating gender in overall program evaluation and adding a dedicated qualitative evaluation;
- 7 developing a communication strategy for the program that takes into account gender-differentiated opportunities and constraints so as to reach both men and women.

Available tools

- ▶ **GENANIM 06** : Illustrative Theory of Change to Integrate Gender in Animal Health
- ▶ **GENANIM 07** : Illustrative Actions for a Gender Action Plan.

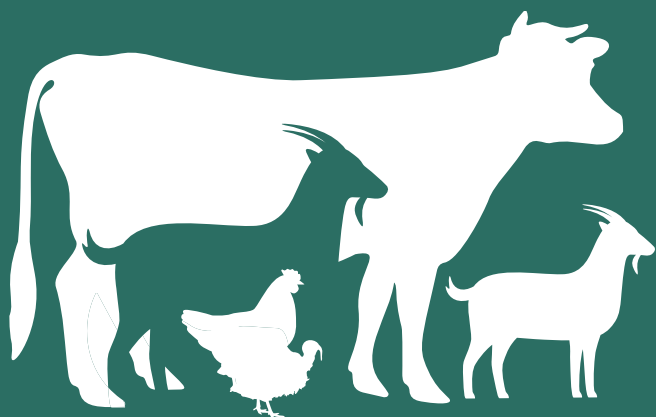
Step 3: Monitor Progress and Results in Addressing Gender Dimensions of Animal Health

The final step is to identify selected number of gender indicators. Reporting against these indicators is useful to track progress and results. At the same time, quantitative indicators do not provide reasons for success or failure nor provide a complete picture of progress on gender-specific achievements in animal health to prevent, detect and respond to zoonoses. It is therefore important to include targeted small gender-specific evaluations and/or to include gender-specific elements in larger project evaluation.

Available tools

- ▶ **GENANIM 08** : Illustrative Results Chain for Gender in Animal Health
- ▶ **GENANIM 09** : Key Steps for Integration of Gender in Monitoring and Evaluating.
- ▶ **GENANIM 10** : Illustrative Indicators to Monitor Progress in Integrating Gender in Animal Health
- ▶ **GENANIM 11** : How to Document Best Practices in Integrating Gender in Animal Health





Tools To Integrate Gender in Animal Health For Infectious Disease Management

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GENANIM 01: Operationalizing Step 1 of a GAP – Example of Brucellosis in Benin

Brucellosis is a bacterial disease caused by various *Brucella* species which mainly infect cattle, swine, goats, sheep, and dogs. The disease in animals is characterized by abortions or reproductive failure. While animals typically recover and can have live offspring following the initial abortion, they may continue to shed the bacteria. Brucellosis is typically spread when the infected animal aborts or gives birth. Humans generally acquire the disease through direct contact with infected animals, by eating or drinking contaminated animal products or by inhaling airborne agents. Most cases are caused by ingesting unpasteurized milk or cheese from infected goats or sheep. Brucellosis typically causes flu-like symptoms, including fever, weakness, malaise, and weight loss, as well as miscarriages in women. However, the disease may present in many atypical forms. In many patients the symptoms are mild and, therefore the disease may not be diagnosed or may be incorrectly diagnosed. Treatment requires antibiotics. Brucellosis results in huge economic losses to dairy, sheep, goat and pig farmers.

Source: <https://www.woah.org/en/disease/brucellosis/>

Operationalizing Step 1: Assessment of Gender-Specific Roles and Responsibilities

- **Use existing data or undertake a rapid assessment to document specific roles and responsibilities of each household member, by gender.** This section provides an example of findings from such an analysis for brucellosis of sheep and goat in production, processing, and commercialization from Benin.

Table GENANIM 01.1: Data on Gender Roles and Responsibilities in Sheep and Goat Production in Benin (%)

ROLES	ALL FAMILY MEMBERS	ADULT MALES	ADULT FEMALES	ADOLESCENT AND CHILDREN
Accessing land	21.2	58	20.5	0
Fattening	41.4	25.8	30.6	0.4
Crop residue collection	35.6	8.6	33.9	5.45
Harvesting of browse	48	22.3	6.8	5.75
Animals to grazing area	37.1	13.5	9.6	9.975
Feeding	51.5	10.8	30	1.925
Pen cleaning	12.9	5.5	34.6	11.78
Watering	47.8	10.4	24.9	4.2
Cut and carry - wet season	38.3	17.2	9.6	8.725
Cut and carry - wet season	40.9	16	13.8	7.2
Processing	18.8	43.8	18.8	4.7
Marketing of live animal	2.2	50.6	44.9	0.575
Marketing of meat	2.9	28.6	68.6	0
Hide marketing	0	50	0	0
Disease control	10.3	48.5	34.6	0.4

Slaughtering	3.7	66.7	1.9	0.475
Deciding when to sell	1.1	49.8	47.4	0.45
Tethering	43.7	14.7	21.1	5.15
Shepherding	35.6	26	23.3	3.775
Money from animal sale	6.3	57.5	35.2	0.225
Milking	60	20	20	0
Food preparation	0.8	3.1	74	5.5

Source: (Osei-Adu et al. 2015)

Analyze data to identify potential entry points for gender actions based on responsibilities. For example:

HOUSEHOLD MEMBER	KEY RESPONSIBILITY	ENTRY POINT
Women	Food preparation and safety; boiling milk	Information to women on significance of boiling milk to avoid contamination of the household by brucellosis.
Women and children	Pen cleaning (including after birthing)	Information to women and children on good hygiene, especially hand washing.
Men	Slaughter of livestock	Information to men on hand washing, hygiene and cleaning up at place of slaughter.
Men and women	Disease control	Training on disease identification, control and prevention in ways that enable access to training for women (hours, location, language, media, etc.)

- Analyze data also to identify missing information. For instance:
 - The data do not specify who manages birthing. This is important to identify to correctly target information on the poor reproductive performance of brucellosis.
 - There are no data on women headed households. Yet, it would be important to understand their time and resource constraints in prevention or detection of brucellosis.
 - There is no data regarding the transformation and commercialization of sheep's and goats' meat and milk. This is important to identify as contamination can happen along the value chain if not contained at the production site.

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GENANIM 02: Examples of Gender-based Constraints in Livestock Sector Activities related to Zoonoses

AREA	GENDER-SPECIFIC CONSTRAINTS
Ownership and control over animals and income	<ul style="list-style-type: none"> ▶ Women tend to own small ruminants, bees, hogs, and poultry because these species require low inputs and can be kept close to home; ▶ Men typically own cattle and buffaloes, which require more land and finance. ▶ Income from selling meat, milk, and eggs can increase women's decision-making and economic power in the family and community, but women frequently lose control over this activity once selling animal products becomes more profitable or when the value chain becomes more complex. ▶ Women's lack of control over income then limits their ability to seek medical advice from veterinarians and purchase drugs or vaccines.
Exposure to zoonotic diseases and food safety	<ul style="list-style-type: none"> ▶ Women often are more exposed than men to zoonotic diseases through their livestock activities and handling of raw animal products. ▶ Women have less knowledge about zoonotic diseases than men. ▶ Women have the main responsibility for household meals and thus training in food hygiene is a priority.
Access to animal health services	<ul style="list-style-type: none"> ▶ Women have limited access to artificial insemination, vaccines, deworming, and veterinary services due to cultural reasons as well as the lack of mobility, time, and finance to pay for private veterinary services, among other constraints. ▶ Even when women may own animals, they are not always recognized as formal livestock-keepers, which limits their ability to request services.
Livestock health priorities	<ul style="list-style-type: none"> ▶ Women may be more likely to identify and seek care for livestock diseases that affect livestock products they control such as milk; ▶ Men to prioritize diseases with high herd mortality rates. ▶ Animal health workers might favor treating large animals, and women and their (typically smaller) livestock are ignored.
Adoption of bio-security measures	<ul style="list-style-type: none"> ▶ Biosecurity measures (including farmer biosecurity) can include social and financial cost as well as changes in roles and responsibilities that affect adoption and effectiveness of measures such as bio exclusion and biocontainment. ▶ Women may have less time than men to adopt bio-security measures with their animals: The cost to human and social capital can be high for them considering that they already have heavy workloads (both productive and at home) with less time to reallocate towards biosecurity measures than men. ▶ Some prevention measures might also not be affordable by women, such as preventive vaccination.
Antimicrobial resistance in animals	<ul style="list-style-type: none"> ▶ There are likely to be gender differences in knowledge of: <ul style="list-style-type: none"> ○ antibiotics usage in livestock; ○ the concept of antimicrobial resistance; and ○ good animal husbandry practices (GAHP). ▶ Men and women's exposure to AMR varies based on livestock species, roles and responsibilities around livestock (at farms, slaughterhouses, markets, etc.).
Pregnancy	<ul style="list-style-type: none"> ▶ Pregnant women are particularly vulnerable as they are immune suppressed. They can be infected by zoonoses (e.g., brucellosis, toxoplasmosis, etc.) while carrying out regular livestock activities or by consuming uncooked or insufficiently cooked animal products, which can lead to miscarriage, preterm birth, or stillbirth.
Gender and COVID-19	<ul style="list-style-type: none"> ▶ COVID-19 worsened existing constraints. For example, in Uganda, motorcycle taxis were forbidden to take passengers, constraining women veterinarians and animal health workers who relied on such taxis, while male veterinarians, who drive their own motorcycles, were not similarly constrained. ▶ Women and men in communities were both affected by canceled government livestock vaccinations. ▶ To supplement income during the pandemic women were known to have been more likely to sell livestock species they controlled than did men.

Sources: (Mollard and Taivalmaa 2017; World Bank, Food and Agriculture Organization, and International Fund for Agricultural Development 2009; World Bank 2019; WHO 2018; IDRC 2020; Watson 2014; IDRC 2020; Kimani 2021)

GENANIM 03: Checklist for Assessing Potential Gender Barriers to Vaccination

Note: Apply an X to note the applicability of each potential barrier to women (female farmers) and/or men (male farmers).

POTENTIAL BARRIERS TO VACCINATION	WOMEN	MEN	COMMENTS
Farmers cannot afford the fees			
Farmers cannot afford to hire additional labor to move livestock to vaccination point			
Farmers focus only on more productive and valuable animals for vaccination			
Perception that farmers should not pay for government vaccination			
Difficulties in taking livestock to vaccination points			
Lengthy distances to vaccination sites			
Insecurity while traveling to vaccination sites (potential animal theft, injuries and insecurity to herders)			
Vaccination site is too far away or otherwise inconveniently located			
Vaccination conducted by male vaccinators			
Vaccination conducted by female vaccinators			
Vaccination conducted by male community animal health workers			
Vaccination conducted by female community animal health workers			
Inadequate vaccination crushes at vaccination site in communities			
Difficulty to restrain animals when there are no cattle crush			
Inconvenient hours of vaccination			
Inconvenient dates and times for vaccination			
Untimely vaccination (compared to when outbreak started)			
Travel time too long to get livestock vaccinated			
Shortness of vaccination campaign duration			
Wait time at vaccination site too long			
Fear of disease spread during livestock vaccination campaigns (due to proximity of other animals (including pests, ticks, etc.) and usage of single needle for vaccination)			
Fear of disease spread during livestock vaccination campaigns because of usage of single needle for vaccination			
Fear of vaccine side effects			
Disinterest in vaccines			

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POTENTIAL BARRIERS TO VACCINATION	WOMEN	MEN	COMMENTS
Lack of or limited access to vaccination information			
Lack of knowledge of vaccine importance			
Not informed about campaign in a timely manner (too long ago or not long enough)			
No access to means of information on vaccination and vaccination campaign			
Lack of veterinary officers to organize vaccination			
Lack of community vaccinators			
Mistrust of veterinary vaccines (issue with cold chain, expired, etc.)			
Mistrust of veterinary officers (
Mistrust of community animal health workers			
Unavailability of vaccines for farmers' specific stock			
Limited decision making about vaccinations			
Limited or no access to roads to reach vaccination sites			
Anti-vaccination religious or other beliefs			
Source: Developed and adapted from (Mutua et al. 2019)			

GENANIM 04: Illustrative Questionnaires for Assessing Constraints to Women's Participation in Trainings

Questionnaire to Understand Perceptions of Female Employees

Read to each prospective respondent: The objective of this survey is to understand your participation in training activities of [organization name] and what would increase your participation or the one of your female colleagues in the different trainings organized by [organization name]. We are interested in improving your participation in [organization name]'s professional trainings and need to understand your constraints and needs so that you too can benefit from the trainings organized. Your responses will not be shared with others and your name will not be used in any analysis. Therefore, any information you share with us will be confidential.

Do you accept to participate?

- ☐ Yes (if the woman answers "yes" continue.)
☐ No (if the woman answers « no », thank her and leave.)

Basic Information:

Name of interviewer: _____

Date of the interview: _____

Province: _____

District: _____

Village : _____

Name of the person interviewed (only women for this questionnaire) :

Professional Title : _____

Married :

- ☐ Yes ☐ No

Children

- ☐ Yes ☐ No

(If the answer is yes, note the number, sex and age of children)

1 Have you participated in any of [organization name] training in the last 3 years?

- ☐ Yes _____
☐ No

(If the answer is No, continue with questions in section 5)

2 If yes, which ones?

Tools for detection « Event Mobile Application »

- ☐ _____

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- 3 If you participated in one or more trainings, why did you participate? (Multiple answers possible, check the box when applicable)

- ☐ The training was recommended/necessary for my job.
- ☐ The training seemed interesting to me.
- ☐ The training was close to my workplace, and I did not need to travel.
- ☐ My other female colleagues were also going to participate in this training.
- ☐ My husband approved of my travel to attend this training.
- ☐ The training was short less than a day.
- ☐ My supervisor and/or colleagues encouraged me to attend.
- ☐ The per diems were sufficient for me to participate.
- ☐ The trainer was a woman, or the trainers included women.
- ☐ Other reasons (give explanations):

If you participated in any training(s), how satisfied were you with it? Complete the tables for each of the trainings in which the respondent has participated (Repeat 3A and 3B up to 3 times to get responses related to the last 3 trainings).

3A. Training 1

What was your level of satisfaction with?

TRAINING 1, NAME AND DATE OF TRAINING:						
	Excellent	Good	Moderate	Poor	Very Poor	Not Applicable
The location of the training						
The period/time of training						
The dates chosen						
The format of the training (face-to-face vs. on-line)						
The content of the training						
The number of female participants						
Number of male participants						
The total number of participants						
The trainer						
Gender of the trainer(s)						
Respect for participants						
Level of per diem						

For any answer above that is less than “good”, ask for an explanation:

3B: Give suggestions to improve the trainings and your participation in the trainings:

TRAINING 1, NAME AND DATE OF TRAINING:	
Aspect of training	Suggestions for improvement
The location of the training	
The period/time of training	
The dates chosen	
The format of the training (face-to-face vs. on-line)	
The content of the training	
The number of female participants	
Number of male participants	
The total number of participants	
The trainer	
Gender of the trainer(s)	
Respect for participants	
Other:	

4 If you were unable or unwilling to participate in any of [organization name's] training(s), what were the reasons?

- ☐ The trainings were not recommended for my job.
- ☐ The trainings did not seem interesting or useful for my work.
- ☐ The trainings were too complex.
- ☐ The training was far from where I work/live and I could not travel.
- ☐ I did not feel safe traveling to this training.
- ☐ No other female colleagues were going to attend this training; I was going to be the only female.
- ☐ My husband did not approve my traveling to attend this training.
- ☐ The training was more than one day (over several days).
- ☐ My supervisor and/or co-workers did not encourage me to attend the trainings.
- ☐ My supervisor did not want me to participate in the training.
- ☐ The per diems were not sufficient for me to participate.
- ☐ I don't have time because I have too much work.
- ☐ The trainer was a man.
- ☐ Other reasons (give explanations) _____

5 Would you be interested in trainings? (multiple responses allowed; mark all relevant boxes)

☐ Where the participants would only be female colleagues.

☐ Whose trainer would be a woman.

☐ Where you don't have to travel.

☐ Where you can participate online.

☐ On other topics. Which ones? _____

☐ Other reasons (please explain) _____

6 How would you improve women's participation in [organization name] training courses? What are your recommendations?

Questionnaire to Understand Perceptions of Male Employees

The aim of this evaluation is to understand what would help increase the participation of your female colleagues in the various training courses organized by [name of organization] as women's participation is relatively low. We are interested in improving their participation in professional training courses and we need to understand their constraints and needs so that they too can benefit from the training courses organized. Your answers will not be shared with others and your name will not be used in any analysis. Therefore, any information you share with us will be kept confidential.

Basic Information:

Name of interviewer: _____

Date of the interview: _____

Province: _____

District: _____

Village: _____

Name of the person interviewed (only men for this questionnaire): _____

Professional Title: _____

1 In your opinion, why do a large majority of your female colleagues do not take part in [organization name] training courses?

- ☐ Supervisors/managers do not suggest to women to participate in [name of organization]'s training courses.
- ☐ Female colleagues are not interested in the trainings.
- ☐ Training content is too complicated for women.
- ☐ Training courses are too long (more than a day).
- ☐ Female colleagues cannot travel far from their families for trainings.
- ☐ Training courses offered are not necessary for women colleagues' work.
- ☐ Female colleagues don't want to take part in training courses where the trainers are only men.
- ☐ Female colleagues do not want to take part in training courses where all other participants are men.
- ☐ Women are not allowed by their husbands to travel to attend trainings.
- ☐ Women have too much work at home to participate in long training courses far from home.
- ☐ Supervisors and/or male colleagues do not encourage female colleagues to participate in training.
- ☐ Women are afraid of being verbally, physically and/or sexually harassed during trainings.
- ☐ Women prefer connected rather than face-to-face training.
- ☐ Women don't feel safe traveling to trainings.
- ☐ Per diems are insufficient for women to participate in training in good conditions (accommodation, transport, etc.).
- ☐ Training dates and times are not convenient for women.
- ☐ Other reasons (give explanations).

2 How would you improve the participation of women in [name of organization]'s training courses? What are your recommendations?

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Questionnaire for Supervisors/Managers on Selection Processes for Training Courses

The purpose of this evaluation is to understand what would increase the participation of your female colleagues in the various training courses organized by [name of organization] as women's participation is relatively low. We are interested in improving their participation in [name of organization]'s professional training courses and we need to understand how participants in organized training courses are selected. Your answers will not be shared with others, and your name will not be used in any analysis. Therefore, any information you share with us will be kept confidential.

Basic Information:

Name of interviewer: _____

Date of the interview: _____

Province: _____

District: _____

Village: _____

Name of the person interviewed: _____

Professional Title: _____

1 How do you select training participants?

I propose to participate in training courses (multiple responses allowed; please mark boxes as needed):

- ☐ To all colleagues who need this professional training for their work.
- ☐ To all colleagues who have the qualifications to participate in this professional training.
- ☐ To colleagues who are interested in the training.
- ☐ Only to colleagues who are top performers.
- ☐ Only to male colleagues, as women are unable to participate in training.
- ☐ To both male and female colleagues.

2 How would you improve the participation of women in “your organization’s” training courses? What are your recommendations?

GENANIM 05: Terms of Reference for a Qualitative Evaluation of Gender Roles, Responsibilities and Constraints in Animal Health for Project X

BACKGROUND

Project X aims to increase the production efficiency of household-based livestock producers and reduce zoonotic infectious diseases through improved prevention, detection, and response. The main project beneficiaries will be household livestock producers. The project components include the following:

- ▶ **Upgrading livestock production**, which will support groups and cooperatives formation, matching grants, animal production and animal health technical assistance.
- ▶ **Strengthening of veterinary and livestock services**, which will support capacity building and training of the Department of Livestock Production and Department of Animal Health staff, improvement of key guidelines for surveillance of animal diseases, food safety and good hygiene protocols, and sampling methods for monitoring prevalence of animal diseases.
- ▶ **Project management, coordination, and monitoring and evaluation**, which will support project implementation through the strengthening of coordination between government agencies at central, provincial and district levels, and project activities and impact monitoring and evaluation (M&E).

1 OBJECTIVE OF THE ASSIGNMENT

The objective of the assignment is to identify and analyze gender-differentiated roles, responsibilities and constraints in animal health pertinent for prevention, detection, response to, and recovery from zoonotic infectious diseases.

2 ACTIVITIES

The consultant will be responsible for the following tasks:

- 1 Synthesize roles, responsibilities, and opportunities of men and women, boys and girls in **different parts of the value chain for each livestock type (small ruminants, cattle, poultry, dairy, meat) to answer the following questions (with regional specificities as relevant):**
 - ▶ Who does what? (For example: milking, selling meat, cleaning dug, animal health care, raising chicks, grazing cattle, including processing, transporting and marketing);
 - ▶ Who controls what? (For example: income, draft implements, donkey transport, grazing lands)
 - ▶ Who has access to information about animal health?
 - ▶ Who knows what? (Disease patterns, availability and quality of water, grazing lands, market trends)
 - ▶ Who is affected by what? (to design more effective processes of prevention, diagnosis, and treatment of livestock disease and to identify who is at risk of zoonoses)
 - ▶ Who has decision-making power over livestock and animal health activities in the household and community?
- a Who has knowledge about animal health particularly to prevent, detect, respond to, and recover from infectious diseases?

- 2 Identify the key gender-based gaps and constraints in the proposed project area :
 - ▶ Ownership and management and their implications for animal health and zoonoses.
 - ▶ Access to technologies, training and extension services, financial services and markets.
 - ▶ Species and breed preferences.
 - ▶ Access to feeds and feed resources.
 - ▶ Access to veterinary services, drugs and animal vaccination.
 - ▶ Decision making on livestock management, health, processing and marketing.
 - ▶ Constraints to membership in farmers' associations or producers' organizations focusing on livestock.
 - ▶ Among service providers: Provision of animal health services at national, regional and local level (for example: among women veterinarians, women community animal health workers, etc.).
- 3 Analyze the constraints that animal health actors face when offering animal health services, vaccination and drugs to men as compared to women livestock farmers to prevent, detect, respond to, and recover from infectious zoonoses.
- 4 Assess availability and quality of gender-disaggregated data and data gaps relevant to gender in animal health and zoonoses for the project.
- 5 Analyze policy, legal and cultural aspects hindering men's and women's ability to access animal health information, training, resources, and services (including vaccination, etc.) to prevent, detect, respond to, and recover from zoonoses.
- 6 Assess the effectiveness of animal health services in meeting the needs of men as compared to women farmers to prevent, detect, respond to, and recover from zoonoses, and identify possible gender-specific constraints (technical, logistical, and attitudinal) to improvements in the delivery of these services (e.g., more equitable access).
- 7 Propose concrete recommendations and suggest activities to integrate gender in animal health for the project.

3 METHODOLOGY

- ▶ Desk study of research, literature, organizational documents such as country gender assessments, and poverty and social impact analyses from different stakeholders and organizations in the country.
- ▶ Key informant interviews using participatory techniques (with, for example, livestock project beneficiaries, women farmers' focus groups, women's groups, community leaders, and farmers organizations).
- ▶ Interviews with men and women staff in national institutes of animal health (such as universities, technical colleges, research centers, etc.) at all levels.
- ▶ Discussions with staff of ministry of livestock and department and staff of women's affairs at the ministry of livestock/agriculture.
- ▶ Discussions with NGOs, donors, and UN organizations working in livestock sector.
- ▶ Interviews of relevant private sector representatives and agencies providing different rural services for animal production and health such as credit, inputs, and marketing.

4 DELIVERABLES

- ▶ A descriptive and analytic report of findings for the issues described above.
- ▶ A power point presentation giving preliminary conclusions and recommendations to be presented to government, other partners, and the project team.

5 TIMETABLE

The indicative timeframe for the assignment:

ACTIVITY	TIMEFRAME
Start of the assignment	
Field work/Mission	
Draft report	
Final report	

6 REQUIRED QUALIFICATIONS AND EXPERIENCE

- ▶ At least a MA degree in agricultural economics, or productive agriculture disciplines, natural resource management or gender and social sciences related to agricultural and rural development.
- ▶ Sound knowledge of gender issues in agriculture and rural development, particularly in livestock.
- ▶ At least 8 years work experience in the field of gender or other social sciences in rural development, agriculture, and/or natural resource management.
- ▶ Familiarity with the region.
- ▶ Knowledge of quantitative and qualitative research methods.
- ▶ Experience in conducting socioeconomic studies.
- ▶ Ability to write well in the language of the country in which the study is being conducted.

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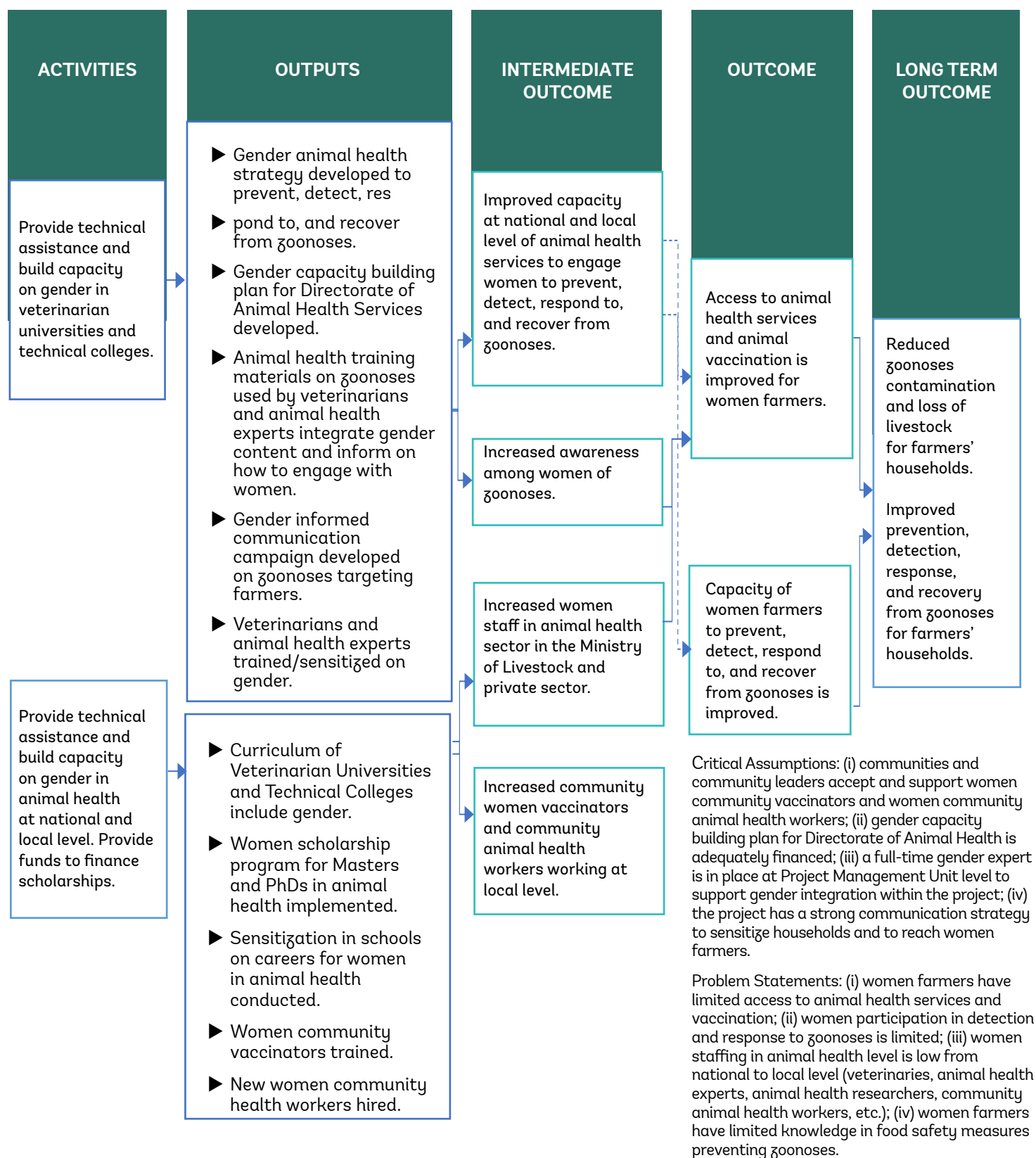
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GENANIM 06: Illustrative Theory of Change to Integrate Gender in Animal Health



GENANIM 07: Illustrative Activities, Approaches and Actions for a GAP

Table 9.3 : Examples of Gender Activities, Approaches and Actions

ILLUSTRATIVE GENDER-RESPONSIVE ACTIVITIES, APPROACHES, AND ACTIONS	
<p>Surveillance and Response at National Level</p> <p>Surveillance and response guidelines, tools and animal health data are usually not gender informed. There is limited gender knowledge among animal health experts and veterinarians of: (i) gender-specific household roles and responsibilities; (ii) women's specific constraints; and (iii) zoonotic disease risks based on household-level activities and responsibilities.</p>	<ul style="list-style-type: none"> ▶ Conduct an assessment on how to better integrate attention to gender in animal health surveillance. ▶ Identify current levels of knowledge among livestock farmers (men and women) on zoonoses, including identification and ways to prevent outbreaks and transmission. ▶ Integrate gender analysis of roles (and gender sensitization), responsibilities, and constraints in animal health in all implementation and training guides. ▶ Train animal health experts and veterinarians on gender aspects of zoonoses surveillance and management of rumors at the community level. ▶ Update format of animal diseases bulletins to include key gender messages for identified zoonoses, including how gender-specific roles and responsibilities influence farmers' experiences of zoonoses. ▶ Include sex of farmer (when feasible), and differences in animal mortality by the sex of farmer in collection and analyses of animal mortality. ▶ Explore use of multiple communication media, like videos, for illiterate farmers particularly women. ▶ Raise awareness among national partners (NGOs, private sector, etc.) about the different roles of female and male farmers in the detection and management of zoonoses. ▶ Develop in collaboration with laboratories the option of having smaller vials for brucellosis vaccination to reach poor households, women headed households and women with small herds.
<p>Animal health workforce</p> <p>Few women veterinarians, para-veterinarians, and animal health experts enroll in and graduate from universities and vocational schools.</p> <p>Women scientists in animal health laboratories have limited leadership opportunities and are often clustered at the lower levels of responsibility and decision-making²⁰.</p>	<ul style="list-style-type: none"> ▶ Conduct a gender-specific livestock health human resources inventory (public and private sector). ▶ Support communication campaigns encouraging women to apply to vet and para-vet school. ▶ Support a rapid assessment to identify reasons for low representation of women in professions related to animal health. Support and finance actions to address identified reasons. ▶ Implement mentorship and leadership programs for women to access leadership position in veterinary health laboratories. ▶ Identify male gender champions where possible (for example a laboratory director) to mentor young women staff working in the laboratories.

²⁰ Data collected from the OIE has shown that 59% of the staff in animal health laboratories is female, while only 16% of lab managers are women (<https://rr-africa.oie.int/en/news/science-is-an-adventure-enhancing-gender-equality-to-foster-development-in-nigeria/>).

<p>Animal Health Workforce Training and Capacity Building</p> <p>Veterinarians, para-veterinarians, and animal health experts have a limited understanding of gender in animal health as animal production and animal health curriculums in technical schools and universities frequently do not integrate gender.</p> <p>Male veterinarians or extension agents encounter difficulties in providing services to women due to cultural reasons or lack of knowledge on how to engage with women in the context of livestock.</p>	<ul style="list-style-type: none"> ▶ Integrate content on gender in animal health (for diagnosis, treatment, biocontainment, etc.) in veterinarians' and animal health workers' university and technical college curricula. ▶ Train frontline veterinarians on gender and how to engage with livestock owners and caregivers across gender. ▶ Integrate gender content in all training manuals for surveillance when feasible. ▶ Include content on gender aspects of animal health when training partners in surveillance of zoonoses (NGOs, farmers, cooperatives, etc.). ▶ Conduct training of trainers who can then train community-level veterinarians and animal health experts on how to conduct "gender friendly training, that is": <ul style="list-style-type: none"> ▶ • select times of day convenient to women and men; ▶ • provide training to both husband and wife in a household; ▶ • provide women's groups with training venues that have daycare, gender-segregated bathrooms, and access to clean water, as feasible; and ▶ • adapt training materials and formats to gender-specific literacy and language.
<p>Surveillance and Response at Community Level</p> <p>Women often are more exposed to zoonotic diseases and have limited access to effective animal health and veterinary services.</p> <p>It is frequently difficult for women to join mixed cooperatives in cultural contexts that frown on intermingling across gender; in these situations, women may gain more benefits from all female livestock-related groups, associations, and cooperatives, which can also serve as an accessible opportunity to have access to animal health information and share knowledge.</p> <p>Women play very important roles in animal care, and it is frequently not acknowledged as they do not own animals (for example women clean, collect cow dung, milk, observe ill health in animals and report this to men, and care for calves, goats, sheep, and chickens.) Even when women may own animals, they are not always recognized as formal livestock-keepers, which limits their ability to request animal health extension and veterinary services.</p>	<ul style="list-style-type: none"> ▶ Hire and train women as community-level animal health workers, including vaccinators, as feasible. ▶ Design household and community trainings to ensure equitable participation of men and women engaged in livestock; take measures such as training at times of day when women and men can participate either together or separately); engaging women livestock herders; ensuring female trainers as contextually appropriate. ▶ Identify women-focused partners such as women cooperatives, women farmer groups, and women model farmers to carry out community-based surveillance. ▶ Train women farmers to identify, prevent, and report livestock diseases. ▶ Raise awareness and disseminate animal health knowledge through mainstream media and communication channels that are most popular among women at the community level (or that specifically target women), such as radio, TV soap operas, billboards, flyers, leaflets, mobile theater groups, hotlines, or text-messaging among others. ▶ Design and implement gender-specific food hygiene training, addressing key health and food safety issues. ▶ Develop mobile teams of veterinarians and community animal health workers to conduct vaccination campaigns directly at households (with particular attention to women-headed households). ▶ Promote knowledge exchange between women livestock owners, such as through WhatsApp group/Facebook groups, cross-community exchange events, and cross-national exposure trips. ▶ Schedule vaccination campaigns, trainings, and information campaigns at times and places that meet women's and men's needs, such as at women's group meetings, women milk cooperatives meetings, with mobile animal health clinics in the fields (with women staff) and at households' level. ▶ Sensitize school students (boys and girls) on other zoonotic diseases, linkages with human health, and intra-household collaboration around livestock.

<p>Livestock emergency recovery</p> <p>Women frequently might not be aware of the possibility of restocking following the culling of infected stock. They may thus be less willing to inform animal health technicians about infected stock.</p> <p>In societies or communities where women have limited control over money, they are also likely to benefit less when compensation is in cash.</p>	<ul style="list-style-type: none"> ▶ Develop an understanding of gender-specific ownership and resource control patterns to inform recovery programs. ▶ Ensure restocking activity targets include small stocks (more likely to be women-owned and/or controlled). ▶ Propose recovery options that are not cash based such as vouchers for school fees or medical costs. ▶ Conduct local communication campaigns targeting women headed households to increase their awareness of zoonoses and government policies for culling and restocking, with clear explanations on how to benefit from such policies.
<p>Project Coordination, Fiduciary management, Monitoring and Evaluation, Data Generation, and Knowledge Management</p> <p>Frequently, gender actions do not have clear budget allocation in activity plans and are not included in the overall implementation process of the project.</p>	<ul style="list-style-type: none"> ▶ Create a gender technical working group at the national level including the project gender expert, gender experts from Women's Affairs at Ministry of Livestock, gender experts from other livestock projects (including other donors) that meet as needed to exchange knowledge, discuss issues, lessons of implementation, tools, training materials, etc. ▶ Develop a targeted gender training to raise awareness among leaders and Ministry of Livestock Directors. ▶ Integrate gender actions identified through a GAP within implementation manuals (defining when these actions take place, how and who is responsible). ▶ Identify male champions who are not gender experts and reward them with special recognition, professional development, or other career opportunities. ▶ Develop and integrate gender indicators in the project results chain and M&E to measure gender progress and impacts (see GENANIM 04). ▶ Conduct small qualitative evaluations following zoonoses epidemics to assess impact on men and women to inform the project and future approaches for epidemics. ▶ Integrate a gender section in project quarterly and annual progress reports that report on the gender action plan, gender specific indicators and overall progress on integrating gender. ▶ Include gender actions within a program's detailed activity plans with a clear budget allocation and targets when feasible. ▶ Ensure that terms of reference for staff are gender sensitive (in wording and description of tasks). ▶ Seek technical support as needed to design and implement the actions above.

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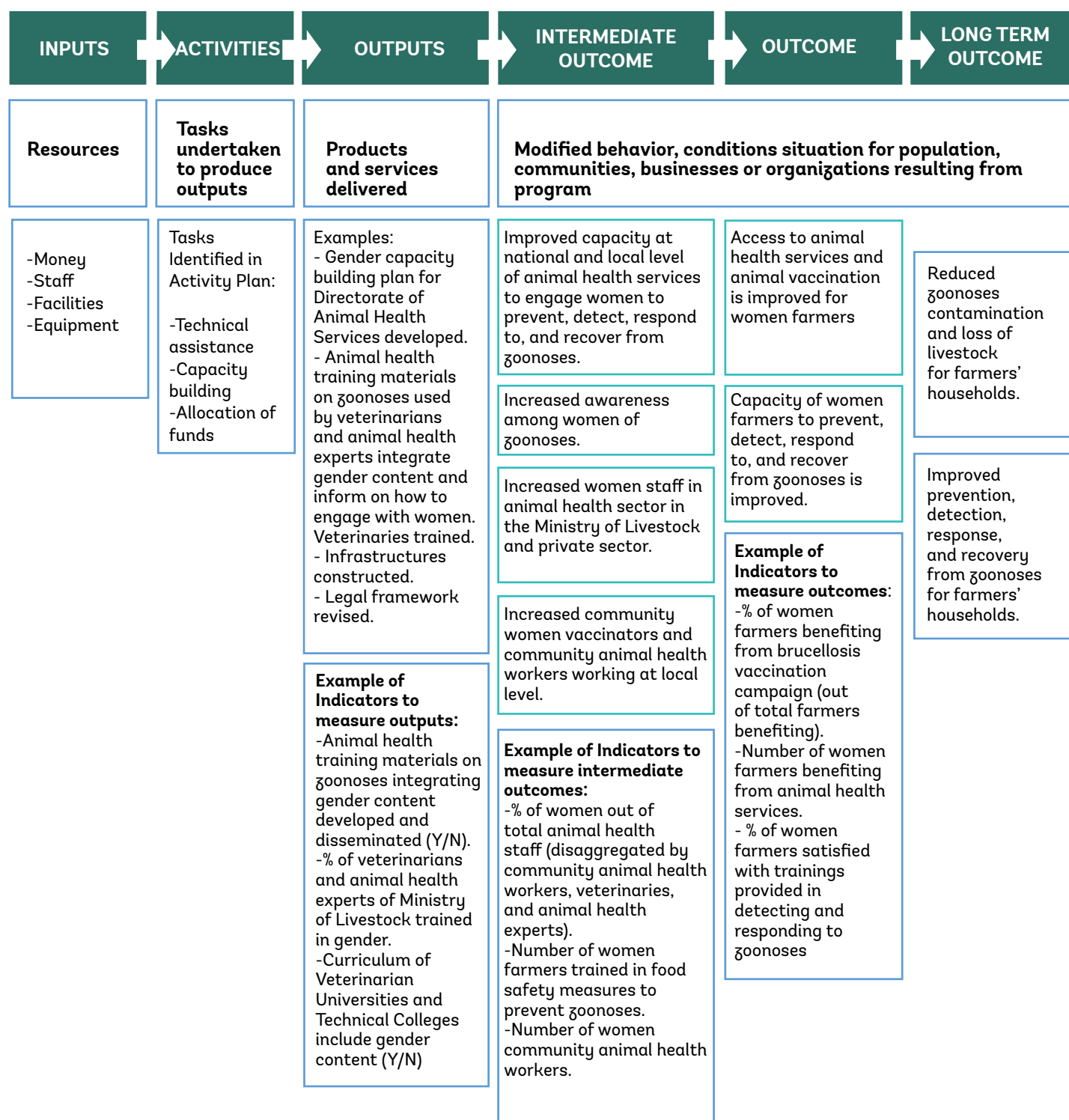
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GENANIM 08: Illustrative Results Chain For Gender In Animal Healthⁱ



ⁱAdapted from Results Agenda Demystified Workshop.

*Results beyond the life of the project

GENANIM 09: Key Steps for Integration of Gender in Monitoring and Evaluating

Integrating Gender in Monitoring and Evaluating at Formulation Phase

- 1 Define **clear, gender responsive objectives** based on a qualitative evaluation of gender roles & responsibilities and constraints in livestock and the Gender Action Plan, for example:
 - a increased women's access to animal health services and vaccination.
 - b increased participation of women farmers in conducting zoonotic surveillance.
- 2 Define a set of **gender-responsive indicators to track progress and results** to include in M&E guidelines and/or manuals that include:
 - a indicators disaggregated by the sex of the respondent; and/or
 - b indicators that are tailored to measure gender-specific progress and results such as the percentage female among community animal health workers.
- 3 Develop a **results chain (and/or theory of change)** for the project (if possible) that includes gender-responsive indicators along the results chain.
- 4 Identify **specific M&E tools** to assess progress on integrating gender in animal health and the quality of implementation for gender responsive activities. Examples include:
 - a A small survey of women farmers to assess their satisfaction with animal health trainings and services provided.
 - b An assessment of the adoption of gender skills taught by the project to (male and female) community animal health workers and veterinarians.
- 5 Ensure that a **distinct budget** is allocated for gender-responsive activities (for example, funds for gender expertise, gender analysis, gender training of staff).
- 6 **Integrate gender in M&E** guidelines, implementation manuals and other relevant documents used to implement the project.
- 7 **Ensure that the terms of reference** for project staffing and capacity building include integrating gender in animal health, for example:
 - a job descriptions for technical staff include integration of gender in their tasks.
 - b capacity building development plans at the Ministry level include training on gender so as to ensure high levels of support for integrating gender into animal health activities.

Integrating Gender in Monitoring and Evaluating at the Implementation Phase

- 1 Ensure **gender-responsive activities** are included in quarterly and annual activity plans.
- 2 Set **gender-disaggregated targets** for the number of beneficiaries.
- 3 **Monitor progress** of gender in animal health through quarterly and annual plans and reports.
- 4 **Conduct data auditing and supportive supervision** to ensure the quality of the gender-specific and other gender-related data reported at all levels of the project.
- 5 Build the **capacity of M&E staff to collect and use quality gender data** for animal health M&E.
- 6 **Ensure that implementing agencies are committed to reporting on gender in animal health** by

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supporting continuous sensitizing (including training and refresher training) on gender and M&E in the context of animal health. Develop mechanisms to hold implementing agencies accountable.

- 7 Integrate **gender in the supervision** of the project. Provide technical assistance in gender and/or M&E based on the issues identified through supervision.

Integrating Gender in Monitoring and Evaluating at Mid-term Evaluation and during the Final Evaluation Phase

- 1 Conduct **qualitative and quantitative evaluations** to assess progress and results. In particular:
 - a Identifying project beneficiaries disaggregated by sex.
 - b Determine the quality of the benefits from the project for both women and men.
 - c Document barriers and bottlenecks; opportunities and lessons learned.
 - d Analyze any changes in men's and women's time-use as a result of project activities.
- 2 Ensure that final evaluation reports **highlight the findings of gender-specific evaluations**, and report gender-disaggregated and gender-responsive indicators.
- 3 **Disseminate lessons learned, materials, and results on gender in animal health** within the project and to external stakeholders, using multiple format and media, including storytelling, case studies, research papers, and fliers or radio programs targeted to different groups of livestock farmers on lessons learned.

Source: Adapted from Module Thematic Note 3: Monitoring and Evaluating Gender Through the CSA Project Cycle in (World Bank Group, FAO, and IFAD 2015)

GENANIM 10: Illustrative Indicators to Monitor Progress in Integrating Gender in Animal Health

Increased Gender Knowledge to Inform Implementation:

- ▶ Gender in livestock analysis to inform the project conducted (Y/N)
- ▶ Integrated animal disease surveillance and response technical guides integrate gender actions (Y/N)

Strengthening Gender Capacity:

- ▶ Animal health training materials integrate gender content (Y/N).
- ▶ Number of households sensitized on gender dynamics during animal health training.
- ▶ Number of veterinarians trained on gender dynamics and gender-specific approaches in animal health and veterinary practice.
- ▶ Number of animal health experts trained on gender dynamics and gender-specific approaches in animal health, at each level (national, district, community).
- ▶ Percentage of livestock animal health veterinarians and workers trained on gender in livestock.
- ▶ Percentage of animal health experts who have undergone gender training that apply skills learned in gender training in daily activities (in the last month/quarter).
- ▶ Number of women trained as community vaccinators.
- ▶ Number of men trained as community vaccinators.
- ▶ Percentage female of community animal health workers in project communities.
- ▶ Number of community leaders sensitized on gender and livestock and the need to support women community animal health workers and vaccinators.
- ▶ Percentage female among veterinarians being trained in surveillance.

Zoonosis Prevention:

- ▶ Number of farmers benefiting from a vaccination campaign (specify which type) for their stock.
- ▶ Percentage female among farmers benefiting from a vaccination campaign (specify which type) for their stock.
- ▶ Percentage of animal health vaccinations conducted by mobile teams at household level.
- ▶ Number of women farmers trained in food safety to avoid zoonoses (specify which ones).
- ▶ Number of women farmers trained on surveillance and reporting of zoonoses (specify which ones).
- ▶ Percentage of women expressing satisfaction with animal health services.
- ▶ Percentage of women trained in bio-security adopting and applying newly learned practices.

Zoonosis Impact:

- ▶ Number of farmers with animals culled due to zoonoses (specify which one).
- ▶ Percentage female among farmers with animals culled due to zoonoses (specify which one).
- ▶ Number of farmers with animals lost to zoonoses (specify which one).
- ▶ Percentage female among farmers with animals lost to zoonoses (specify which one).

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GENANIM 11: How to Document Best Practices in Integrating Gender in Animal Health

Why collect best practices in integrating gender in animal health for the project and how to use them?

- ▶ Best practices can be used to:
- ▶ Illustrate specific elements of a project that successfully addressed gender-based differentials or constraints.
- ▶ Identify best practices for knowledge sharing within and outside the project and the country.
- ▶ Showcase concrete examples of success to donors and government with concrete examples.
- ▶ Support scaling up and institutionalization of key activities implemented under the project.

Potential format of a documentation of best practices: The format varies based on its purpose and can be defined with the help of communications and/or knowledge management specialists. Below are some key rules of thumb:

There should be only one story per best practice template.

- ▶ Include some pictures of male and female beneficiaries to make the story lively and more concrete.
- ▶ Include quotes from female and male participants and/or other members of their households.
- ▶ Use a user-friendly documentation style targeted to intended type of readers.
- ▶ Consider using storytelling and/or presentations in a range of formats such as leaflets.
- ▶ A best practice can also be transformed into a video.

Regardless of the format, a best practice documentation should clearly differentiate between the situation of gender inequality – or women's constraints if that is the relevant story – before and after the implementation of an intervention designed to address the defined inequality or constraints.

Potential content of best practices

Situation before the project (for example, in a case focusing on women farmers):

- ▶ Describe women farmers and their households and their characteristics.
- ▶ Discuss pre-project capacity of women farmers and households to prevent, detect, respond, and recover from zoonoses.
- ▶ Discuss the pre-project state of women farmers' access to animal health, animal health information and vaccination, etc.
- ▶ Discuss the pre-project impact on women farmers and households of a specific zoonotic outbreak (size of livestock herd, labor, livelihood, income, impact on the whole household, etc.)

Project gender-specific interventions

- ▶ Describe the support provided by the project to participating women farmers and households (trainings, free access to vaccination, etc.).
- ▶ Discuss implementation issues faced by all implementers and how they were resolved.
- ▶ Discuss women farmers' and households' satisfaction with the support provided by the project.

Project impact on women and households

- ▶ Discuss the changes among women and their households in terms of knowledge and practices to prevent, detect, respond, and recover from zoonoses.

- ▶ Discuss women's new knowledge and practices, and access to animal health and vaccination.
- ▶ Discuss the impact on women farmers and households in terms of frequency and type of zoonoses, the size of herds, labor, livelihood, income, impact on the whole household, etc.

Lessons learned

- ▶ Describe critical lessons learned in terms of implementation, critical activities of the project that had the highest impact on addressing gender inequalities or women's constraints in animal health, capacity to prevent, detect and respond to zoonoses, etc.
- ▶ Discuss: Can the success of this best practice be replicated to other communities, scaled up in the discussed country under the project, and replicated to other countries? How?
- ▶ Discuss: Can the elements of this best practice be institutionalized in government systems to be sustained after the end of the project? How? Who would be responsible?

An illustrative format for documenting a best practice:

Headline: _____

A good headline or title is simple, jargon free, and has impact; summarizes the story in a nutshell; include action verbs that bring the story to life.

Location: _____

Situation before the project

Project interventions

Project impact (include some beneficiaries' quotes and some pictures)

Lessons learned

What was learned? How did this make a difference for the women involved in the project, their household, and the country overall? What were the innovations in planning and implementation that made it different?

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Gender in Infectious Disease Epidemic Preparedness and Response TOOLKIT

