sex & age matter.

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sex & age matter. Improving Humanitarian Response in Emergencies

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Foreword

We know that good data aids decision making and programming, both crucial to our humanitarian enterprise. But if the data is not specific about the impact of our work on different groups of people, women, girls, boys, men, older people or disabled, then it is difficult to know if the specific needs of these people have been met.

This study by the Feinstein International Center shows us clearly that the humanitarian community has not invested enough in collecting and using sex and age disaggregated data to inform our programming. We do not know the differing needs of people affected by emergencies, and so we don't know if we have met them. From Haiti to Pakistan, case studies have demonstrated that not collecting sex and age disaggregated data puts the lives and livelihoods of different groups of people at risk.

There is no sufficient intellectual, logistical or financial justification for not collecting and using SADD to inform and improve humanitarian response.

This report is clear about what we can do. What we need to do now is commit to doing it.

Valerie Amos

Under-Secretary-General for Humanitarian Affairs
and Emergency Relief Coordinator

Robert Glasser

Secretary-General
CARE International

I. Executive Summary
sex & age matter

A. Study Rationale

Humanitarian aid remains largely anecdote rather than evidence driven. Currently, the humanitarian system shows significant weaknesses in data collection, analysis and response in all stages of a crisis or emergency. The present humanitarian system is much less evidence driven than it should be and than it would like to be.

To ensure that vulnerabilities, needs and access to life-saving services are best understood and responded to, it is necessary to collect information based on sex and age. Having information gaps on sex and age limits the effectiveness of humanitarian response in all phases of a crisis.

Proper collection, analysis and use of sex and age disaggregated data, or SADD, allows operational agencies to deliver assistance more effectively and efficiently than without SADD. Doing this increases the effectiveness and efficiency of saving lives and livelihoods in a crisis. The net outcome is both more lives saved and a reinforcement of basic human rights in a situation where rights are often brushed aside.

Intended Audience

This report is intended for policy makers and senior operational actors, both within the United Nations and INGOs, and in particular Humanitarian Coordinators, Heads of Offices and Cluster leads. This report is also intended for donors that fund humanitarian response to natural disasters and situations of armed conflict.

Study Commission

This study was commissioned by OCHA and CARE International with the wider support of the United Nations Sub-Working Group on Gender.

B. Objective

This study's overall objective is to provide information on the collection and use of SADD and gender and generational analyses of SADD. It is intended to inform assessment processes by humanitarian actors responding to natural disasters and situations of armed conflict.

C. Study Methods and Evidence Used

Literature Review and Analysis

For this study, the researchers carried out a thorough review of academic publications, and United Nations (UN), INGO, NGO and civil society organizations' (CSOs) published reports on the effects of natural disasters and armed conflict on civilian populations, with a focus on publications that used SADD, gender and generational analyses (GGA) to document and analyze those effects. In total, over 300 studies, including over 250 organizational reports and 45 policy documents were reviewed.

In-depth Interviews

The researchers also carried out in-depth interviews with Cluster leads, GenCap advisors, NATF and ACAPS actors, and key humanitarian experts in the field. The researchers carried out 38 interviews in total.

D. Report Overview

Evidence Matters

This report begins with a discussion on why evidence matters, indeed is essential, to inform and strengthen humanitarian response to emergencies. The report details why sex/gender and age matter for evidenced based humanitarian response, giving examples of how natural disasters and armed conflict are in fact deeply discriminatory processes that affect women, men, girls and boys in significantly different ways.

Sector Studies

The report then turns to the five sectors that are the focus on the study: Agriculture/Food Security, Education, Emergency Shelter, Health and WASH. The report reviews key findings from the extensive literature on gender and generational impacts of natural disaster and armed conflict on women, men, girls and boys for each of the five sectors. It presents key studies from each sector in which SADD was collected and gender and generational analyses were used to identify important differences among women, men, girls and boys that are essential to consider in designing and implementing humanitarian response.

The report also offers examples from within each sector of when SADD was not collected and gender and generational analyses were not used, and the consequently lackluster results. It then reviews the mandates and guidelines on the collection and use of SADD within each sector. The report concludes each sector review with detailed recommendations regarding how agencies can ensure SADD and gender and generational analyses are used in all phases of assessment (from pre-disaster to **Phase III**).

Reasons Agencies Are Not Collecting and Using SADD

Most informants interviewed for this study believed that collecting SADD and using gender and generational analysis was essential to improving humanitarian programming and response. However, the study found extremely limited, ad hoc, sporadic use of SADD in **Phase I and II**, and only marginally better use in **Phase III** assessments by most of the clusters.

> OCHA plans its emergency response on the basis of three phases, and our recommendations are based on OCHA's three phase assessment. OCHA uses different means of assessments in each of the three phases of a crisis and there are four different information needs linked with the different phases of the crisis and response:
>
> - Pre-crises and contingency planning information (baseline data).
> - **Phase I** Initial cross-sectoral investigation. Flash Appeal (days 1-2 of the crisis) and the revised Flash Appeal (days 5-10 of the crisis).
> - **Phase II** Rapid inter-sectoral assessments (weeks 3-5 of the crisis).
> - **Phase III** In depth cluster/agency specific assessments (8 weeks and beyond).

Senior officials within many of the clusters admitted that their use of evidence-based programming derived from assessments was weak. Though many officials were trying to change it, SADD was collected rarely and only on an ad hoc basis. Notably, when SADD is collected, field offices don't necessarily know what to do with it. Thus, the presence of SADD guidelines or even data in and of itself does not necessarily or reliably indicate more gender sensitive approaches, programming or better results.

The primary reasons why agencies were not

routinely collecting SADD and using gender and generational analyses in their assessments during crises are summarized as follows:

- Overall, the response by the humanitarian system is not evidence-driven.
- There are no routinely harmonized ways to collect, manage and analyze the data and use it to inform programming.
- The cluster leads lack training and understanding of the need for and how to collect, analyze and translate SADD into programming.
- Cluster leads at headquarters and in field may not be aware of the key resources for SADD collection for assessment and analysis during emergencies.
- Because cluster leads and donor agencies do not show strong interest in or understanding of the value of SADD, the field does not collect it.

Report Overview

The final report is 85 pages in length and contains 14 case studies and 21 figures presenting SADD within humanitarian response around the world.

E. Main Findings

1 Impartiality in recognizing and prioritizing needs among crises-affected populations requires data and a linking of that data to processes of decision-making and response. Without proper data and analysis of that data, one cannot estimate the scale of need or specific needs within a population.

2 Sex/gender and age matter in terms of how people experience natural disasters and armed conflict. Scholarly and academic publications and UN, INGO, NGO and CSO reports clearly and overwhelmingly reflect that there are often significant differences in experiences of natural disasters and armed conflicts in terms of access to essential, life-saving services based on a person's sex/gender and age.

3 One of the most effective ways to understand different needs within a population is to collect data by sex and age (SADD) and to analyze that data, in part, using a gender and generational analysis that is situated within the context of the particular country, region and crisis.

4 When agencies fail to use SADD and/or gender and generational analyses, their interventions can be misguided, fail or put vulnerable groups at risk.

5 Our study found that virtually all of the guidance notes, both targeting general audiences (such as the Sphere Handbook) and sectorial or agency specific ones (such as agency handbooks, sectorial standards or emergency specific guidelines) require collection of SADD and to plan the assistance accordingly.

6 Our study found almost no documented and published cases in which lead agencies within the five sectors under study collected SADD properly, analyzed the data in context, used those findings to influence programming, and then carried out proper monitoring and evaluation to determine the effect on programming.

7 Collection and use of SADD and gender and generational analyses enable operational agencies to deliver assistance more effectively and efficiently than without those data and findings, as our case studies and examples throughout this report testify.

F. Entry Points for Change: Recommendations

The need for data to inform evidence driven response surfaces at all stages in the humanitarian response programming system. Understanding what relevant and necessary data to collect and when to do it is essential to inform response,

and this depends greatly on the phase of the crisis.

Collecting and using quality SADD allows for a more rigorous analysis and diagnosis; identifying who needs what, when and why. It is then important to also use SADD and gender and generational analyses to track the response through monitoring and evaluation to assure that intended assistance is delivered and that it is delivered to the right people.

We provide detailed recommendations for each of the five sectors and break these out according to the phase, and we also offer overall recommendations on the following pages.

G. Conclusion

Since the first day of Phase I, when the different actors agree on the baselines, tools and indicators, to the data analysis in Phase III, the inclusion of SADD can make the data and the findings much stronger and more useful for planning programmes. SADD considerations matter in each phase. Omitting them at the beginning is particularly dangerous because if SADD is not considered in Phase I while designing the tools, then it is likely that the information gaps will continue.

Core Recommendations for Ensuring Good Data Collection and Use of SADD

PRIOR TO AN EMERGENCY, AS PART OF DISASTER PREPAREDNESS

1 Conduct a solid SADD collection using appropriate methods including:

- **a** Adding age and gender-relevant gauges to surveys and monitoring systems;
- **b** Holding separate interviews and focus group discussion with males and females in different age groups;
- **c** Reviewing key sectoral data and coping strategy data divided according to sex and age groups.

2 Prepare gender and age mainstreaming tools which are specific enough to be applied to local contexts and to specific sectors. Prepare a localized SADD checklist, possibly to be conducted prior to a disaster as a form of preparedness, including inputs from local responders and communities.

DURING PHASE I AND PHASE II ASSESSMENTS

1 Review existing literature and data to identify the different roles of male and female older people, adults, youth and children in key sectoral areas prior to the crises, so that when the initial assessment data comes in, there is a basis from which to extrapolate, and it will be easier and clearer to understand which groups have been most impacted.

2 Review previously published key studies and reports on vulnerable groups or particular risks or threats already existing among the affected populations, with instructions to seek out studies using gender and generational perspectives to draw out differences among sexes and ages.

3 Review the legal and customary frameworks to identify potential areas of gender and age discrimination.

4 Create concise reports on priority, cross-cutting issues such as gender, children and older people by drawing from previously published studies and reports and the expertise of the authors.

5 Ensure that the teams in charge of conducting assessments (assessors and translators) include men and women. Carefully examine the trade-off between having teams which are technically prepared (e.g., agronomists, nutritionists, veterinarians, clinical health officers), and teams that are diverse, as in many societies there are almost no women with a high level of technical, specialized education.

6 Ensure key female informants are interviewed who often have information on immediate needs of women; including community leaders, including midwives, nurses, leading market women, and teachers.

7 If using focus groups, ensure they are comprised of 50% women and older girls, ideally exclusively of women and girls (given males' tendency to dominate public and mixed-sex conversations).

8 When a group speaks on behalf of another and makes assumptions about it's access to life-saving services, triangulate this

Core Recommendations for Ensuring Good Data Collection and Gathering SADD *contd*

information with either the involved group or when this is not possible (e.g., for infants) make sure best informants are identified.

9 Ensure SADD is recorded regarding all key informants, individuals, and household composition; this will enable:

- **a** Assessment of whether there are important segments of the population that have not been reached who may have views needed to inform responses;
- **b** Assessment of any important differences across gender and age in terms of needs and access to essential and life-saving services among the most vulnerable populations.

10 Ensure observations are made by team members on effects to infrastructure and impact on civilian populations, noting where access to life-saving services is more difficult or blocked for certain segments of the population.

11 Ensure that when individuals are registered for distributions, recorded data include their sex and age (or age-group).

12 Coherently summarized data, with evidence based recommendations, and provide these reports to the necessary decision makers.

DURING PHASE III ASSESSMENTS

1 Apply all recommendations for **Phase I and II** above.

2 Gather and or build upon baseline SADD of those who receive assistance and inputs (e.g., food and non-food items, health clinic visits, etc.). This will enable:

- **a** Understanding of who is and who is not actually coming to the access services, and hence how outreach and access need to be improved;
- **b** Understanding about whose essential needs are being met and whose are not, and why, and how this might be addressed;
- **c** Carrying out of regular reviews of the findings to ensure that response is shaped to reflect improving access, decreasing vulnerabilities, and meeting real needs.

3 Carry out more specific, detailed and nuanced qualitative and quantitative studies on key issues of concern, ensuring collection of SADD where relevant and gender and generational analyses to interpret findings within the context.

4 Ensure that in qualitative data collection methods SADD for individual respondents is collected and analyzed to determine significant differences in vulnerabilities, needs and priorities among sexes and ages.

5 Ensure that all quantitative data collection methods (usually where the unit of analysis is the household or individual) capture SADD as relevant.

6 Ensure that Sentinel sites capture SADD for beneficiaries, such as health clinics recording who comes in, who is diagnosed with what injuries or aliments, and who is treated and who is unable to be treated.

II. Why Evidence Matters in Humanitarian Response

A. Study Rationale and Objectives

The need for this study originates from the recognition that sex and age disaggregated data, or SADD, are not systematically collected, analyzed or used to their full potential to inform humanitarian response to natural disasters and situations of armed conflict. To ensure vulnerabilities, needs and access to life-saving services are best understood and responded to, it is necessary to collect information based on sex and age. Information gaps on sex and age limit the effectiveness of humanitarian response in all phases of a crisis.[1] Proper collection and use of SADD is essential to ensure impartiality; it allows operational agencies to deliver assistance more effectively and efficiently. Having SADD can also bring attention to important protection issues and integrate a response to them in humanitarian action.

Gender and age differentiation on important resources and processes exists in society. It is both possible and doable in a crisis to collect data on this. It is possible to design programs to differentiate by sex and age in their targeting and in what they deliver. Doing this increases the effectiveness and efficiency of "saving lives and livelihoods" in a crisis. It is possible to monitor such programming to show that this effect exists. The net outcome is both more lives saved and a reinforcement of basic human rights in a situation where rights are often brushed aside.

This report is intended for policy makers and senior operational actors both within the United Nations and INGOs, in particular Humanitarian Coordinators, Heads of Offices and Cluster Leads.

This study's overall objective is to provide information on the collection and use of SADD and gender and generational analyses of SADD. It is intended to inform assessment processes by humanitarian actors responding to natural disasters and situations of armed conflict. This study determines, documents and analyzes how males and females, older people, adults, youth and children experience and are affected by natural disasters and armed conflict. The five sectors of education, food security, health, emergency shelter and water, sanitation and hygiene (WASH) are particularly emphasized. Within each of these sectors, practical recommendations on using SADD are offered based on existing mandates, guidelines and country case studies.

This study was commissioned by OCHA and CARE International, with the wider support of the United Nations Sub-Working Group on Gender. OCHA and CARE International selected five of the total eleven clusters for incorporation within the report. These sectors were selected to represent the breadth of the sectors in which SADD and gender and generational analysis can be useful to help inform and thus improve programming.

B. Study Methods

For this study, we carried out a thorough review of over 300 academic publications, and United Nations (UN), INGO, NGO and civil society organizations (CSOs) published reports on the effects of natural disasters and armed conflict on civilian populations, with a focus on publications that used SADD, gender and generational analyses to document and analyze those effects. Within these publications we focused our attention on the sectors of education, food

security, health, shelter, and WASH. We also reviewed previous studies by academics, the UN and INGOs on data collection and assessment methods during crises resulting from natural disasters and situations of armed conflict, including studies on the collection and use of SADD, gender and generational analyses.

Furthermore, we carried out 38 interviews. We interviewed Cluster leads, focal points and key officers for agriculture/food security, education, health, protection, shelter, WASH, as well as focal points for Gender and Age, which are cross-cutting issues within the Cluster System. We also interviewed key UN and INGO officials both at headquarters and in field offices whose areas of responsibility include education, food security, health, emergency shelter, and WASH and who have experience in assessment and response in these sectors during natural disasters and situations of armed conflict.

We furthermore interviewed GenCap advisors with experience in crises assessment and response around the globe; the Gender Standby Capacity Project (GenCap) is an IASC interagency initiative that deploys gender experts to crises areas to help improve gender mainstreaming in humanitarian response. We also interviewed lead actors from the the Needs Assessment Task Force (NATF) and the Assessment Capacities Project (ACAPS), which are high-level, joint UN and INGO lead initiatives to improve assessment to enhance evidence based humanitarian response. We also interviewed key academic humanitarian experts in the relevant sectors, and key specialists on monitoring and evaluation.

C. SADD, Gender and Generational Analyses

SADD is data that is broken out according to a person's sex and age or age group. SADD can be collected using both quantitative and qualitative methods. For example, SADD is easily collected in surveys, distribution lists, clinic records, and in census samples. SADD can also be collected using key informant interviews, focus group interviews, one-on-one in-depth interviews, and a variety of ethnographic methods.

Gender analyses examine the relationships among males and females, as well as between females or males of different age sets. SADD allows for the examination of power dynamics and how they might shape gender roles, access to resources, and the constraints people face in relation to others. During assessments in crises situations, gender analyses reveal an understanding of who is affected, why and how. Such an analysis can also highlight what people's immediate needs are and identify what resources they can or cannot access to help themselves or others.[2]

Generational analyses examine the relationships among age groups. They examine power dynamics and how these shape the different generations' roles and responsibilities, access to and control of resources, and the constraints they face relative to the others of a different generation or within their own generation. During assessments in crises situations, generational analyses enable an understanding of who in the population is affected, why and how. Such an analysis can also highlight what their immediate needs are and identify what resources they can or cannot access to help themselves or others.

The definition of older persons and children must always be adapted to the context and achieved in consultation with the local population. The Sphere Project Handbook notes that "detailed disaggregation is rarely possible initially but is of critical importance to identify the different needs and rights of children and adults of all ages. At the earliest opportunity, further disaggregate by sex and age for children 0–5 male/female, 6–12 male/female and 13–17 male/female, and then in 10-year age brackets, e.g. 50–59, male/female; 60–69, male/female; 70–79, male/female; 80+, male/female. Unlike the physiologically-related age

groupings in the health chapter, these groupings address age-related differences linked to a range of rights, social and cultural issues." This age grouping is different from the one that Sphere recommends for the physiologically-related age groupings concerning the health sector. Rather, this age grouping addresses age-related differences linked to a range of rights, social and cultural issues.[3]

Gender Mainstreaming & Gender Equality

The global commitment to incorporate gender perspectives in peace and security issues was established in the Beijing Declaration and the Platform for Action in 1995, with the endorsement of gender mainstreaming as a global strategy for promotion of gender equality. Other central events include the 1995 Fourth World Conference on Women; the 1997 United Nations Economic and Social Council call for gender mainstreaming; the 1998 recommendations by the Commission on the Status of Women for increasing women's participation in conflict prevention, peacekeeping, and post-conflict peace building and reconstruction; and the support shown by numerous United Nations entities, including members of the Security Council, during the March 2000 discussions on "Women Uniting for Peace" for women's involvement in peace activities.[4] The need for gender equality in all humanitarian response is spelled out with great clarity in the 2011 Sphere Project Handbook.[5]

Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. It is a goal that has been accepted by governments and international organizations and is enshrined in international agreements and commitments.[6] Two main strategies are used to obtain gender equality: gender mainstreaming and targeted actions that result from gender analysis.[7]

Gender mainstreaming is defined in the ECOSOC agreed conclusions 1997/2 as: "the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality."[8] Gender mainstreaming entails bringing the perceptions, experience, knowledge and interests of women as well as men to bear on policy-making, planning and decision-making.

D. Why Evidence Matters in Humanitarian Programming

The Problem with Impartiality

At the core of humanitarian action is a belief that it should be needs-driven, and only needs-driven. We know there are never enough resources to meet all life-saving needs in all crises, so we practice 'triage' by assigning resources to the most urgent needs first. This is basically the definition of impartiality. The challenge is that in order to be impartial, one has to have a good understanding of what the needs are. Another challenge is that to prioritize assistance requires one to have a good understanding of the needs across a whole population, and thus the ability to identify the most urgent cases.

Impartiality in recognizing and prioritizing needs among crises affected populations requires data and a linking of that data to processes of decision-making and response. Without proper data and analysis of that data one cannot estimate the scale of need or specific needs within a population. Scholarly and academic publications and UN, INGO, NGO and CSO reports clearly and overwhelmingly reflect that there are often significant differences in experiences of natural disasters and armed conflict and access to essential, life-saving services

based on a person's sex/gender and age. One of the most effective ways to understand different needs within a population is to collect data by sex and age and to analyze that data, in part, using a gender and generational analysis that is situated within the context of the particular country, region, and crisis.

However, our study found almost no cases in which lead agencies within the five sectors we studied collected SADD, properly analyzed the data in context using a gender and generational analysis, used those findings to influence programming, and then carried out proper monitoring and evaluation to determine the effect on programming. Importantly, this finding does not contradict our earlier statements that SADD and gender and generational analysis enable operational agencies to deliver assistance more effectively and efficiently then without those data and findings, as our case studies and examples throughout this report testify.

Gathering Data in Acute and Protracted Crises

Understanding what relevant and necessary data to collect and when to do it is essential to inform response, and this depends greatly on the phase of the crises. OCHA plans its emergency response on the basis of three phases. OCHA uses assessments in each of the three phases of a crisis and there are four different information needs linked with the different phases of the crises and response:

- Pre-crises and contingency planning information (baseline data).
- **Phase I** Initial cross-sectoral investigation. Flash Appeal (days 1-2 of the crises) and the revised Flash Appeal (days 5-10 of the crises).
- **Phase II** Rapid inter-sectoral assessments (weeks 3-5 of the crises).
- **Phase III** In depth cluster/agency specific assessments (8 weeks and beyond).[9]

In **Phase I** monitoring by the UN indicates that a crisis has emerged that needs international attention and intervention. Within 1-2 days of the crises, UNOCHA will make a Flash Appeal to donors that they will need a certain amount of money to enable the initial response. During days 5-10, OCHA will revise that Flash Appeal based on a more full, coordinated, rapid multi-sectoral needs assessment for all sectors where assistance is needed. Donors, however, have often made their own decisions about initial response in the first 48 hours, during which time the collection and analysis of on-the-ground data is extremely limited.

In **Phase II**, specialized teams are deployed for rapid, multi-sectoral assessments. These assessments may provide the data for a Consolidated Appeal (CAP) in which different sectoral needs are detailed and identified for particular agencies to respond to.

At the early phases of crises (**Phase I and II**), there are significant challenges to the collection, management and analysis of information; data collection efforts at these times must be honed, streamlined and targeted. At the early phases of a natural disaster, teams may be on the ground for short periods of time, at times traveling by helicopter to enable access, and populations are often reeling and communities disorganized after what has happened. At the early phases of an armed conflict, teams may not be able to enter into the areas where the conflict is active and may have to interview survivors who have fled out of the conflict affected areas, sometimes into neighboring countries. They may also rely on satellite imagery or sporadic and limited information from people on the ground, including UN or embassy staff or journalists.

For both natural disasters and early phases within armed conflict, information collection at the early phases must be rapid and accurate, and must address the key concerns of the different clusters. The data collected must not overwhelm those trying to use evidence to inform response.

Because of time and resource constraints, the sampling method most useful in the early phas-

es is purposive sampling at a limited number of sites with key informants who are knowledgeable about the affected community. Questions are honed to uncover the most pressing needs of women, men, girls and boys within the community and to flag key vulnerabilities within populations. The focus is on populations' access to essential services, needs and priorities to save lives in the onset of a crisis.

The greatest challenge in **Phase II** then comes in managing the data, processing it, and analyzing it in a way that can quickly and accurately inform response. Having key experts available to help analyze the data and contextualize the findings is essential. In other words, teams

Key criteria for heads of assessment teams and lead analysts for ensuring good data collection in Phase I and II should include:

1 Ensure the composition of teams (assessors and translators) sent to collect information includes women to ensure greater access to females;

2 Identify key informants and streamline questionnaires for key informants. Ensure that some key informants include females knowledgeable about the community, including midwives, nurses, community leaders, leading market women, and teachers;

3 When possible, ensure that half of all focus groups are made up of females (as males tend to dominate public and mixed-sex discussions);

4 When possible, ensure that some of the focus groups, divided by gender, are also divided by age groups (i.e., children, adolescents, adults and older people) as adults and elders tend to dominate public and mixed-age discussions;

5 Ensure observations are made by team members on effects to infrastructure and impact on civilian populations, noting where access to life-saving services is more difficult or blocked for certain segments of the population;

6 Review previously published baseline data on the affected areas and populations, including SADD where available;

7 Review previously published key studies and reports on vulnerable groups or particular risks or threats already existing among the affected populations, with instructions to seek out studies using gender and generational perspectives to draw out differences among sexes and ages;

8 Create concise reports on priority, cross cutting issues such as gender, children and the elderly by drawing from previously published studies and reports and the expertise of the authors;

9 Ensure that when individuals are registered for distributions, recorded data include their sex and age (or age-group);

10 Coherently summarized data, with evidence based recommendations, and provide these reports to the necessary decision makers.

The data sources in methods 6, 7 and 8 listed above are essential to help analysts extrapolate the findings from the data collected by methods 2, 3, 4 and 5. Method 1 is essential to enable necessary access to female informants and populations.

Having the right data at the right time is critical in emergency settings.

At each stage of an emergency, it is important to put relevant, reliable data into the hands of those who need it. The level of disaggregation required depends on the phase of humanitarian relief and the nature of the intervention. However, collecting data for data's sake is not acceptable. Rather, having reliable, relevant, and timely information can be achieved through strategic planning and advanced thinking to identify the questions that need answers and what data is required to answer those questions.

Initial assessments call for baseline numbers of affected populations to establish the magnitude of funding required. During an initial response, decision-makers may not recognize the need for details about the sex/age structure of the population. It is also not practical to administer a detailed age and sex-focused questionnaire in every situation. However, having sex and age-disaggregated data is often crucial for focused relief delivery over the longer term.

As the emergency unfolds, program specific information is required to identify priorities and assess the impact of the interventions. As such, advanced thinking of information needs and how information will be used to inform program decisions must take place prior to data collection. In parallel, data collection methodologies can then be developed that are practical, feasible, and address the identified information needs.

Inter-Agency Standing Committee Gender Sub-Working Group. Sex and Age Disaggregated Data in Humanitarian Action: SADD Project. IASC: New York (May 2009).

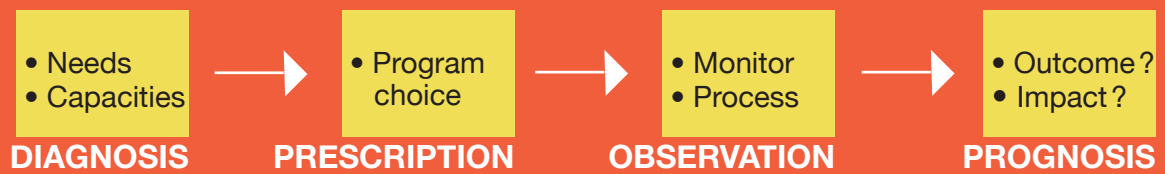
should include members with expertise on the particular country and affected region/populations to help make sense of the implications of the findings from the early assessments. Experts observe that response agendas by the primary international donors are usually set within the first week of a natural disaster, and once those responses are set in motion, it is difficult to revise or alter them. Thus, it is essential to get the analysis right from the very onset of a crisis.

As emergencies progress over time, opportunities and resources exist to collect and analyze further detailed and nuanced data and to use those findings to inform response.

In **Phase III**, it is now possible to use a wide array of rigorous qualitative and quantitative methods to gather specific, detailed data to inform programming. SADD can be collected through both qualitative and quantitative data collection methods. Very often SADD and gender analyses of the data collected in **Phase III** is essential to informing short, medium, and long-term response and ensuring agencies meet their objectives and mandates.

Phase III assessments and monitoring and evaluation provides the necessary details and translates the needs identified in **Phase II** assessments into detailed responses. During **Phase III** there should be even more ability to design gender and age aware and or gender and age specific programming, and to refine and monitor programming from gender and generational perspectives.

FIGURE 1: THE USE OF EVIDENCE TO DRIVE PROGRAMMING



For instance, WFP has an operational goal that 70-80% of food aid recipients should be women, so if it does not collect SADD then it cannot know if objectives are reached. A good example comes from **Pakistan** in late 2009.[10] A review of receipt of WFP food rations found that 95% of registered men were collecting food rations, but only 55% of registered women were collecting food rations. WFP then identified there was an access problem for the women and began efforts to understand access constraints and how to ensure women beneficiaries received their food rations.[11]

As the WFP example shows, it is not enough to simply collect SADD. Gender and generational analysis of SADD within the larger context of an emergency and the country and region in which the emergency is occurring is necessary to inform response. Another example comes from **Eritrea** in which some male youth who were former fighters living in internally displaced persons (IDP) camps were showing high levels of malnutrition. This was noticed by the part-

Key criteria for heads of assessment teams and lead analysts for ensuring good data collection in Phase III should include:

1 Ensure the composition of teams sent to collect information (assessors and translators) includes women to ensure greater access to females;

2 Ensure that in identification of key informants, some key informants include females knowledgeable about the community, including midwives, nurses, community leaders, leading market women, and teachers;

3 Ensure where possible that half of all focus groups are made up of women and where possible convey women-only focus groups (as males tend to dominate public and mixed-sex discussions) and age set focus groups (as adults tend to dominate public and mixed-age discussions);

4 Ensure that in qualitative data collection methods SADD for individual respondents is collected and analyzed to determine significant differences in vulnerabilities, needs and priorities among sexes and ages;

5 Ensure that all quantitative data collection methods (usually where the unit of analysis is the household or individual) capture SADD as relevant;

6 Ensure that Sentinel sites capture SADD for beneficiaries, such as health clinics recording who comes in, who is diagnosed with what injuries or aliments, and who is treated and who is unable to be treated;

7 Ensure that when individual are registered for distributions, recorded data include their sex and age (or age-group).

GLOBAL CLUSTERS AND LEAD AGENCIES

Agriculture/Food Security – FAO and WFP
Camp Coordination and Camp Management – UNHCR and IOM
Early Recovery – UNDP
Education – UNICEF and Save the Children
Emergency Shelter – UNHCR and IFRC
Emergency Telecommunications -- WFP
Health – WHO
Logistics – WFP
Nutrition – UNICEF
Protection – UNHRC
Water, Sanitation and Hygiene – UNICEF

GLOBAL CROSS-CUTTING ISSUES COORDINATION AND LEAD AGENCIES

Age – HelpAge International
Environment – UNEP
Gender – OCHA, Relief International, International Medical Corps and UNICEF
HIV/AIDS – UNAIDS and IFRC
Mental Health and Psychosocial Support – UNICEF and World Vision, International

ner agency which increased their food rations. However, malnutrition continued to rise among the group and some of the young men died. The agency then realized that the young men did not know how to cook, and they were separated from female family members who would have cooked for them. As a result, they were eating the bulgur wheat and other rations raw, which their bodies could not process and resulted in their severe malnutrition and in some cases death. The agency then implemented a response to ensure the young men had assistance preparing their food rations.[12]

Evidence at all Stages

The need for data to inform evidence driven response surfaces at all stages in the humanitarian response programming system. Figure 1 depicts this schematically, with a nod to the public health model.

Quality SADD data allows for a more rigorous analysis and diagnosis, identifying who needs what, when and why. Researching past aid interventions allows for an understanding of the probable outcomes of different programming choices. For example, does one address acute malnutrition with food aid or cash interventions to change the food market? How did the selected programming choice actually affect women's, men's, girls' and boys' malnutrition levels? For better data to lead to better programming, an evidence-based model is needed to highlight how interventions might unfold within particular contexts.

It is then important to track this change through monitoring and evaluation to assure that intended assistance is delivered and that it is delivered to the right people. Is the best change-model being used, or, on the basis of evidence is it necessary to change the direction of programming? Finally, what is the prognosis? Again this requires the collection of evidence, usually associated with the measurement of impact.

If we are honest, the humanitarian system shows significant weaknesses in data collec-

tion, analysis and response at all these stages. The humanitarian system is much less evidence driven than it should be and than it would like to be. Today in the humanitarian field we see calls for a shift from being anecdote driven to evidence drive.[13]

The Cost and Benefit of Evidence

Evidence comes at a price. There are two key challenges we face as we move towards being more evidence based. One is practical and one intellectual. The practical problem is over return on investment. It costs to collect and analyze data. Is the cost of collecting and analyzing data outweighed by the benefits in better programming? Thirty years ago agencies did not collect market data when they were programming for famine, they focused on malnutrition rate data and responded using food aid, usually imported from halfway round the world. The collection of market data has allowed us to understand better what is actually happening in a food crisis and to meet food needs from local markets or by altering the terms of trade (through buying off livestock, improving roads, or subsidizing grain transporters). Better use of targeted data has led to more efficient and more effective programming.

The second challenge is in regards to relevance and understanding. The biggest challenge here is organizational capacity to understand what are the relevant and necessary data that need to be collected, at what point those data can be and need to be collected, how to properly manage and analyze that data, and how to use the findings to inform programming and policy.

The Cluster Approach

In December 2005, the Inter Agency Standing Committee (IASC) identified Global Cluster Leads for 11 sectors of humanitarian activity to help bolster field-level response to emergency relief. At the international level, the goal of the cluster approach is to reinforce "system-wide preparedness and technical capacity by ensuring that there is predictable leadership and accountability."[14]

Within the cluster approach, numerous actors are engaged to identify and respond to the complex information needs required to address crises response. However, a study by the IASC (2009) on data collection and management at the Cluster level found that:

> The development of a system to collect, analyze, store, and share information has not progressed as required. There is duplication of effort in data collection and little harmonization of concepts and questionnaires. There is no central depository to facilitate data sharing. There is also a lack of technical skills to support questionnaire design, data collection, and analysis.[15]

There are various initiatives under way to address these challenges, including the Needs Assessment Task Force (NATF), under the leadership of OCHA and IFRC and the Assessment Capacities Project (ACAPS). NATF's purpose is to harmonise and promote cross-sector needs assessment initiatives for consistent, reliable and timely data on humanitarian needs in sudden-onset crises, and to strengthen informed decision-making and improve humanitarian response. ACAPS is dedicated to improving the assessment of needs in complex emergencies, sudden onset disasters and protracted crises. ACAPS contributes expert advice, training and human resources and they deliver these services to a wide range of humanitarian actors. ACAPS works with a community of experienced practitioners committed to developing new and innovative approaches to needs assessment.

Our interviews with leadership within the Clusters, NATF and ACAPS demonstrate that they all recognize the necessity of the right information at the right time. They also all recognize the importance and need for SADD, though they have different views on the timing of collecting it, as well as how best to collect and analyze SADD and how findings could inform programming.[16]

Endnotes

1. Inter-Agency Standing Committee Gender Sub-Working Group, "Sex and Age Disaggregated Data in Humanitarian Action: SADD Project." New York: IASC. May 2009.

2 Ibid.

3 The Sphere Project, "Humanitarian Charter and Minimum Standards in Humanitarian Response." 2011 Edition. Distributed for the Sphere Project by Practical Action Publishing and its agents and representatives throughout the world, p. 63.

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6 United Nations Office of the Special Adviser on Gender Issues and Advancement of Women, "Gender Mainstreaming: An Overview." New York: United Nations. 2001.

7 IASC, "Women, Girls, Boys and Men – Different Needs, Equal Opportunities Gender Handbook" in Humanitarian Action, 2006, p. 1. Available online at http://www.humanitarianinfo.org/iasc/gender.

8 Report of the Economic and Social Council for the Year 1997. General Assembly Official Records. Fifty Second Supplement, No. 4.

9 Ibid, p. 14.

10 Delphine Brun, GenCap advisor, interview with authors, February 8, 2011, Geneva.

11 Deborah Clifton, GenCap advisor, interview with authors, February 8, 2011, Geneva.

12 Ibid.

13 Gregg Greenough, Rahim Nazerali, Sheri Fink and Michael VanRooyen, "Non-governmental Organizational Health Operations in Humanitarian Crises: The Case for Technical Support Units." Prehospital Disaster Medicine. September/October 2007, 22(5): 369-76; Feinstein International Center, "Humanitarian Horizons — A Practitioners' Guide to the Future." Working paper. January 2010. Available online at https://wikis.uit.tufts.edu/confluence/display/FIC/Humanitarian+Horizons+--+A+Practitioners%27+Guide+to+the+Future.

14 "Humanitarian Horizons — A Practitioners' Guide to the Future," p. 8.

15 Ibid., p. 13.

16 The authors interviewed Cluster leads and the heads of ACAPS and NATF between December 2010 and May 2011.

III. Why Sex/Gender and Age Matter for Evidence-Based Programming and Response

A. Natural Disaster and Armed Conflict Discriminate Based on Sex and Age

Millions of people are affected by natural disasters and armed conflict each year. Natural disasters[1] affected on average more than 250,000,000 people per year in the past decade.[2] The number of reported disasters has also increased over time, from an average annual total of 90 in the 1970s, to a figure near 450 per year in the last decade. Natural disasters are triggered by extreme natural phenomena and become disasters because of the heightened vulnerability of the people and places where they occur. Natural disasters directly destroy lives, as shown by the disaster fatality rates, and they devastate and wreak havoc on livelihoods, often with long term consequences, as depicted in the numbers of disaster-affected.[3]

Armed conflict devastates the lives of many civilians caught in its path. There remains a shortage of reliable data on civilian victims of war, and assessing civilian death due to armed conflict continues to be difficult. The first finding in a recent report by the International Peace Research Institute in Oslo was that "there are practically no global data available that allowed us to investigate conflict mortality disaggregated by gender."[4] While the fallacy of dramatically increased proportion of civilian to combatant mortality rates as a result of armed conflict since the early 20th century (often cited as 9:1) has been exposed, the more reliable proportion ranging from >1:1 to 3:1 in many late 20th and 21st century armed conflicts is still staggering. Where even higher proportions of death among civilian populations are seen, as in **Cambodia** 1975-1979, **Rwanda** 1994, **DRC** since 1996, northern **Uganda** since 1986, and the Darfur region of **Sudan** since 2003, it is often due to a combination of the direct targeting of civilian populations, weak health systems, high pre-existing burden of disease, widespread poverty, great potential for food insecurity, and demographic profiles of a high proportion of infants and children vulnerable to death from disease and malnutrition.[5] The direct and indirect affects of armed conflict kill and maim and damage the lives of millions of people.

Natural disasters and armed conflict do not affect all people evenly, in fact, they are deeply discriminatory; "pre-existing structures and social conditions determine that some members of the community will be less affected while others will pay a higher price."[6] Among the key factors that determine how people are affected by both natural disaster and armed conflict is that of gender and age.

As humanitarians, we need good information about who is affected and how because it tells us something important about how disasters are unfolding; how armed conflicts are being carried out, experienced, and why; who lives and who dies; and the likely condition of those surviving the aftermath.

Gender and age matter when it comes to who dies, who is injured and how, who lives, who is affected and in what ways, and what their

lives are like during and after the violence and crises. The following case studies on the 2004 Tsunami illustrates why it is important for humanitarians to collect data and evidence that pays attention to sex and age.

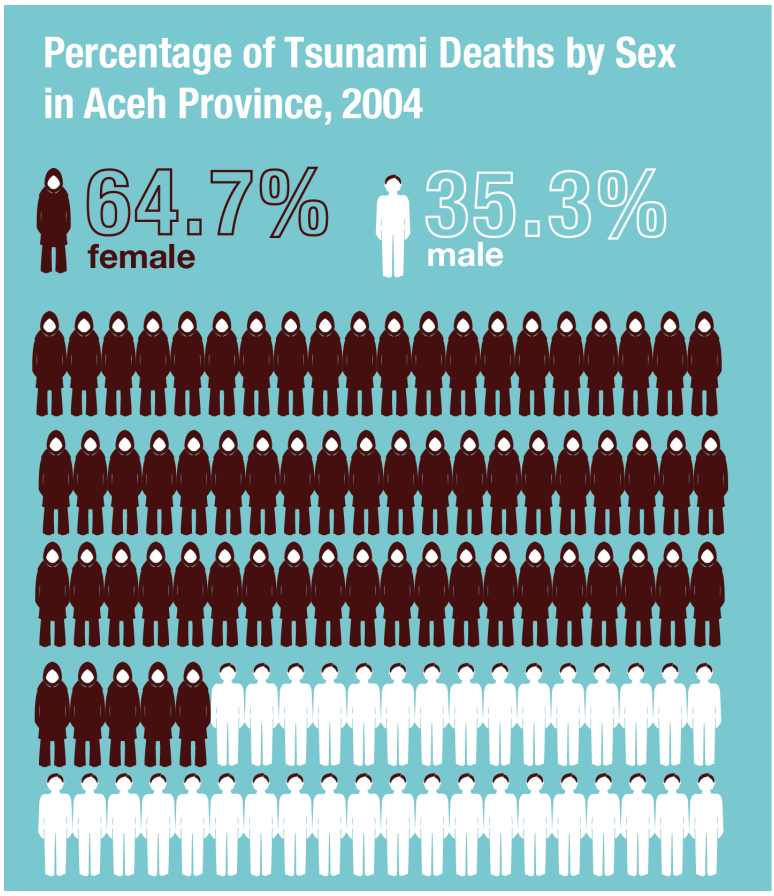
B. Sex, Age and Death in the 2004 Indian Ocean Tsunami

On the morning of December 26, 2004, an earthquake measuring 9.0 on the Richter scale occurred off the coast of northern Sumatra, **Indonesia** causing gigantic waves that inundated coastal countries along the rim of the Indian Ocean. By July 2005, the official figures on the numbers of dead reached 175,000, with 50,000 missing and 1.7 million displaced. Aceh was near the epicenter of the earthquake and was particularly hard hit. By March 2005, **Indonesia's** national disaster recording agency listed 128,645 people dead, 37,063 missing and 532,898 displaced.

Rofi, Doocy, and Robinson carried out a survey of households displaced by the tsunami in Aceh province and within their study they gathered data on the sex and age of household members who were victims of the tsunami. Using SADD data they were able to understand important factors about who died and who lived. They found that two-thirds of those who died were female (Figure 2).[7]

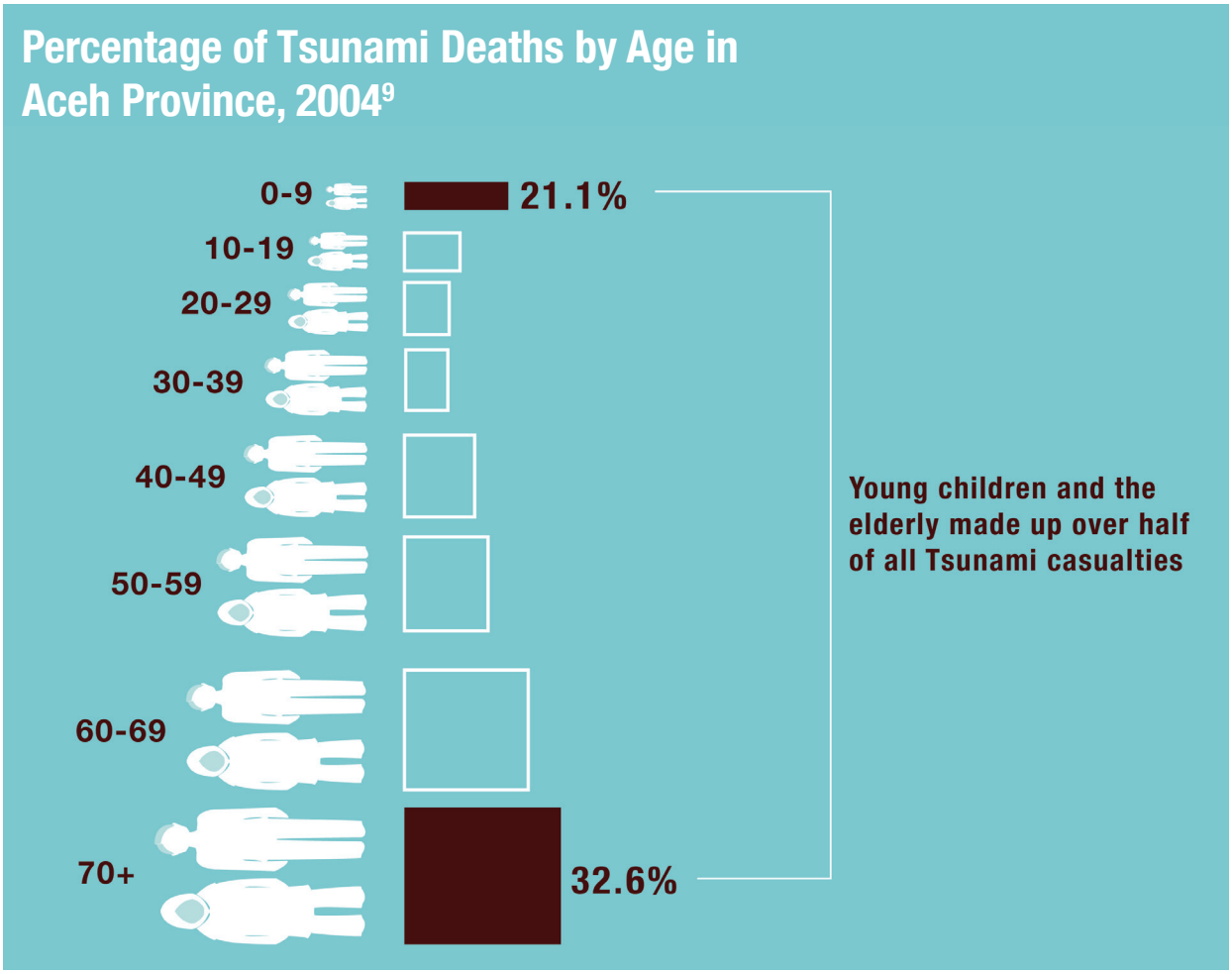
They also found that it was primarily people nine years and younger and 60 years and older who were killed during the tsunami (Figure 3).[8] Rofi, Doocy, and Robinson also looked at the survivors of the tsunami in Aceh province, again ensuring they collected SADD. They found that among displaced families, a significantly higher proportion of female headed-households were living as displaced persons among villages and towns, opting not to go into displaced camps, in part due to the fact that many were now widowed and perceived the camps as unsafe for them and their remaining family members.

FIGURE 2



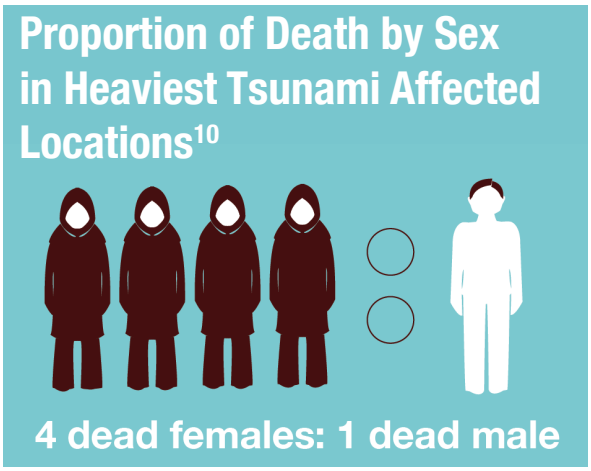
The implications of these data are important for humanitarian response, including, at a minimum, the need to: a) recognize increased numbers of female headed-households and an increase in widowers with young children; b) recognize that the disproportionate death of the older people and women means adult males with children will not have the necessary resources to provide care for themselves or their children; c) recognize that many children will be left without their mothers or their older care givers (as most older people helped care for their grandchildren); d) recognize services should not be solely concentrated within displaced

FIGURE 3



camps; and e) seek out displaced families within villages and towns (with particular attention to seeking out female-headed households).

FIGURE 4



Oxfam also carried out household surveys in tsunami-affected areas of Aceh and **India**, and qualitative work in tsunami-affected regions of **Sri Lanka**.[10] Oxfam's findings are in line with Rofi, Doocy, and Robinson's findings, as they found approximately 2/3 of the dead were female. However, Oxfam also found in the heaviest affected areas the death rates of females to males at 4:1 (Figure 4), and more startling, in some villages all the dead were females.

In making sense of the high death rates among females, the Oxfam report uses a gender analysis to conclude:

> In rural coastal areas, many men who were fishing far out at sea survived, as the giant waves passed harmlessly under their small boats. When

> the waves hit the shore, they flattened coastal communities and killed many of the women and children, most of whom were at home on that Sunday morning. In agricultural areas men were often working out in the fields or doing errands away from the house, or taking produce to markets… The sheer strength needed to stay alive in the torrent was also often decisive in determining who survived. Many women and young children, unable to stay on their feet, or afloat, in the powerful waves simply tired and drowned. Women clinging to one or more children would have tired even more quickly.[11]

Oxfam also used SADD and gender analyses to understand the impact of the demographic changes and raise important questions of immediate and direct relevance to relief responses and long-term reconstruction:

> How safe are women in crowded camps and settlements, when they are so outnumbered by men in several of the countries in question? Will widows…have access to land once owned by their husbands? Will younger women enter into marriages with much older men, as already seems to be happening in some locations? And will this carry risks in terms of compromising their education and reproductive health? In the fishing communities…, what rights will surviving women enjoy under new arrangements and programmes? In whose names will newly built houses be registered? Will men take on new domestic roles, or will women's workloads increase?[12]

Clearly, the affects of the tsunami were and are being experienced differently depending on people's gender and age.

Yet, a GenCap advisor, Pennells discusses that in the aftermath of the Tsunami, there were few efforts to collect SADD during the initial assessments.[13] She contends that people responded based on what they thought had happened. In the most affected communities in Aceh, **India** and **Sri Lanka** however, many more women died than men and even observational data from Oxfam and others at the outset of the disaster were reporting higher numbers of female corpses. As a result, there were many husbands and young men who had no wives, mothers, or sisters to cook for them while they were away at work or to watch and raise their surviving children. There was then a bubble of early marriages–girls attracted or pushed into early marriage–as the men did not have the skills to care for themselves or their remaining children.

Early marriages resulted in early pregnancies, which resulted in increased reproductive health problems and risks for the young brides/mothers. Pennell argues that if humanitarian actors had ensured basic SADD and gender analysis in their assessment efforts, they would have immediately seen the significantly higher death rates among women and older people, and using gender analysis could have thought through some of the implications for the death of women and older people on the society and households. They could have then worked to help mitigate, for example, the risk of early marriage, through looking to assist the men in other ways for child support, food, etc. without their resorting to early marriage of young girls.[14]

As the example of the 2004 tsunami illustrates, focused collection of particular SADD and gender and generational analysis of that data is necessary, even at early assessment phases, to understand the affects of natural disaster on the population. Simply put, without key inputs made by SADD, we are left with an unclear understanding of who was affected, how, and what this means for the immediate and long-term future of the surviving families and communities.

Endnotes

1 These figures are derived from the International Emergency Disasters Database http://www.emdat.be/. Their figures for natural disasters include not only those triggered by hydro-meteorological events, but also by earthquakes and tsunami. However, earthquake- and tsunami-triggered events are small in number and affect relatively few people (with the exception of the 2004 Indian Ocean tsunami). The inclusion of these events in the term "natural disaster" has little effect on the overall trends.

2 These figures only reflect disasters that are reported internationally and may receive international assistance. Lower-level, but much more frequent, small-scale events typically slip under the international radar.

3 MacKinnon Webster, Justin Ginnetti, Peter Walker, Daniel Coppard and Randolph Kent, "The Humanitarian Costs of Climate Change." Feinstein International Center, Tufts University. December 2008.

4 Christin Ormhaug, Patrick Meier, and Helga Hernes, "Armed Conflict Deaths Disaggregated by Gender." Oslo PRIO Paper. 23 November 2009.

5 Adam Roberts "Lives and Statistics: Are 90% of War Victims Civilians?" Survival Vol. 52, No. 3 June-July 2010, pp. 115-136.

6 Oxfam, "The Tsunami's Impact on Women." Oxfam Briefing Note 30. March 2005, p. 2. Available at http://www.oxfam.org.uk/resources/policy/conflict_disasters/downloads/bn_tsunami_women.pdf

7 Data reproduced from Abdur Rofi, Shannon Doocy and Courtland Robinson, "Tsunami Mortality and Displacement in Aceh province, Indonesia." Disasters. Vol. 30, No. 3, 2006, pp. 340-350.

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11 Ibid.

12 Ibid.

13 Linda Pennells, GenCap advisor, interview with authors, February 8, 2011, Geneva.

14 Ibid.

IV. Clusters

In the following sections we focus on five clusters:

1 Education
2 Emergency Shelter
3 Food Security
4 Health
5 Water, Sanitation and Hygiene (WASH)

These five clusters were chosen by the Steering Committee for this study, headed by OCHA and CARE. Within each cluster, we concisely present information from the published literature on how gender and age matter within these sectors for people living in crises caused by natural disaster and armed conflict. We then draw on interviews and published literature to examine if SADD is collected by UN lead cluster agencies, their partners and local agencies operating within these clusters and if so what, if any, difference it makes for programming.

We illustrate each section with case examples to highlight key points. We then make recommendations about what are realistic and practical methods for SADD collection for the different phases and make recommendations on how to use SADD and gender analysis to enhance needs assessment in the different sectors.

V. Education

A. Introduction

During crises, ensuring children and youth remain in school and receive their education is a high priority because the children, their right to education and their futures are at stake. Many families make significant investments in educating their children, in part because they see their children's education as an investment in the entire family's future. The nation as a whole also needs educated citizens to ensure its development. Yet natural disasters and situations of armed conflict can seriously undermine children's access to quality education. Studies find that even restricting or cutting off access to education for a short time greatly increases the likelihood that a child will not complete their education.[1]

numbers of teachers decline as teachers flee or are injured or killed. Natural disasters damage and destroy schools. In armed conflict, fighting groups from all parties use schools as recruitment centers, barracks, and emergency health centers; sometimes using materials such as desks for fuel wood. In other cases, opposition fighters burn schools to the ground because they symbolize the state.[2]

Gender discrimination and gender-based violence in schools is a problem for both boys and girls even in normal times.[3] During situations of armed conflict or disaster, gender discrimination and risk of sexual assault on the way to and from school may increase. Achievements in improving educational access for marginalized groups are put at risk, particularly for minorities, females, and disabled children within the affected regions.

THE RIGHT TO EDUCATION IS LAID OUT IN

- **UDHR (Article 26)**
- **ICESCR (Articles 13 and 14)**
- **CRC (Articles 28 and 29)**
- **CEDAW (Article 10)**
- **ICERD (Article 5(e))**
- **Convention Relating to the Status of Refugees**

Education is a human right that helps empower people and enables them to realize their other human rights. Education plays an essential role in helping socially and economically marginalized people climb out of poverty and helps enable their ability to more fully participate as citizens in their communities and countries. Natural disaster and armed conflict often deprived populations, and particularly females, of their right to education.

IASC. Women, Girls, Boys and Men: Different Needs – Equal Opportunities. IASC. December 2006.

Quality of education, often low in poor, rural areas and large urban centers, can become even more degraded during disasters, including: classrooms can become overcrowded, often there are not enough supplies, students can suffer from hunger and malnutrition, and the

At the same time, crises can provide unique opportunities for marginalized groups to increase their access to school and can help build the foundation for continued equitable access in the future.[4]

EDUCATION IN EMERGENCIES

The term *education in emergencies* refers to formal and non-formal education in situations where children lack access to their national and community educational system due to complex emergencies or natural disasters. Because modern conflicts are often of very long duration and may be chronic in nature, the word "emergency" refers not only to initial non-formal education programs, but also to the establishment of formal education programs during the conflict, as well as the eventual re-establishment of community and governmental educational structures in a post-conflict environment. Education in emergencies is typically not an intervention of a month or a year, but a long-term, multi-year process that eventually merges with normal models of development….

Although education in emergencies may share some of the same challenges as education in poor countries, the emergency setting requires education programs to set different priorities, consider different factors, and design different activities than would otherwise be the case in a peaceful environment. This is especially true during the early phases of emergency programming. In emergency situations, education activities initially focus on protection, providing survival messages, psychosocial support, and stability to children who have been forced to flee their homes. As the situation stabilizes, education programs can focus on expanding access for all children and improving the quality of educational services. Attention can then turn to curriculum development and education standards.

Carl Triplehorn, Education: Care and Protection of Children in Emergencies: A Field Guide. Save the Children Federation. 2001, pp. 3-4.

B. Case Studies on Use of SADD

We offer two case studies to illustrate how gender and age influence access to education and how the use of SADD and gender analysis is used in each case to reveal and illuminate the affects of armed conflict and natural disaster on people's access to education. The two case studies include: 1) the impact of gender on access to education and distance to schools in **Afghanistan**, and 2) using SADD to determine both mixed sex and same sex vulnerability in access to education in Northern **Uganda**.

*Case Study I: Girls' and Boys' Access to Education and their Distance to Schools in **Afghanistan** during Armed Conflict*

Historically, access to formal schooling in rural areas of **Afghanistan** has been very limited. Access to secondary education has been almost exclusively restricted to urban areas. Less than 10% of the Afghan population and only 2% of women could read and write by the early 1950s.[5] The remote and isolated nature of many Afghan settlements means that many rural people remain unable to access educational facilities.

Researchers working with the Feinstein International Center, Tufts University worked closely with WFP and key Afghan Ministries to analyze country-wide survey data on education in which SADD was collected. The study found that the school attendance of boys from poor households is highest in the north and northeast and lowest in the southern regions (Figure E1).[6] Tufts' analysis of 2003 survey data also shows that lack of schools and distance from schools are the primary reasons boys from poor households who are under 14 years of age are not in school, with the southern and central regions most affected. This problem is compounded by lack of transport, poor roads, and the need of families to use all available labor in pursuit of their livelihoods.

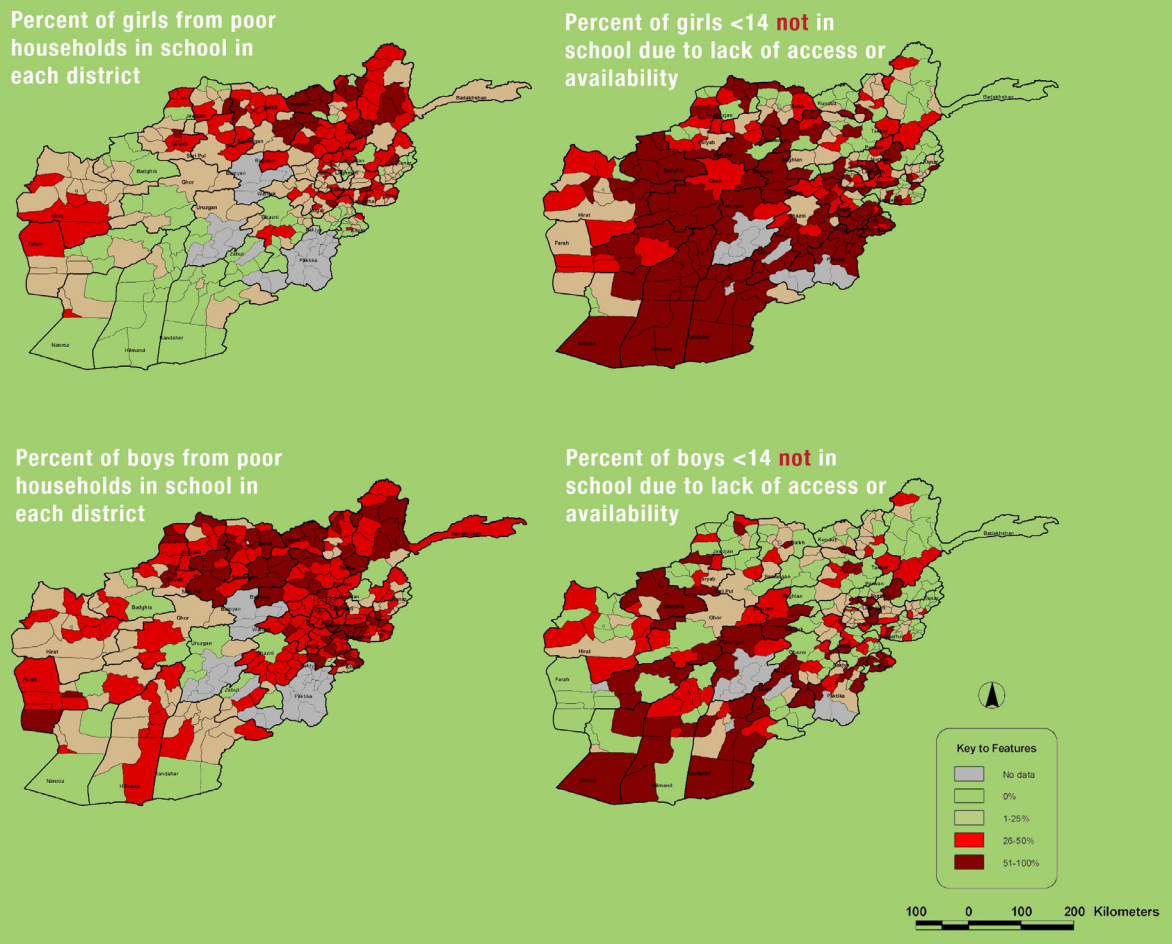
Tufts' analysis of the survey data finds that rural girls from the poor wealth group are less likely to attend school than boys from the same wealth group. Percentages of rural girls attending school are highest in the northeast. However, there are only a few districts countrywide where more than 50% of school age girls in villages are actually attending school. School attendance for rural girls is largely nonexistent in the southern and south central regions of **Afghanistan**. Tufts' analysis finds that, as for boys, the primary reasons girls are not in school is due to lack of schools (including schools that were not open to girls), or distance of schools. Not surprisingly, the regions with the highest non-attendance rates for girls are those where the fewest schools for girls exist.

Yet, distance from school is a greater constraint for girls than for boys. Girls do not travel as far from the home or village as do boys and, due to cultural practices, girls are usually not allowed to walk alone. Since there are far fewer schools for girls than for boys across the country, it is more difficult for remote rural families to send their girls to school.

A gender analysis found that the end of the Taliban's restrictions on education for girls brought an increase in female enrollment in some areas

FIGURE E1

School Attendance Rates and Reasons for Not Attending for Girls and Boys by District in Afghanistan, 2003



of the country. However, barriers to education for girls continue to exist in many regions and for many families. Where schools exist, most remain segregated by gender and therefore there must either be two schools in an area (one for girls and one for boys), or the school must operate in two shifts. Furthermore, girls who were unable to attend school during the Taliban years fell behind both their male age cohorts than girls who attended private (and covert) home schools.

Finally, a gender analysis of available teachers finds that traditional families may prefer that their girls study under female teachers, but educated female professionals in **Afghanistan** are more likely to live in urban than rural areas. Teaching was one of the most readily available professions for Afghan women prior to the start of the war with the Soviets,[7] but the numbers of women teachers dropped as many people left the country. The Taliban's edicts against women working or attending school brought a further decline in the number of female teachers.

The Afghan Ministry of Rural Development and Reconstruction and USAID used the findings to help target building of schools and increase enrollment of girls in particular provinces.

*Case Study II: Mixed Sex and Same Sex Vulnerability in Access to Education, Northern **Uganda***

Youth have been both the primary victims and the primary actors in the two-decade long war in northern **Uganda**. Yet, while we know that youth have suffered, we have not been able to answer with confidence some crucial questions: Who is suffering, how much, and in what ways? The state of knowledge regarding women and girls is especially lacking. One consequence of this lack of knowledge is that programming is often based on immediate and observable needs and possibly erroneous assumptions about who needs help and what sort of help ought to be provided. With only rough measures of well-being at our disposal, a second consequence is unavoidably crude targeting of services.

With UNICEF support two representative surveys of 1018 households and 1369 male and female youth (ages 14-30) were conducted to i) identify the short and long-term effects–as measured by social, psychological, educational, economic, and health indicators–of abduction, war violence, forced marriage, and motherhood on young women and girls; ii) compare and contrast the experiences of men, women, boys and girls, both those who had experienced abduction into the rebel forces and those who had not been abducted; and iii) use this knowledge to improve the targeting and design of humanitarian assistance and protection initiatives for war-affected youth in northern **Uganda**.[8]

When looking at overall education for males and females (with the first data presented for males and females overall, both those who experienced abduction by the rebel forces and those who did not). The research found that one in five female youth have received no education whatsoever, and only one in three are functionally literate.[9] Additionally, 19 percent of females aged 14 to 30 never attended school, compared to just 1 percent of males the same age. The result of this under-education is that young women possess only 4.9 years of schooling on average, compared to 7 for young men. Young women who have attended primary school are more likely to have dropped out. Among youth who completed their first grade, 45 percent of females failed to complete seventh grade compared to 19 percent of males (excluding those youth currently enrolled). As a result, even among those who reached the first grade, females lag a whole year behind males with an average attainment of grade 6 (versus grade 7 among males ever enrolled in school).

Low enrollment and early dropout has dire consequences for female literacy. Reading and writing skills are typically developed in the later primary grades, especially 6 and 7. In rural areas and internally displaced persons (IDP)

camps, the early years of primary school appear to confer few skills. Thus 43 percent of female youth report currently that they are unable to read or write at all, and 60 percent are unable to read a book or newspaper (what is deemed 'functional illiteracy'). In comparison, males report just one quarter the rate of complete illiteracy, and half the rate of functional illiteracy.

Significantly, this education and literacy gap, however, is driven primarily by older females. The education and literacy gap is most acute among adult women rather than adolescents. Figures E2.1 through E2.4 display levels of educational attainment, functional literacy, any literacy, and current school enrolment by current age. All four measures fall steeply with female age – far more steeply than for males. Under-education and illiteracy among older females is dramatic. Among women aged 26 to 30 in the sample, 38 percent have never attended school, only 18 percent can read a book or a newspaper, and none have attended university.

Unfortunately, there are few opportunities for these young adult women to 'catch-up' in literacy or education. Only a small number of adult learning programs exist, and fewer still (if any) offer accelerated learning.

Now looking at education for abductees versus non-abductees both between the sexes and among same sex groups. For girls, with

FIGURE E2.1

Average educational attainment for young males and females, N. Uganda

By age of respondent

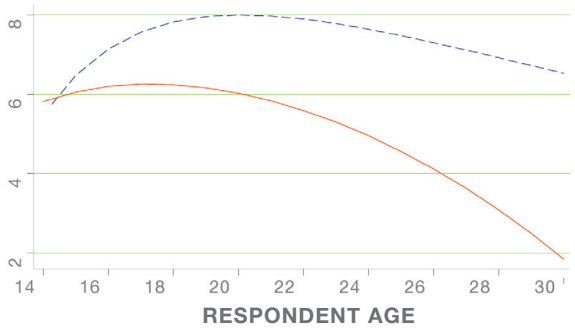


FIGURE E2.2

Reports being able to read a newspaper, N. Uganda

By age of respondent

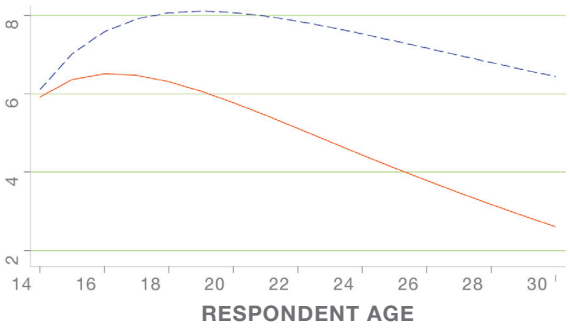


FIGURE E2.3

Reports being able to read or write at all, N. Uganda

By age of respondent

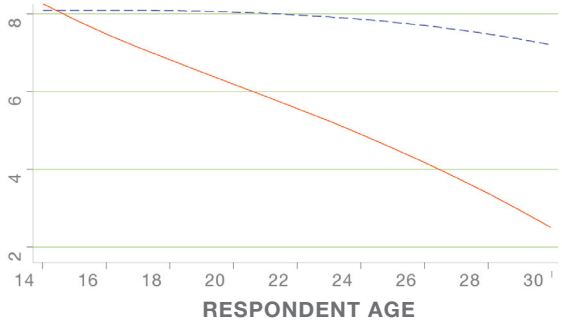
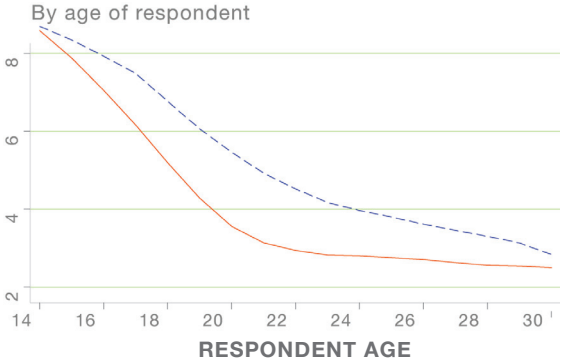


FIGURE E2.4

Proportion enrolled in school, N. Uganda

By age of respondent



MALES, 2005/06 ▪▪▪▪▪▪▪ FEMALES, 2006/07

the exception of longer term abductions, there is relatively no difference in education rates for abductees and non-abductees. (The study found that overall long term abductees display lower educational outcomes, largely due to time away.). One reason that abduction may have little systematic association with female education is that, by the time of abduction, most girls would already have been out of school; the data show that more than half of women were abducted at age 15 or older. As they were more likely to drop out of primary school than boys, abduction would be expected to have a lower impact on their educational attainment than in the case of young men.

Another reason that there is little average impact of abduction on education is that most female abductions were not only short, but also slightly shorter (on average) than that of young men. Long abductions, however, do appear to be associated with educational gaps among both male and female abductees. Each year of abduction is associated with roughly a quarter of a year loss in educational attainment among young women.

Comparing abducted females, it was found that returning from captivity with children born as a result of that captivity is associated with nearly a third less education, in large part because young women with children are unable, disallowed, or unwilling to attend school.

Women who have returned from the bush with children today have attained significantly less schooling–roughly 1.3 fewer grades–than their other abducted peers. These young mothers are also considerably more likely to be illiterate. This education and literacy gap persists even when accounting for abduction length, forced marriage, age of abduction (or return), education level at the time of abduction, and other possible confounders. Considering that average educational attainment is less than five years among women in general, and that long abductions are associated with falls in education of 0.5 to 1 year, an additional fall of 1.3 years is quite considerable.

Roughly 41 percent of former abductees returned to school following abduction, including 28 percent of long-term abductees (those held captive for eight months or more). The likelihood of returning to school following return is reduced to nearly zero, however, for women returning from the bush with children. This gap persists even after controlling for abduction length, age of return, and forced marriage. Interestingly, females who experienced "forced marriages" during rebel captivity, but who did not bear children, were no more or less likely to return to school than unmarried long-term abductees, further suggesting that children are the binding constraint on women's education.

The policy implications of these findings are clear. For example, there is a need for Education Cluster partners to increase attention on retaining females in school and assisting with the transition to secondary school. There needs to be age-appropriate programming for young adults, in particular remedial and non-formal education, with an emphasis on females. Additionally, there needs to be an effort to engage the Government of **Uganda** to allow girls with young children to attend school, something currently not allowed under national policy, including possibly supporting schools where girls with infants and young children can attend (as has been successfully done in one school in northern **Uganda**).

C. When Organizations Don't Use SADD or Gender or Generational Analyses to Inform Education Response

GoThailand for several years collected SADD on school enrollment, then as figures for boys and girls reached near gender parity, they concluded that boys and girls were equally in school and stopped collecting SADD data on school enrollment and attendance. A few years later, reports began coming in that boys were

dropping out of school. The gap in boys' attendance was not identified as early as needed to be, and when SADD data was collected the results were that due to economic pressure there had been a sharp drop of boys in schools in some regions. Due to lack of SADD data to monitor, they had missed the phenomenon and were late to address it, so it took extra effort and resources to struggle again to reach gender parity.[10]

In **Somalia**, there was good use of SADD to monitor school attendance across the country. UNICEF, **Somalia** found that 22-40 percent of children were attending school across **Somalia**, and within that figure, girls accounted for 22-25 percent. Thus, while girls' school attendance was lower than boys, boys' attendance was also very low. The program response was a heavy emphasis on getting girls into school, with very little attention on trying to understand more about why boys were not going to school. This emphasis on girls' education caused a backlash in some communities against education programs, which were seen as a western focus that disregarded the communities' values.[11]

D. SADD Guidelines and Data Collection Tools for Lead Education Cluster Agencies

UNICEF and Save the Children are the joint lead agencies within the Education Cluster. Among the Cluster system, the Education Cluster is one of the most advanced in terms of the collection and use of SADD and in using gender and generational analyses to inform their response. The Education Cluster is strong on promoting in words and action the right to education, even during emergencies, and have a strong emphasis on girls' education.

To illustrate, during an interview for this study by the authors the UNICEF Education Cluster lead remarked, "It is very well accepted that you have to have SADD, I would not have an example of where this is not considered important or where there is not attention to this in Education Cluster."[12] SADD is located throughout their Rapid Joint Education Needs Assessments, the data requests they make within the rapid multi-sectoral needs assessments, and their own assessments within **Phase III**.

- While the Education Sector is not included in the Sphere Handbook, the Minimum Standards for Education: Preparedness, Response, Recovery notes that assessments should collect disaggregated data to inform the education response and assess continuing risk from conflict or disaster. Here disaggregating data means that the information is separated into its component parts, and in this case analyzed by sex and age group. Data should be collected that identify educational capacities, resources, vulnerabilities, gaps and challenges to upholding the right to education for all affected groups.[13]

- For **Phase I and II** assessments, the Global Education Cluster's "Short Guide to Rapid Joint Education Needs Assessment" has SADD throughout nearly every section – from framing the assessment, indicators and questions, data collection and management, sharing and applying findings, to the sample data collection tools.[14]

- For **Phase III** assessments SADD and gender and generational analyses are included throughout the guidelines and tools.[15]

The assessments carried out by the Education Cluster are clearly disaggregated by sex, but less so by age. Rather there is attention to generational groupings, such as early childhood, adolescents and youth, as well as attention to grade levels within school groups (primary 1, 2, 3 and so on), since often different aged children are in the same school group.

Importantly, the Education Cluster leadership recognizes that while assessments may contain SADD, field offices often do not have the skills to analyze the findings or put those into action through response. Therefore, they are hiring staff that will be based at headquarters (with some ability to travel to field offices) to help field offices analyze and think through the implications of the findings for response. We see this as an important and innovative initiative forward in making evidence-based humanitarian response a reality.

E. Core Recommendations for Education Cluster for Ensuring Good Data Collection and Gathering SADD

The Education Cluster should maintain and strengthen their collection and analysis of SADD during all phases of a crisis. The Education cluster should also focus on supporting field teams to:

a- Ensure data collection is in line with its own assessment guidelines and tools;
b- Provide support to field teams during data analysis;
c- Provide support to its implementing agencies to translate relevant findings into response;
d- Ensure proper monitoring and evaluation of response to inform practice.

Prior to an emergency, as part of disaster preparedness, and as recommended by the Global Education Cluster:

1 Establish buy-in, procedures and responsibilities for the collection of data, making sure data collected is SADD;

2 Add age- and gender-relevant gauges when preparing and agreeing upon assessment and monitoring tools;

3 Review and compile the existing education data that is SADD;

4 Understand the basic features of the education system, including key education statistics, policies, curriculum and cultural practices that affect learning;

5 Develop a list of schools and their locations in the country.

During Phase I and II Assessments

1 Look at existing data collected prior to the disaster, where possible, to quickly assess the demographic profile of the population; this facilitates an understanding of how many boys and girls to expect may need assistance allowing for initial data assessment to be extrapolated.

2 Locate and use pre-disaster SADD education data and information about local capacities (e.g., location of schools, number of teachers, ratio of boys to girls in school), pay particular attention to context and other pre-existing factors that may increase the crises' impact on the education and well being of particular groups, such as girls or adolescents. Assess current and potential safety concerns related to learning venues and practices, noticing whether they affect certain groups more than others;

3 Ensure that the teams in charge of conducting assessments are composed of men and women;

4 Ensure that key female informants are interviewed who often have information on immediate educational needs of women and girls, such as teachers, students and community leaders;

5 Carry out a rapid initial assessment collecting SADD to identify who is and who is not participating in educational and learning opportunities;

6 Ensure SADD is recorded regarding all team members, key informants, individuals and focus group discussion participants. This will enable:

> **a** Assessment of whether there are important segments of the population that have not been reached who may have views needed to inform response;
> **b** Assessment of any important differences across gender and age in terms of access to learning opportunities.

7 Analyze **Phase I and II** assessment data reflecting on the pre-crisis information to assess changes in the context caused by the crisis, identifying any new factors that create or

increase vulnerability, such as the practice of enrolling boys or girls as child soldiers or the need to marry off girls or restrict their mobility for real and perceived security risks.

During Phase III Assessments

1 Assess the coping capacity, skills, resources and recovery strategies of the affected people and the response plans and capacity of the state. Ensure that this assessment differentiates the resources and capacities addressing different sex and age groups (e.g., male/female teachers, gender and age dimensions that affect safe travel to and from schools, state of educational infrastructure, etc.).

2 Gather basic SADD of those who can access educational and learning opportunities. This will enable and enhance:

a Understanding of who is and who is not actually attending school/ classes, and hence how outreach and access need to be improved;
b Understanding about whose learning needs are being met and whose are not, and why, and how this might be addressed;
c A response that is shaped to reflect improving access, decreasing vulnerabilities, and meeting real needs.

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3 Carry out detailed and nuanced qualitative and quantitative studies on key areas of concern, ensuring collection of SADD where relevant, and gender and generational analyses to interpret findings within the country and crisis context.

Endnotes

1 See Carl Triplehorn, "Education: Care and Protection of Children in Emergencies: A Field Guide." Save the Children, Federation, 2001. Available online at http://www.savethechildren.org/publications/EducationFieldGuide.pdf; Plan UK, "Because I am a Girl." The State of the World's Girls 2007-Real Choices, Real Lives. Plan UK: London. 2007; Marc Sommers, "Emergency Education for Children." Mellon-MIT Program on NGOs & Forced Migration. Cambridge: MIT. 1999; UNESCO, "Out of School Adolescents." Montreal: UNESCO Institute for Statistics. 2010.

2 Ibid.; UNESCO, "Reaching the Marginalized." EFA Global Monitoring Report 2010. UNESCO: Paris. 2010; Marc Sommers, "Children, Education and War: Reaching EFA Objectives in Countries Affected by Conflict." Working Paper #1. Conflict Prevention and Reconstrucion Unit. Washington, D.C.: World Bank. 2002.

3 Gender-based violence against women, men, boys and girls often increases in crisis settings. These violations undermine and obstruct people's enjoyment of their rights and ability to achieve gender equality. See IASC, "Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies." 2005. Available at http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=3.

4 Carl Triplehorn, "Education: Care and Protection of Children in Emergencies: A Field Guide." Save the Children, Federation, 2001. See also INEE, "Minimum Standards to Education in Emergencies." 2010. Available at http://www.ineesite.org/post/know_updated_inee_minimum_standards_handbook/.

5 Barnett Rubin, "The Fragmentation of Afghanistan: State Formation and Collapse in the International System." Second Edition. Hartford: Yale University Press. 2002.

6 This material is reproduced from Neamattolah Nojumi, Dyan Mazurana and Elizabeth Stites, "After the Taliban: Life and Security in Rural Afghanistan." Oxford & Boulder: Rowman & Littlefield. 2008.

7 Rubin, p. 79.

8 See Jeannie Annan, Chris Blattman, and Rodger Horton, "The Youth and Youth Protection in Northern Uganda: Findings from the Survey for War Affected Youth." UNICEF: New York. 2006. Available at http://chrisblattman.com/documents/policy/sway/SWAY.Phase1.FinalReport.pdf; Jeannie Annan, Chris Blattman, Khristopher Carlson and Dyan Mazurana, "The State of Female Youth in Northern Uganda: Findings from the Survey of War Affected Youth — Survey for War Affected Youth, Kitgum, Uganda." Feinstein International Center, Tufts University. 2008.

9 These findings are reproduced from Jeannie Annan, Chris Blattman, Khristopher Carlson and Dyan Mazurana, "The State of Female Youth in Northern Uganda: Findings from the Survey of War Affected Youth — Survey for War Affected Youth, Kitgum, Uganda." Feinstein International Center, Tufts University. 2008.

10 Linda Pennells, GenCap advisor; Ellen van Kalmthout, Global Education Cluster Coordinator (UNICEF); Interviews with authors, February 8 and 11, 2011, Geneva.

11 Siobhán Foran, GenCap with the Global Clusters, Interview with authors, February 8, 2011, Geneva.

12 Ellen van Kalmthout, Global Education Cluster Coordinator (UNICEF); Interviews with authors, February 8 and 11, 2011, Geneva.

13 Inter-Agency Network for Education in Emergencies (INEE), "Minimum Standards for Education: Preparedness, Response, Recovery." New York: INEE c/o UNICEF. 2010, p. 37. Available online at www.ineesite.org.

14 Global Education Cluster, "Short Guide to Rapid Joint Education Needs Assessments," 2010. The Short Guide to Rapid Joint Education Needs Assessments is part of a larger toolkit produced by the Global Education Cluster in 2010 called The Joint Education Needs Assessment Toolkit. Both are available online at http://oneresponse.info/GlobalClusters/Education.

15 For more resources on SADD sensitive education assessments, see http://www.educationfasttrack.org/resources/key-documents-for-fti-partners/

VI. Emergency Shelter

A. Introduction

The provision of emergency shelter and essential non-food items (NFI) to populations affected by disasters is often one of the first forms of relief provided. As highlighted by IASC, "in the initial stages of an emergency where populations have been displaced, shelter and site selection are especially important for safety, protection and human dignity, and to sustain family and community life."[1]

According to UNHCR, in the majority of refugee and IDP situations at least 50 percent of the uprooted people are women and girls, who are often at a heightened exposure to risk. Refugee and IDP populations nearly always require the provision of relief shelters and NFI. Once again, gender and age–together with the broader socio-cultural, political and economic landscape–have a crucial role in shaping shelter and NFI needs. Male and female older people, adults, youth and children differ in their roles, responsibilities and needs, and they also differ in their perceptions of what constitutes an appropriate form of shelter. Conscious efforts to address these differences lead to better project design and performance, and thus greater impact and efficiency.

Gathering good data on the needs of the different groups of beneficiaries is essential to inform response. A World Bank study on housing in development settings found that a focus on gendered needs in planning has multiplier effects: it leads to benefits that go as far as ensuring better maintenance and hygiene awareness.[2] These same benefits are also likely to be observed in emergencies, especially in the case of protracted crisis.

THE RIGHT TO ADEQUATE HOUSING IS LAID OUT IN

- **Universal Declaration of Human Rights**
- **Pact for Economic, Social and Cultural Rights**
- **Pact for Civil and Political Rights**

The human right to adequate housing is recognized as a basic human right and has a central place within the body of human rights in general. The recognition of this right guarantees the respect of other rights such as human dignity; non-discrimination; an adequate standard of living; the freedom to choose one's place of residence; freedom of association and expression; security; and the right to not be subjected to arbitrary intervention into one's private life, home and correspondence.

IASC. Women, Girls, Boys and Men: Different Needs – Equal Opportunities. IASC. December 2006.

B. Case Studies on Use of SADD

This section presents three case studies illustrating how gender and age influence needs and access to shelter and non-food item requirements. The three case studies include: 1) an investigation into household energy, settlement and NFI through firewood collection in Darfur, **Sudan**; 2) the impact of age on mobility and housing needs in **Uganda**; and 3) the role of age in those who remained behind and did not flee the violence in **Croatia**. These examples demonstrate how collecting SADD for shelter needs in emergency situations is indeed possible, and when it is done properly

provides a better understanding of male and female older people, adults', youth, and children's distinct needs, roles and responsibilities around shelter.

Case Study I: Household Energy, Settlement and NFI through the Case of Firewood Collection in Darfur, ***Sudan***

The shelter sector is typically responsible for the campsite selection, for the provision of shelter materials and for coordinating the composition and distribution of Non-food Items (NFIs). The Sphere Handbook recognizes that "access to basic goods and supplies is required to enable affected populations to prepare and consume food, provide thermal comfort, meet personal hygiene needs and build, maintain or repair shelters."[3] The individual and household NFIs needs must thus be assessed and met as appropriate.

Gathering information from women, men, girls, and boys is necessary to identify and meet their common and separate needs. Additionally, linking women's, men's, girls', and boys' NFIs, shelter and settlement needs with needs related to health, protection and other spheres can dramatically improve the level of assistance provided.

The Darfur region of **Sudan** presents an illustrative case study for the shelter sector, showing the link between the collection of firewood and the risk of rape. Since 2003, Darfur has been the site of a massive humanitarian crisis and response, in which sexual and gender based violence has been used by belligerents as a weapon of war against civilian populations. The scope of the sexual violence was immense. Chronically under-reported, according to Médecins sans Frontières, over 200 rape survivors were assisted per month in 2005.[4] In August 2006 the International Rescue Committee (IRC) reported 200 assaults in a five-week period from a single camp.[5]

By May 2011, the number of internally displaced people (IDPs) in Darfur was between 1.9 million and 2.7 million,[6] with an additional 2 million people considered conflict-affected.[7] IDPs depend to a large extent on firewood for cooking and making bricks for building their shelters. Collection of firewood is predominately carried out by women and girls in the areas surrounding the camps and settlements. Some firewood is available for purchase in the camps, but at a high price. The need for most families to collect firewood has exposed women and girls who go out of the camps in search of firewood to the risk of sexual assault. Since 2005, the international community has known of the link between firewood collection and rape in Darfur.[8] An early identification of the need for IDPs to access firewood coupled with the use of sexual violence as a weapon of war against civilian populations by the belligerents should have alerted humanitarian responders of the need to take measures to avoid or diminish the threat of violence, including sexual violence, for those collecting firewood.

The mitigation of the risk of sexual violence for women and girls collecting firewood could be achieved in several ways: by avoiding overcrowded living conditions; identifying sites after a careful assessment of the wood resources available in and around a camp site; avoiding the need for women and girls to travel farther and farther away from the relative safety of the camp to find cooking fuel; reducing the amount of wood needed for cooking, for instance by providing fuel efficient stoves; and reducing the amount of wood needed for brick-making, for instance providing presses to produce stabilized soil blocks.[9] All these measures are possible to implement, but the first step is the identification of the problem at an early stage, which can only be achieved by proper consultation with knowledgeable parties and carefully listening to and taking into account the different needs and concerns expressed by women, men, girls, and boys.

Breastfeeding Challenges in Transition and Emergency Contexts

Following the October 2005 earthquake in Kashmir, Pakistan, women frequently shared a shelter with distant male relatives and/or non-related men. The lack of privacy and support led many women to stop breastfeeding as they felt uncomfortable exposing their breasts in front of men. This emphasizes the urgent need for lactation corners in emergency settings to ensure continued breastfeeding.

From IASC. Women, Girls, Boys and Men: Different Needs – Equal Opportunities. IASC. December 2006.

*Case Study II: Age, Sex and Shelter Construction in **Uganda***

Another issue that emerges when collecting SADD is that not everyone is able to physically assemble a temporary shelter. While in many cases temporary shelters are simply a tent of tarpauline, on other occasions they require the recipient of materials. Shelley Gornall, Information Management focal point for Emergency Shelter, Protection and CCCM Cluster, recalled a case in **Ethiopia** in the 1990s where a disproportionately high number of unaccompanied refugee children arrived from **Sudan**. These children were unable to build their own shelters, so rather than distributing the material for the construction of temporary shelters, UNHCR had to provide them with assistance to build their shelters.

In another study, World Vision, **Uganda** reported on the resettlement capacity of men and women and pointed to the fact that:

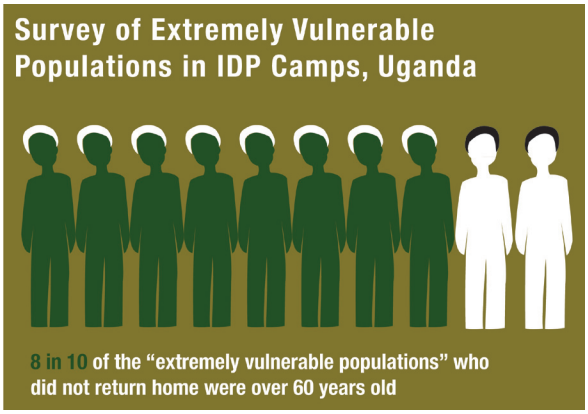
> Traditionally, the Acholi people live in typical African huts made up of round mud or brick walls with grass-thatched roofs. (...) House construction is a male domain activity, and as a result, only 7% of the single female headed households acknowledged to be endowed with house construction skills, and can construct their own huts without seeking male participation. Male participation is usually paid for in cash or in-kind, and the study discovered that some women have had to trade unwanted sex in exchange for the required male construction skills.[10]

This example highlights that disaggregated data by sex and age can help provide better assistance, but just as important, ensure protection.

The challenges of shelter construction can be exacerbated by age, too. Older people experience greater mobility challenges than younger people, restricting their capacity to flee insecurity, settle in temporary shelters or return to their places of origin when distant travel is required. A study conducted by HelpAge International in **Uganda** found that when the Government ordered the disbanding of the IDP camps not all persons were able to return home. For those who did not return home, they were labeled as "extremely vulnerable populations" and were able to receive some assistance from WFP and partner organizations. HelpAge's research found that 80% of these "extremely vulnerable populations" were people over 60 years of age (Figure ES1).

Furthermore, HelpAge International identified a problem that affected single, older women. These women cited the main reasons for not returning to their villages of origin as the lack of shelter and a concern over their physical capacity to return. A group of older women without family members to support them told researchers that they wanted to return home but they had no one to help them, and they lacked

FIGURE ES1



the strength or the skills to build shelters.

Others lamented the fact that, as a result of the breakdown of solidarity networks, younger people demanded cash payment when asked to provide assistance with constructing shelters. As a result they remained in IDP camps.[11]

These problems could be addressed differently if assessments pay attention to SADD, and this case highlights the importance of collecting data on the number of unaccompanied older people and children as well as female heads of households, in order to accurately plan practical and effective assistance and carefully allocate resources.

It is also important to investigate who retains the skills for construction and who is seen as responsible for this task, as it is very context-specific. In northern **Uganda**, for instance, men are responsible for shelter construction. Conversely, women are responsible for constructing shelters in the Dadaab refugee camp in **Kenya**.[12]

Case Study III: Understand Who is Missing

Often, understanding the needs of those who are missing is as important as understanding the needs of those who are present in a camp setting. This is often the case for older people, who remain behind either to look after the family properties, letting the rest of the family leave, or because they are too weak to flee.

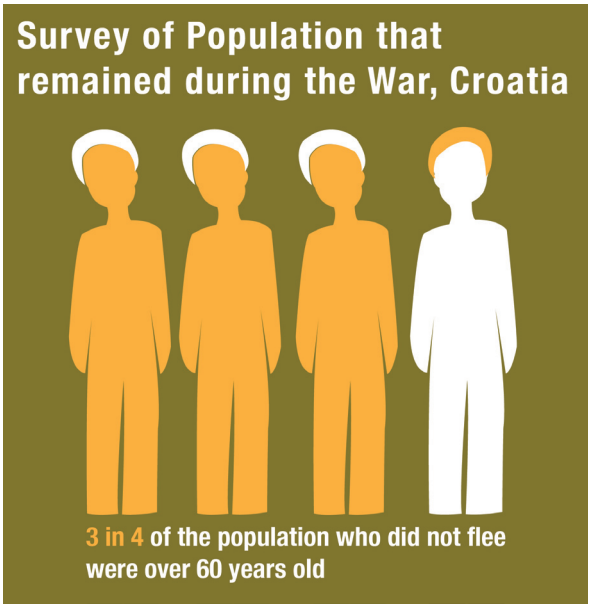
The IDP profiling report conducted in **Yemen** with the support of the Joint Profiling Service (JIPS) in December 2010 shows, for instance, that 11% of all the IDPs claimed to have missing members of their families. Based on the interviews conducted with those who managed to flee, the main reasons why some members stayed behind was that they died (28%); they were too old or disabled to travel (9%); or stayed behind to look after land and properties (26%).[13] Very often, these reasons overlap, and older people as those who remain behind to protect the family's belongings.

Family separations represent a major risk and pose higher hardships on families already in distress. Additionally, it also leaves entire groups in need of assistance, very frequently in terms of shelter and food and NFIs, as those remaining behind are in some cases unsheltered, or unable to access even the most basic NFIs required for their daily lives.

One of the most thorough studies on this subject was conducted by the Croatian Red Cross and 28 Social Welfare Centers in **Croatia** during the war in the Balkans.[14] The study is quite unique given the wealth of data gathered in the midst of a conflict, data that are generally unavailable, or at least less rigorously collected, in other crisis settings. The study gathered data regarding 10,594 persons, in 524 settlements, and found that the 97% of the inhabitants of the area examined fled, leaving behind only 3% of the pre-war population.

More than 75% of the remaining population were over the age of 60 (Figure ES2); they were furthermore scattered in 524 villages or hamlets, with only one inhabitant in 73 of

FIGURE ES2



them. Only one in every four remaining inhabitants had access to a supply of goods, and one in two had electricity in their homes. Approximately one in every ten needed emergency assistance concerning their shelter needs.[15]

Based on this humanitarian assessment, an humanitarian operation called "Save Lives" was established and included immediate material assistance, increase in security, as well as a gradual establishment of contacts with families.

In the case of "Operation Save Lives," careful data collection allowed the humanitarian agencies on the ground to understand that the exodus of the inhabitants left behind a selected population of older people, and thus it was necessary to establish an operation targeting this population.

While in **Croatia** and **Yemen** age mattered the most in determining who was left behind, in other cases sex matters the most. In the initial phases of the crisis in **Libya**, UNHCR was able to observe that that the majority of refugees fleeing from the country were men; thus, one can conclude that there are many that there are many unaccompanied women trapped in the country, in need for assistance.[16] In **Cote d'Ivoire**, on the contrary, UNHCR has currently observed the opposite phenomenon. There is a disproportionate number of women leaving the country. This has protection implications, as well as practical ones for the design of camps and the provision shelter, because when agencies are planning the establishment of camps, and the assistance there, it must be kept in mind that there are more women in the camps and plan shelters accordingly.[17]

C. When Organizations Don't Use SADD or Gender or Generational Analyses to Inform Emergency Shelter Response

According to Shelley Gornall, UNHCR and its partners prioritize and are generally successful in collecting SADD data in the case refugees and, to a lesser extent, in the case of IDPs. For returnees, however, where NFIs distributions are frequently made at community level, the data are seldom disaggregated, unless there is a registration of particularly vulnerable individuals.

For refugees, there are three main circumstances in which the Clusters have problems collecting SADD. The first is when the onset of an emergency is extremely rapid, and thus those in charge of registrations are unable to keep up with the collection of data. In such cases, UNHCR and its partners may resort to community level distributions, but this is something the organization tries to avoid. The second circumstance is dictated by specific security concerns that prevent UNHCR and its implementing partners from either collecting data or using targeted distributions. This is infrequent, and at present it is the case in only two operations-**Iraq** and **Somalia**-where shelter and NFIs assistance is provided. In these situations, at times the implementing partners on the ground can collect some disaggregated data, but at the Cluster level data are only seen as aggregated, and largely do not inform programming.

In 2010 in **Yemen**, UNHCR observed a very low number of singe female heads of households showing up to receive NFIs. UNHCR investigated and discovered that for cultural reasons, women did not feel they could come to the distribution sites. UNHCR worked around the distribution processes, and allowed the women to designate–in the registration phase–a person who could collect the items for them. In this way, UNHCR managed to provide these women with assistance.[18]

Finally, when there are many small NGOs working on small projects, it may be hard for them to do SADD collection, as it increases their reporting burden.

D. SADD Guidelines and Data Collection Tools for Lead Emergency Shelter Agencies

SADD Guidelines

All the key actors within the Emergency Shelter/NFI cluster recommend collecting SADD. Furthermore, SADD is important to inform efforts to minimize protection risks correlated with camp life. This includes how camp infrastructures have different impacts on the level of threat, and how these threats are experienced by the different genders and generations.

UNHCR and the International Federation of Red Cross and Red Crescent Societies (IFRC) share leadership of the emergency shelter cluster. UNHCR leads in conflict-generated displacement, while the IFRC leads in natural disaster situations. Both agencies have guidelines that include recommendations on the collection of SADD.

- The Sphere Handbook notes the link between NFIs and protection and recommends to: "help people find safe options for meeting their subsistence needs. This might include, for example, the provision of goods such as water, firewood or other cooking fuel that helps people meet their daily needs without having to undertake hazardous and arduous journeys. This is likely to be a particular issue for older people, women, children and persons with disabilities."[19]

- UNHCR, in its publication Measuring Protection by Numbers, writes: "UNHCR is mainstreaming age, gender and diversity considerations to ensure that meaningful participation of refugee girls, boys, women and men of all ages and backgrounds is integral to the design, implementation, monitoring and evaluation of all its policies and operations."[20]

- In the majority of refugee camps and settlements UNHCR is able to carry out a full individual registration of women and men. UNHCR noted that, "In cooperation with WFP and other partners, UNHCR has made continued efforts to ensure that refugee women participate in the management and distribution of food and non-food items. In 2005, the majority of the refugee camps met, or nearly met, the 50 percent standard of involving women in food distribution."[21]

- In 2011, IFRC and HelpAge published guidelines on including older people in emergency shelter programmes. The first action point recommends programme staff should "understand both the needs and the abilities of older people," and be sensitized on the importance of collecting data on older people.[22] The guidelines also recommend examining "traditional support systems for older people, in order to build on these and assess existing safety networks (community and family assistance), and to find out how far these have been eroded since the emergency – which are still effective and which are breaking down."[23]

SADD Data Collection Tools

For settlements, shelter and NFIs, UNHCR mostly uses the same data collected for Camp Coordination and Camp Management (CCCM) and for Protection. These three sectors are kept closely interrelated, and this has a positive impact on organizational capacity to collect and use SADD and ensure gender and age sensitivity for protection concerns within IDP and refugee settings.

In case of refugees, there are two ways in which data is collected for registrations: at the household level and at the individual level. At the household level, the registration takes more details for the head of household, who receives a registration card for the family; at the same time, however, data about the demographic of each member of the household is also collected. The individual level data collection results in more accurate SADD, as the registration is done for each individual, assigning a card to

everyone, and gathering more information on each person. These data are in turn used for shelter needs and both general and targeted distribution of NFIs. When vulnerable categories are targeted for distributions, such as Unaccompanied Older People, Unaccompanied Minors, Single Females Head of Household, this is done on the basis of the individual registration/data collection. Even when data are collected at community levels using qualitative tools, the tool used is the Participatory Assessment Form (PAF), which requires the facilitators to collect qualitative data from different groups of people the data is collected in ways to enable SADD.

Such qualitative assessments are useful to get an idea of what people need, i.e., what type of NFIs would be more appropriate, and what they can provide by themselves. Then registration can be used to know the quantities needed.

E. Core Recommendations for the Emergency Shelter Cluster for Gathering SADD

Phase I Assessments

1 Look at existing data collected prior to the disaster, where possible, to quickly assess the demographic profile of the population to estimate how many women, men, children and older people may need assistance and so that when initial assessment data comes in, you have a basis from which to extrapolate.

2 Work with gender and culture specialists in country, where possible, and draw from the existing secondary data to get an idea of the socio-cultural norms and requirements concerning space and housing to plan accordingly.

3 Review the legal and customary frameworks to identify potential areas of gender and age discrimination.

Phase II Assessments

1 Work with gender specialists in country, where possible, to draw from the existing secondary data to quickly assess the status of women and girls prior to the crises so that when initial assessment data comes in, there is a basis from which to extrapolate.

2 Ensure that assessment team members, interviewers and translators include females.

3 Ensure that you interview key female informants who often have information on immediate shelter needs of women and girls, this may include local midwives, nurses, teachers, community leaders, and leading market women. Ensure SADD is recorded regarding all key informants, in order to ensure awareness of whether there are important segments of the population that have not been reached who may have views needed to inform responses;

4 Ensure that if you are using focus groups, 50% of those focus groups are comprised of women and older girls, ideally exclusively of women and girls (given males' tendency to dominate public and mixed-sex conversations).

5 Ensure that the sex and age of persons interviewed is recorded; this will enable you to:

- **a** Assess whether there are important segments of the population you have not reached who may have necessary views to inform your response;
- **b** Assess if there are important differences across gender and age in terms of needs and access to shelters among the most vulnerable populations.

6 Assess specific needs that may emerge in relation to SGBV threats and privacy concerns when planning camp settings and typologies of shelter.

Phase III Assessments

1 Gather basic SADD (i.e., sex and age) on those who come into camps and ensure SADD is recorded in data bases that can be used for analyses. This will enable the data to be used to:

a Understand who is and is not actually coming into the camps, and hence how outreach and access need to be improved;
b Carry out regular reviews of the findings to ensure that response is shaped to reflect improving access, decreasing vulnerabilities, and meeting real needs.

2 Assess who is able and who is unable to set a shelter independently; gauge information on the types of skills necessary to set up and maintain shelters; and help to ensure vulnerable groups have access to assistance from persons with shelter building skills or shelters are erected for them.

3 Carry out more detailed and nuanced qualitative and quantitative studies on key issues of concern, ensuring collection of SADD where relevant and gender and generational analyses to interpret findings within the context.

Endnotes

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Endnotes *contd*

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20 UNHCR, in its "Summary Report: Age, Gender and Diversity Mainstreaming 2004-2005" notes a discovery made "through the participatory assessments was that refugee women finally felt confident enough to talk about their problems, including on SGBV, while before the participatory assessments, women simply did not talk about these problems." UNHCR, Measuring Protection by Numbers, November 2006, p. 22.

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VII. Food Security

A. Introduction

In both developing and developed countries, livelihoods and the distribution of resources tend to be divided along gender and generational lines. According to FAO, on average, women comprise 43 percent of the agricultural labor force in developing countries; this figure ranges from approximately 20 percent in Latin America to 50 percent in parts of Africa and Asia, exceeding 60 percent in a few countries.[1]

It is thus not surprising that food security, which is closely connected to resource production and distribution, is strongly influenced by gender and generation, and this influence becomes even more apparent, and important, in situations of crisis. Numerous studies, assessments and reports describe how different sex and age groups are involved in different livelihood activities and sectors. In some cases, while these sex and age groups are employed in livelihood activities in the same sector, a closer look often reveals profound differences in the roles carried out by the different genders and ages and the status and access to resources attached to those roles.

Another recurrent finding throughout the literature is the difference in the distribution of resources among different members of the same household, and again gender and age are key factors in explaining these differences. All these differences along generational and gender lines – involvement in livelihood activities and sectors, status and access to resources, and distribution of resources – matter when it comes to the provision of humanitarian assistance.

Gender and Age in Livelihood Sectors

In many societies, male and female older people, adults, youth and children engage in different livelihood activities. The gender and age differences in livelihood activities are often apparent in pastoralist societies, as well as urban or semi-urban settings and refugee and internally displaced persons (IDP) camps.[2]

Some forms of work, either because of the physical attributes required or for cultural reasons, are only or predominately carried by a specific sex or age group, or a combination of the two. As a result, if a certain type of livelihood activity is more affected by a natural disaster or armed conflict, the food security of that group is more endangered than that of other groups. To illustrate, Ansell, in a study on the impact of AIDS on food security in Africa, noted "where female involvement with livestock is taboo, widows may become dependent on paying non-kin to care for livestock and for plowing. If particular

THE RIGHT TO AN ADEQUATE STANDARD OF LIVING, INCLUDING THE RIGHT TO FOOD

The right to food, including the right to non-discrimination in accessing food, is guaranteed under UDHR (Article 25) and ICESCR (Article 11). The right to food encompasses every person's right to physical and economic access to quality, adequate and culturally acceptably food, or the means through which to procure it.

IASC. Women, Girls, Boys and Men: Different Needs – Equal Opportunities. IASC. December 2006.

occupations are reserved for those above a certain age, early orphanhood may be more damaging."[3]

People's livelihood strategies are often framed by the legal and cultural norms prevalent in a given context. Women and girls are often disadvantaged by these norms (although this is not always the case). Additionally, in times of crises, assets may become liabilities, and advantages turn into disadvantages. Brouwer and Nhassengo, in a study of the floods that hit **Mozambique** in 2000, noted that the general expectations of the international community were that the most vulnerable households would be those who had no cattle – as it would mean less diversification in their livelihoods strategies – and single female-headed households. However, the data they gathered proved quite the opposite, "Those with cattle herds were most affected by these floods at least in the immediate term. All who lost their houses and domestic goods were cattle owners. The research thus showed that, in the case of this flood, those traditionally expected to be worse off were actually the less affected."[4]

In other cases, some segments of males and females, youth and older people are similarly affected, but the assistance they receive targets one group more than the others. For instance, according to Devapiriam, after the tsunami hit **India's** shorelines in 2004, a disproportionate number of NGOs involved in the relief operations donated fishing boats as a way to support livelihoods. However, fishing was a livelihood activity only carried out by men, who were therefore inadvertently supported to a greater extent than women. Women, on the other hand, were more often employed as petty traders and street vendors, and their goods and stalls were also affected by the tsunami. But their loss was less visible to the humanitarian responders and thus few agencies responded to assist them.[5]

In other instances, one group can even be unaware of the existence of livelihood strategies carried by the other. Only the collection of data by separately interviewing different sexes and ages can unveil the phenomena. An example of this comes from a study that Maxwell, Levin and Csete conducted in Kampala, **Uganda** using SADD collection and gender analysis.[6] The authors found that married women were involved in urban agriculture without their husbands knowing, and that this proved an extremely successful strategy in buffering the impact of economic hardship on nutritional status. The men were, conversely, involved in various forms of informal employment. The authors note that nearly 80% of the labor for urban agriculture activity was provided by women, who were also largely responsible for both production and consumption decisions. Women, however, usually kept their farming activities secret, or at least marginal in appearance, for fear that their husbands' financial contributions to household would decline.[7]

B. Case Studies on Collection and Use of SADD in Food Security

We offer three case studies to illustrate how collection of SADD helps provide greater understanding of groups' involvement in livelihood activities and sectors, status and access to resources, and distribution of resources. These include case studies 1) examining roles, responsibilities, and mobility in agricultural production in **Nepal**; 2) the role of age and gender in the AIDS crises and the affects on food security in Southern Africa ; and 3) needs and awareness for infants' food security in **Pakistan**.

*Case Study I: Same Livelihood Sectors but Different Roles, Responsibilities and Access in Agricultural Production in **Nepal***

Despite the fact that different genders and age groups are involved in the same livelihood activities, they have different roles and, as a result, their food security is affected in different ways during crises. But only if SADD is col-

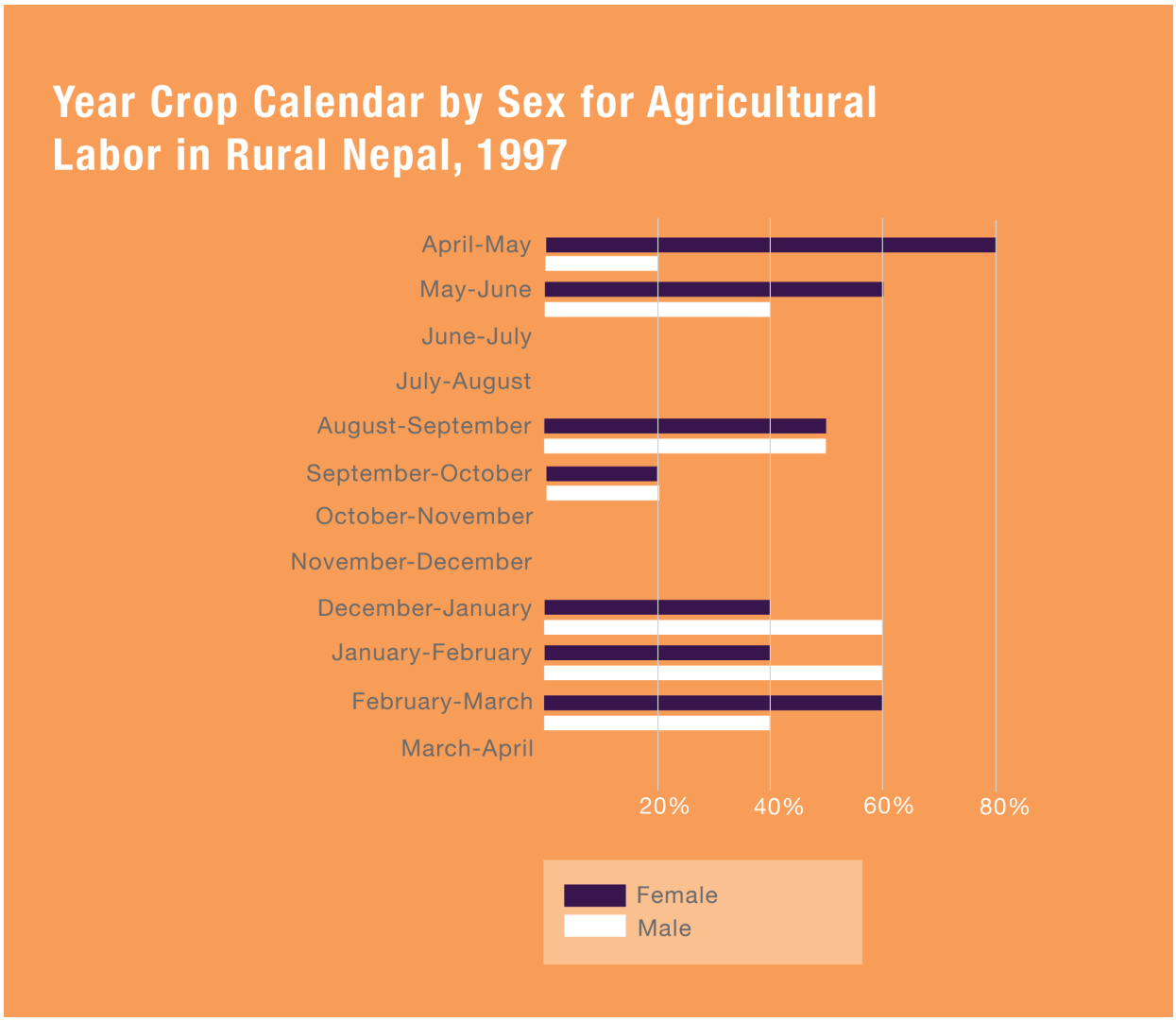
lected, using qualitative or quantitative means or a combination of both, do these differences clearly emerge. A telling example comes from a project review conducted by FAO in 1997. FAO was reviewing its recent projects that focused on women with one of these implemented in **Nepal**, "Improving Information on Women's Contribution to Agricultural Production for Gender Sensitive Planning."[8]

The project team in **Nepal** conducted a large number of group meetings, dividing the participants on the basis of their sex, and using participatory rural appraisal techniques. The findings that emerged from the assessments held that in all study areas, men and women's roles in agriculture greatly differed, and so did their access to all kinds of services. Another important finding concerned women's priorities: in all the study areas, women consistently gave very high priority to having access to education and trainings, which they saw as the first step towards greater involvement in decision making processes and in food security.

Furthermore, the team, which was composed of both project staff and researchers, noted key differences in men's and women's mobility. Women created a much more curtailed list of locations they normally visited. Notably, the women's map did not include schools, agricultural training centers and village development committees, all of which showed up on the maps created by the men (Figure F1). Differences in size of the circles represent limited or restricted access. The programmatic implications of these findings are clear: a) women have curtailed access to extension and training services (among many others); b) the service and training centers had to be mobile in order to provide training and advice to women; and, c) men have much tttgreater mobility and access to agricultural inputs and services.

FIGURE F1

FIGURE F2



Another important result revealed by the sex disaggregated data concerned the division of tasks and labor between men and women over the time span of a year. Most notable, men and women had different workloads for different crops at different times of the year (Figure F2).

Clearly such gender realities have important implications for planning, distributions and trainings.

Case Study II: Gender, Age, AIDs and Food Security in Southern Africa

The impact of AIDS on food security is influenced by the gender and age dimensions both of those who fall sick and die, and of those family members who remain behind. A study by Ansell finds that,

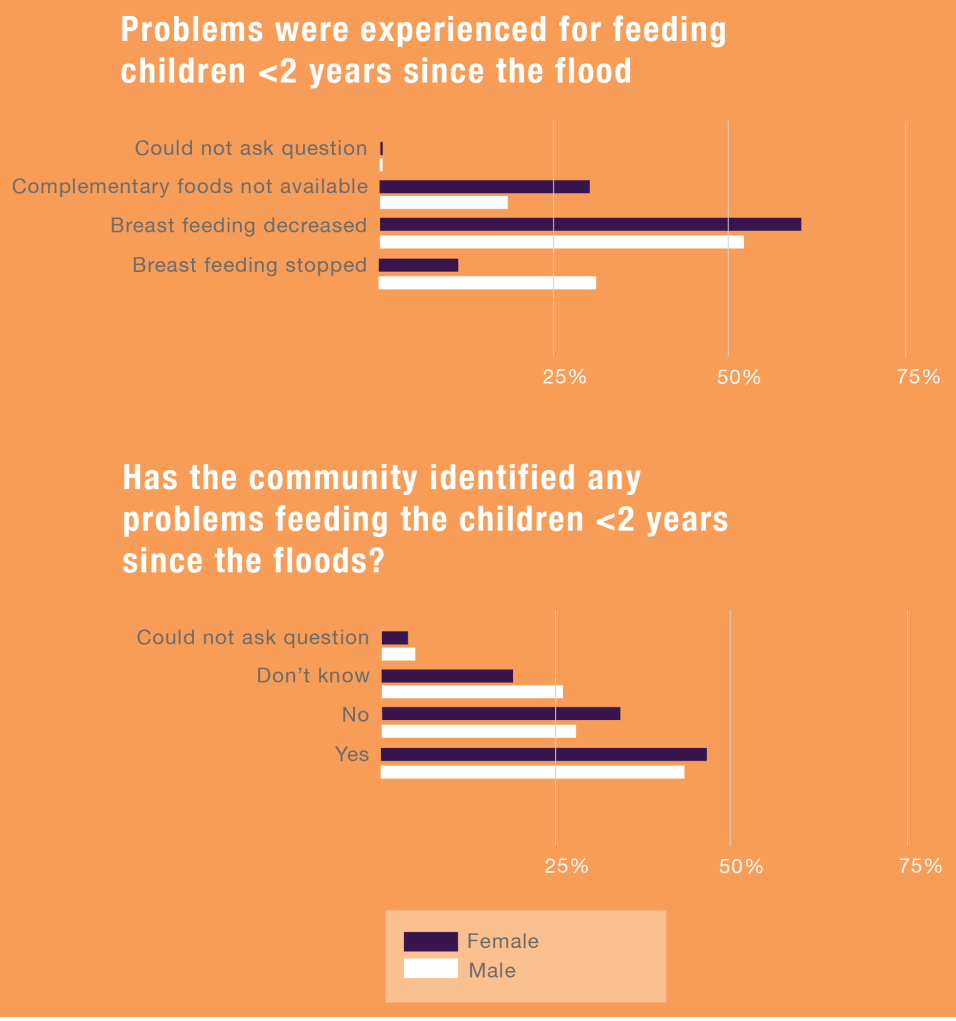
> The differential impacts of AIDS on men and women are significant in shaping its effects on food security. When a couple becomes infected it is usually the man who dies first. Rural areas are left with a preponderance of households comprised of women and children (...). It is, to a large degree, social relations of age and gender that produce these effects. While gender and age help explain differences in experiences within households, they should not be understood simply as individual attributes or attributes of households (as in 'female-headed

households') but structural characteristics of society that shape both the AIDS pandemic (see Parker, 2001) and food insecurity. Furthermore, gender, age and AIDS are all fluid and are co-constructed in southern Africa.[9]

Ansell shows how key livelihood knowledge is influenced by gender and carried by adults and older people. For example, he remarks that "where livelihood knowledges are gendered, the loss of an individual of that gender has a greater impact, such as knowledge of wild foods and how to prepare them is passed from mother to daughter." Ansell also discusses the significant differentials in pay based on age and gender, showing that in **Malawi**, for example, men make twice the amount women and children are able to earn in a day, and hence the death of the adult male significantly affects income and food security among the surviving family members. Ansell also documents that women are more restricted to livelihood opportunities close to home for reasons of social propriety and domestic responsibilities, which have specific implications for food security. Further, he finds that within the AIDS ep-

FIGURE F3

Problems experienced in feeding children <2 years of age, by sex of respondent, since the flood, Pakistan, 2010



idemic, customary marriage practices may also render girls vulnerable, as orphaned girls may be seen as an asset to be exchanged in marriage, and may affect their long-term food security.[10]

*Case Study III: Gender and Age Differences in Distribution of Food Resources in **Pakistan***

Male and female older people, adults, youth and children have different abilities to access resources because of the physical, legal, cultural and customary constraints affecting them. These social and cultural norms shape not only their access to food in general, but also to more specific sub-categories of assistance. For instance, in **Pakistan**, the Multi-Cluster Needs Assessment was conducted by teams of male and female researchers immediately after the 2010 flood in 27 districts, 2500 households and with male and female community focus groups in 383 villages and settlements.[11] The assessment found that the number of males (95 percent) receiving food aid was much higher than those of female (55 percent).[12] However, women were receiving more aid targeted to infants, and were much more aware of the needs of their toddlers, as shown in Figure F3.

More specifically, breast-feeding of infants was greatly reduced and many women felt they could not breastfeed because of the lack of privacy, but they did not share these concerns with their male relatives, who could not therefore report their concerns. The SADD show that women were better informants on the needs of infants than their male counterparts, and highlight a possible area of risk in those recently widowed men who were responsible for infants and toddlers, as they were both less aware of the children's needs and less aware of the availability of assistance for their young children.

C. When Organizations Don't Use SADD or Gender or Generational Analyses to Inform Food Security Responses

Despite a wealth of evidence and guidelines, more often than not the policy requirement of collecting SADD is not reflected in actual practice. A 2009 evaluation of FAO and WFP information management finds that: "According to the survey conducted by the Evaluation, Information Systems for Food Security (ISFS) users found that overall FAO and WFP supported ISFSs have a limited coverage of nutrition and gender, and of urban food security issues. This finding was corroborated during interviews."[13]

According to Delphine Brun, Gen-CAP Advisor who worked in the **Demographic Republic of Congo (DRC)**, it is very likely that in DRC the numbers set by policy makers were not reflected in the reality on the ground. While WFP policy recommended that 80 percent of the targeted households receive their food rations through adult female members, in North Kivu only 23 percent of the IDP women and 8 percent of returnee women were registered for ration cards. Similarly, in South Kivu, while 80 percent of IDP women were reached, figures were as low as 20 percent among returnee women. For agriculture the situation was even worse, as 96 percent of the agricultural kits were given to men, in a country where women produce 75 percent of the food.[14]

At times when specific needs and priorities are recorded in the collection of SADD, often they are not reflected in programming. In **Ethiopia**, for instance, in a WFP food for work project, the women told WFP they needed to arrive up to an hour late and leave an hour early in order to be able to still participate in the scheme and obtain assistance, thus receiving smaller quantities of food, while at the same time attending their domestic chores. However, this provision was largely ignored by the organization, thus forcing women to either pull out of the project

or work late into the night to complete their domestic duties.[15]

D. SADD Guidelines and Data Collection Tools for Lead Food Security Agencies

The lead agencies within the food security and agriculture cluster, FAO and WFP, have produced numerous guidelines on how to best collect and use SADD.

- In its 2009 Emergency Food Security Assessment Handbook, WFP notes that: "The characteristics that make a group vulnerable depend on the nature of the crisis. For example, in a conflict, the primary indicator of vulnerability might be displacement. In other situations, gender, education level or the presence of a chronic disease such as HIV/AIDS may be used to categorize groups."[16] The handbook repeatedly recommends repeatedly to "describe the food-insecure and/or malnourished population in terms of their individual and socio-economic characteristics–gender, ethnicity, etc.-and livelihoods."[17] WFP also recognizes that "targeting women with food aid is a particularly effective means of achieving the objective of reducing hunger, particularly among children, through increased consumption at the household level" and thus, has an internal policy that recommends that 70–80 percent of food aid should be distributed to female adults.[18]

- The Sphere Handbook refers in many different sections to gender and age sensitivity in relation to food security. For instance, it recommends that the design of distributions should have the active participation of women and representatives of persons with disabilities and older people.[19]

- FAO has similar recommendations in the Rome Declaration on Food Security (FAO 1996) in which signatories commit to gender equality in participation in ensuring food security. The FAO furthermore created the Socio-economic and Gender Analysis (SEAGA) Programme in 1993 to promote gender awareness when meeting development challenges. FAO is advanced in collecting and using SADD and it has two main divisions in charge of this:

  1) the Gender, Equity and Rural Employment Division (ESW) which supports FAO's efforts to promote the economic and social well-being of the rural poor, with a focus on women,[20] and

  2) the Socio-economic and Gender Analysis (SEAGA) Programme, established in 1993 to promote gender awareness when meeting development challenges.[21]

- The International Federation of the Red Cross and Red Crescent (IFRC), in its manual on how to conduct food security assessments, explicitly notes the need to ensure a disaggregated demographic profile of the population to assess, asking the staff to respond to questions such as: What is the composition of households, for example, numbers of children, women and older people?[22]

- In the IASC Gender Handbook for food security and livelihoods guidelines recommended collecting SADD, including through qualitative means. Suggestions include, "Record the perceptions of women and men regarding changes in their lives (positive and negative) as a result of food security interventions and address the implications in programming"; "Conduct assessments of specific changes occurring in the livelihood systems of beneficiary female, male and child-headed households"; and "Analyze how women's and men's different needs could have been met more efficiently; use data to inform future programming."[23]

- Guidelines to collect SADD are reiterated in the recommendations and plans for specific emergencies. For example, in the recent **Pakistan** flood, the Initial Flood Emergency Response Plan repeatedly stressed the importance of SADD. For instance, in relationship to food security, it was noted: "Vulnerable female-

headed households, unaccompanied children and the elderly will be prioritized for assistance. The Food Security Cluster explicitly aims to facilitate the receipt of relief rations by women and female-headed families (an estimated 10 percent of all those supported). Separate facilities will be established for women at distribution points, and female staff will be deployed. Assessment teams aim to include women where possible and beneficiary data will be disaggregated by gender."[24]

SADD Data Collection Tools

Frequently, data within the food security cluster are gathered either through ad hoc questionnaires or through registrations of individuals and households, which are in turn used to organize distribution of food and non-food items. These data are often disaggregated by sex, but less frequently by age. Many of the qualitative data collection techniques, such as focus group and group interviews, are not often included in assessments of **Phase I** or **Phase II** of an emergency.

There are many well-established data collection mechanisms that include questionnaires administered at household and individual level, which use standard procedures in various crises. These include, for instance, the Comprehensive Food Security and Vulnerability Analysis (CFSVA) undertaken by WFP-FAO, which is done mainly through surveys and has a focus on vulnerability. Many of these tools, and the CFSVA is no exception, have guidelines on how to integrate gender perspectives into the vulnerability and food security analysis for a thorough treatment of qualitative approaches. The CFSVA is relatively complete and well referenced, including guidelines on how to carry out a survey, describing methodologies for qualitative analysis/assessment, and Participatory Rapid Appraisal (PRA) techniques.[25]

In other cases, food security and agriculture data are gathered through ad hoc assessment, designed for a specific emergency. In the most recent emergencies, such as the 2010 earthquake in **Haiti** and the 2010 flood in **Pakistan**, there is an increasing number of SADD available for the Food Security and Agriculture cluster in comparison to the past emergencies. The level of detail is still limited; however, SADD is used to help identify the most affected categories. The way the data is collected, however, gives greater weight to the opinion of key informants, whose sex and age are too often not factored into the analyses (for example, to see if male and female informants have different opinions on people's needs, vulnerabilities and access). In the Rapid Initial Needs Assessment for **Haiti** (RINAH) done by the ACAPS in February 2010, for instance, it was reported that the categories most affected by food insecurity were children below 13 and older people (reported as vulnerable by the informants interviewed in 77 percent and 59 percent of the locations respectively). However, in this case, the data was gathered through a consultation of local authorities; the perceptions of those considered most vulnerable – children and older people – were not included in the assessment.[26]

E. Core Recommendations for Food Security Cluster for Ensuring Good Data Collection and Gathering SADD

Prior to an Emergency, as Part of Disaster Preparedness:

1 Conduct a solid SADD collection using appropriate methods including:

- a Adding age and gender-relevant gauges to surveys and monitoring systems;
- b Holding separate interviews and focus group discussion with males and females of different age groups;
- c Reviewing nutrition and coping strategy data divided according to sex and age groups.

2 Prepare gender and age mainstreaming tools that are specific enough to be applied to

local contexts and to specific sectors.

a Prepare a localized SADD checklist, possibly to be conducted prior to a disaster as a form of preparedness, including inputs from local responders and communities.

During Phase I and II Assessments

1 Review existing census data to determine whether certain age groups or a sex are over-represented or in need of extra assistance.

2 Review existing literature and data to identify the different roles of male and female older people, adults, youth and children in key livelihood activities prior to the crises, so that when the initial assessment data comes in, there is a basis from which to extrapolate, and it will be easier and clearer to understand which livelihoods and groups have been most impacted.

3 Review the legal and customary frameworks to identify potential areas of gender and age discrimination.

4 Ensure that the teams in charge of conducting assessments (assessors and translators) include men and women.

a Carefully examine the trade-off between having teams which are technically prepared (i.e., agronomists, nutritionists, veterinarians), and teams that are diverse, as in many societies, there are almost no women with a high level of technical, specialized education.

5 Ensure you interview key informants that are female who often have information on immediate food security needs of women and girls, this may include teachers, community leaders, and leading market women.

6 Ensure that if using focus groups, 50 percent of those focus groups are comprised of women and older girls, ideally exclusively of women and girls (given males' tendency to dominate public and mixed-sex conversations).

7 When a group speaks on behalf of another and makes assumptions about its food security, triangulate this information with either the involved group or when this is not possible (i.e., for infants) make sure best informants are identified.

8 Ensure SADD is recorded regarding all key informants, individuals, and household composition, this will enable:

a Assessment of whether there are important segments of the population that have not been reached who may have views needed to inform responses;

b Assessment of any important differences across gender and age in terms of needs and access to food assistance among the most vulnerable populations.

During Phase III Assessments

1 Gather basic SADD of those who receive food aid and livelihoods inputs (i.e., food and non-food items). This will enable:

a Understanding of who is and who is not actually coming to the distribution points, and hence how outreach and access need to be improved;

b Understanding about whose food needs are being met and whose are not, and why, and how this might be addressed;

c Carrying out of regular reviews of the findings to ensure that response is shaped to reflect improving access, decreasing vulnerabilities, and meeting real needs.

2 Carry out more detailed and nuanced qualitative and quantitative studies on key issues of concern, ensuring collection of SADD where relevant and gender and generational analyses to interpret findings within the context.

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VIII. Health

A. Introduction

A person's health risks, access to adequate nutrition, clean water and shelter, and access to necessary mental and physical health care are all influenced, in part, by their sex, gender and age.[1] Sex, gender and age influence differences in mental health symptoms, as well as coping strategies and health seeking behaviors.[2] Exposure to particular epidemics and diseases is also experienced, in part, through sex, gender and age dimensions.[3] The forms of grave violations and war crimes one is exposed to during armed conflict and the ability to access adequate care to address the resulting mental and physical affects are also influenced by sex, gender and age.[4] Sex, gender and age also factor significantly in a person's risk for disability and experiences of being disabled.[5]

B. Case Studies on Use of SADD

We offer three case studies to illustrate how sex, gender and age influence health risks and access to health services and how the use of SADD and gender analysis is used in each case to reveal and illuminate the health affects of armed conflict and natural disaster to different sectors within a society. The three case studies include: 1) the increase death rates of females in conflicts worldwide, 2) the role of gender and age in how people are subjected to grave violations during armed conflict and their access to treatment in Northern **Uganda**, and 3) the role of age in people's health services needs during crises in **Haiti**.

THE RIGHT TO HEALTH IS LAID OUT IN

- **UDHR (Article 25)**
- **ICESCR (Articles 12)**
- **CRC (Articles 3, 17, 23, 24, 25, 28, 32)**
- **CEDAW (Article 11, 12 and 14)**
- **The Additional Protocol to the American Convention on Human Rights**
- **The African Charter on Human and People's Rights**
- **The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**
- **The European Social Charter**

The right to health encompasses the right to timely and adequate health care, access to safe and potable water, adequate sanitation, healthy occupational and environmental conditions, and access to information about health issues, including sexual and reproductive health.

The ISESCR notes that the collection of SADD is essential to enable the identification and remedy of inequalities in peoples' right to health.

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Case Study I: Females Die More Frequently and Younger Due to Armed Conflict

Until the mid 2000s, at the level of the UN and INGOs, little attention was paid to the gender-specific or age-specific aspects of the negative impacts of violent conflict.[6] This began to change with the release of several key international studies by the United Nations (UN) Gen-

eral Secretary to the Security Council, the UN Development Fund for Women, and the International Committee of the Red Cross.[7] Today, it is widely recognized that the affects of armed conflict are not gender or age neutral.

It is known that armed conflict directly kills and injuries more males than females since combatants are predominately male youth and adults. Yet direct fatalities "do not provide a remotely adequate account of the true human costs of conflict."[8] In fact, indirect consequences of armed conflict are more significant to people's lives and livelihoods than the direct casualties, and within those consequences sex and age matter. Yet these indirect consequences often go unnoticed and are not fully understood.

In their study of 14 ethnic conflicts and four non-ethnic conflicts that lasted for at least 10 years, Plümper and Neumayer found that over the span of the entire conflict period, on average, interstate and civil wars affect women more negatively than men. In most countries around the world not at war, women typically have longer life spans than men. Yet by using data that was disaggregated by sex and age the authors found that armed conflict, particularly ethnic wars and wars in failed states, decreases the gap between female and male life expectancy. In other words, the direct and indirect consequences of armed conflict (and in particular ethnic conflicts and conflicts in failed states) kill more women, and or kill those women younger, than their male counterparts.[9] Using a gender analysis to understand why more women are dying as a result of armed conflict, Plümper and Neumayer find:

> Our estimation results show that on average women are overall more negatively affected by armed conflict than men, suggesting that the indirect consequences are stronger than the direct effects… The indirect effects of militarized conflicts result from, among others, reduced access to food, hygiene, health services, and clean water--and by lifting the thin veil of civilization. Women suffer more severely from the damage to health and other infrastructure and the wider economic damage, as well as from displacement and dislocation during and after conflict. The breakdown of social order and the ensuing brutalization fuels male aggression against women, who suffer from gender-based and sexual violence both within and outside their domestic household.[10]

Why do women have reduced access to food, hygiene, health services and clean water? The authors continue,

> Women are likely to suffer more from an increase in food prices and famines than men. For physiological reasons, women are particularly susceptible to vitamin and iron deficiencies in diets. In addition, in male-dominated societies, males get priority in food distribution at the expense of girls and women. The decline in basic health care hits women more because of their specific reproductive roles. Damage caused to the health infrastructure reduces obstetrical care and increases the number of miscarriages as well as maternal and infant mortality.[11] More generally, a significant decline in purchasing power will affect women differently than men because in many cultures men receive preferential access to resources. When resources become scarcer, then the part of the population suffering from discrimination is necessarily hit even harder. Many of the negative effects of armed conflict on women are thus not due to biological reasons, but are due to what Carpenter calls "preexisting gendered social structures."[12]… Thus in societies where female discrimination is wide-spread even during peacetime, women will suffer particularly strongly from the destructive power of violent conflict.[13]

These findings necessitate that policy makers and humanitarian organizations work to ensure that their policies and programs mitigate and try to prevent the affects of armed conflict on women that are killing them more often and at a younger age. In particular, the study's findings emphasize that key areas that must be addressed to reverse higher death rates for women include strengthening health infrastructure, addressing and working to prevent sexual violence, and enabling return from displacement.

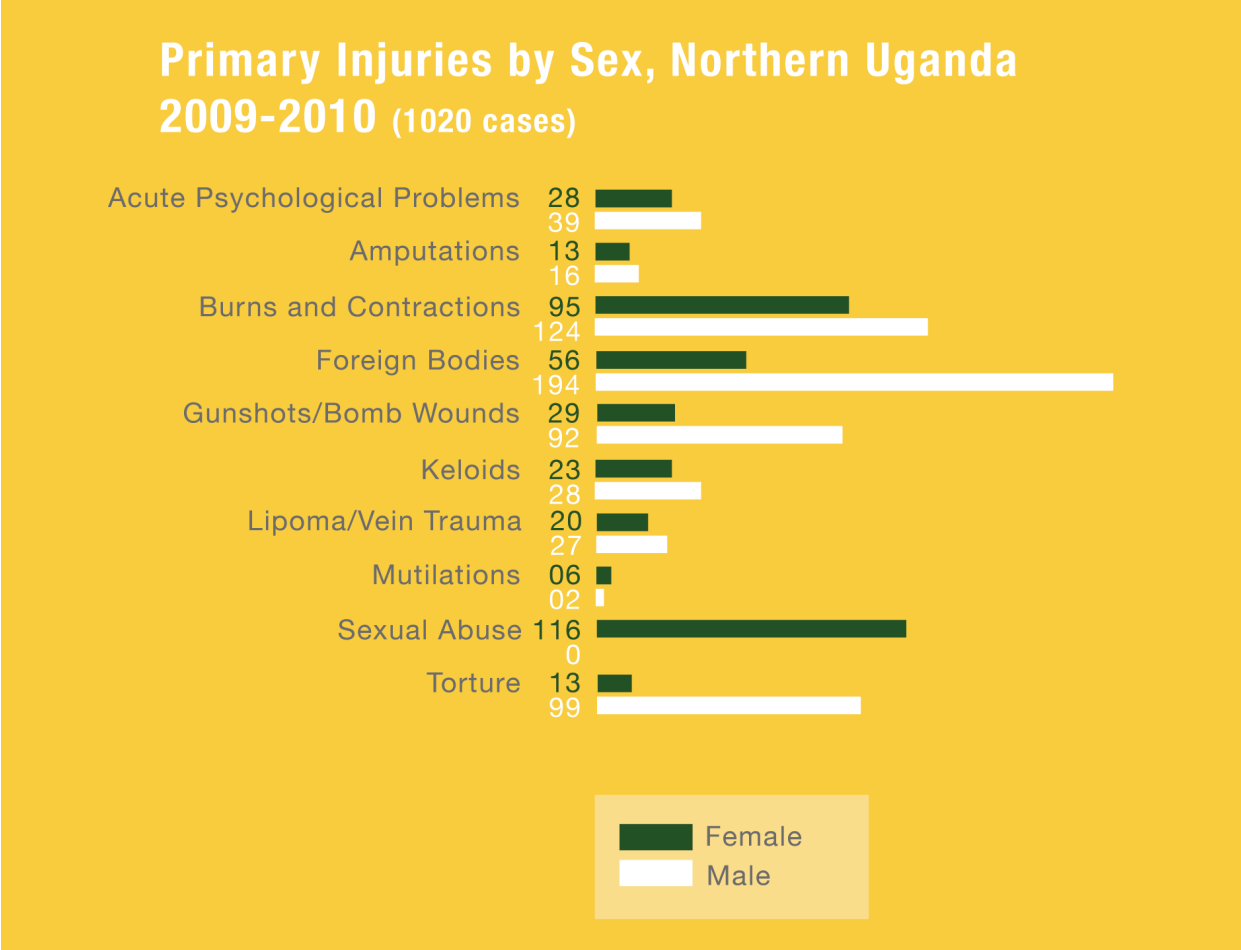
Case Study II: Grave Violations and Access to Treatment

Many people the authors interviewed for this study expressed concern while they agreed that SADD would be useful in informing their assessments and response, in the end they did not do it because gathering, managing and analyzing SADD was too expensive and too time intensive to gather, and SADD was too complicated to analyze and then figure out how to use to inform programming. Yet knowing what one wants SADD for and collecting basic SADD is not too complicated, expensive, nor time intensive to gather. Nor is it particularly complicated to analyze and the results can be highly informative.

The following data and case study come from a local civil society organization, AYINET, which works in the heart of the region affected by 20+ years of armed conflict in northern **Uganda**. AYINET was created and is run by members of the war affected community, who run their medical response programs on less than $75,000 a year. It's also a strong example of how SADD was used by the organization to document and analyze the differences in the kinds of harms people suffered, how they came forward to be assisted, who was assisted and who was not, and how they modified their programming to address these realities.

In the area of medical rehabilitation, AYINET treats victims who have experienced the most serious physical and emotional harm due to physical trauma, maiming, abuse and torture, and who are in critical medical need of recon-

FIGURE H1

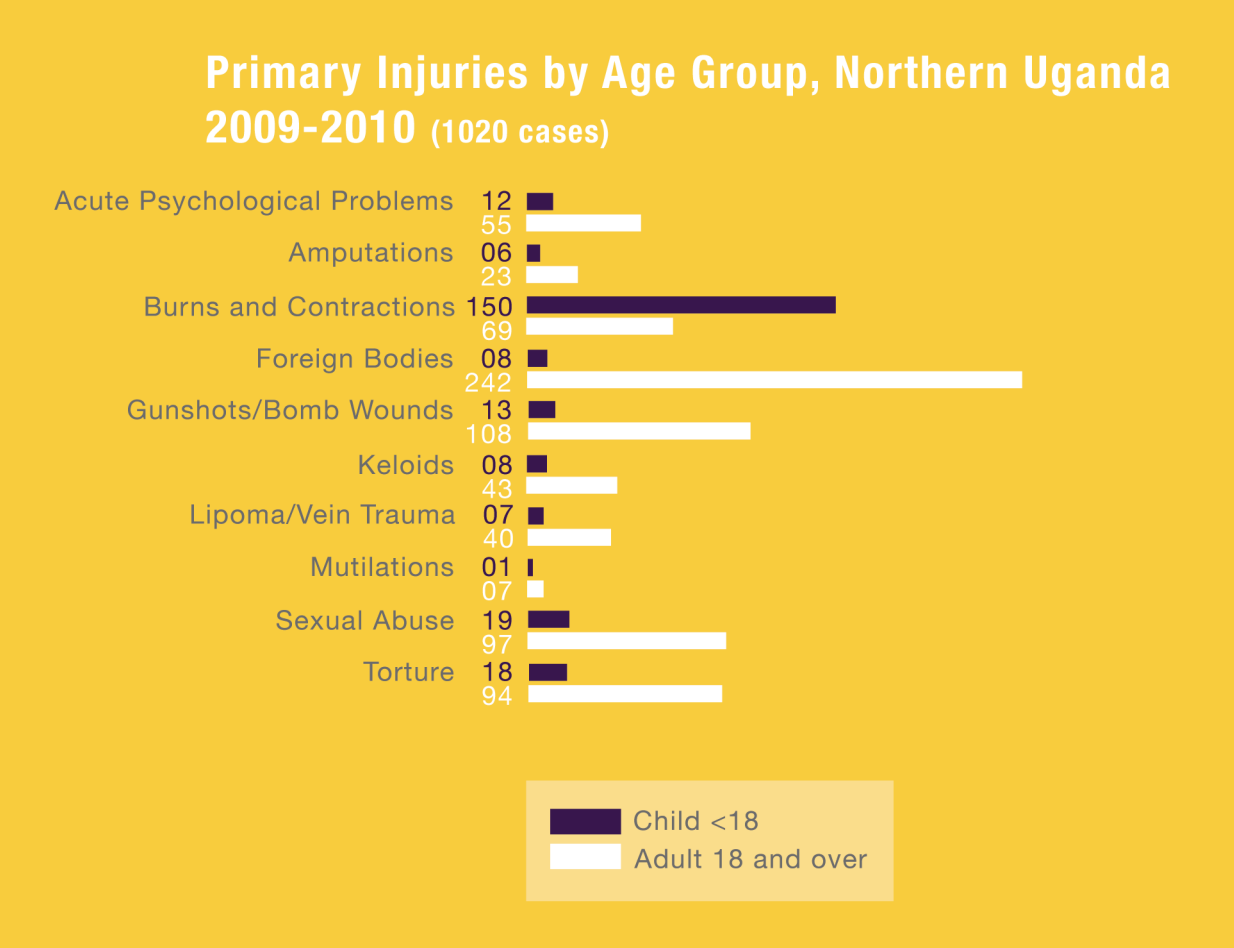


structive surgery and psychosocial support. This case study presents data generated by AYINET for its surgical and medical rehabilitation project between 2009 and 2010, during which period, they screened 1,020 patients who were within the project's mandate and provided medical treatment and rehabilitation to 367 adults and children.[14]

AYINET's data shows that access to the medical screening teams and the kinds of injuries people suffered were often largely influenced by their gender and age. Of the 1020 registered victims for primary injuries, 400 (39.2%) were females and 620 (60.8%) were males (Figure H1). The majority of primary injuries among females were burns and contractions and sexual and reproductive health injuries. Furthermore, although there were far fewer injuries that resulted from deliberate mutilation of the victims, 75% of the mutilation victims were females, and the vast majority of these were adult women. Males had higher figures of retained foreign bodies and bomb shrapnel, injuries that resulted from torture, and gunshots/bomb wounds.

As depicted in Figure H1, females suffered, by far, the highest number of primary injuries due to sexual abuse and mutilation compared to their male counterparts. AYINET used a gender and generational analysis to understand why more women were mutilated. AYINET documented that the majority of young women who were seriously wounded in captivity by the rebels suffered as a result of their persistent refusal to engage sexually with their captors, which lead to them being severely beaten, tortured,

FIGURE H2



maimed (e.g., by having their breasts cut off or being raped with machetes), or in some cases killed.

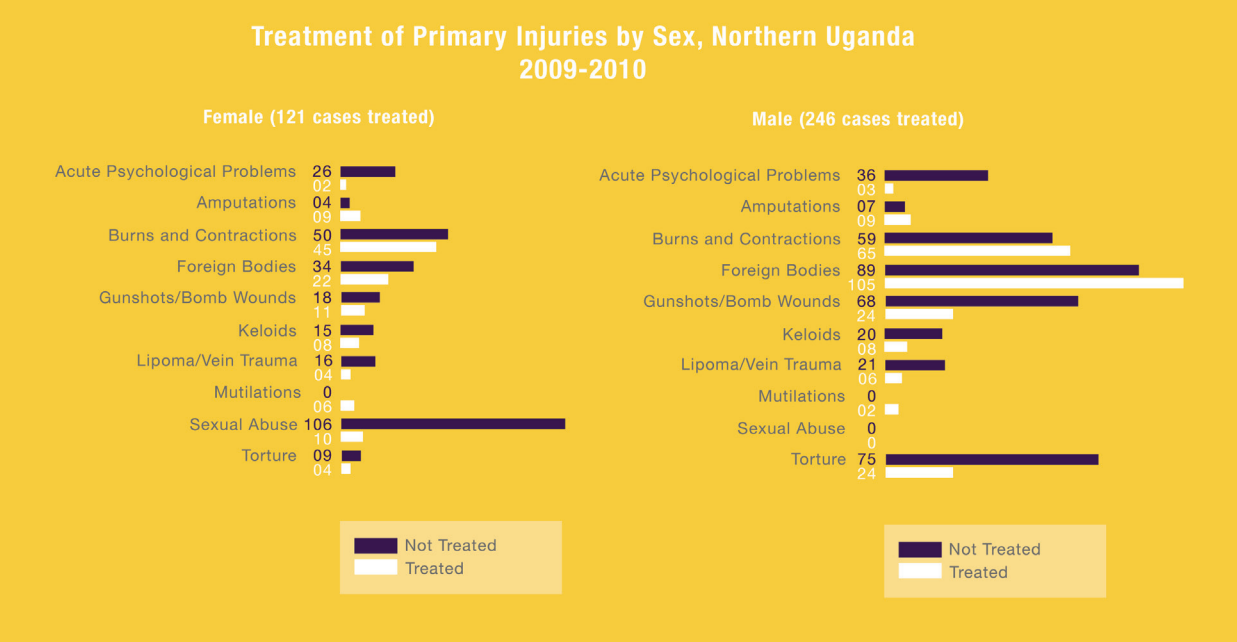
As shown in Figure H1, adult males suffered the highest number of primary injuries due to foreign bodies, torture and gunshot and bomb wounds. AYINET believes this was because young men were abducted and used for active combat, including being used as human shields for the more advanced fighters. Additionally, males are often those forced to serve as porters, which resulted in injuries to their backs and chests. Finally, given that males comprised the majority of abducted LRA fighters, they were often severely beaten and tortured as part of their indoctrination into the LRA, or (less frequently) as a means of retaliation and punishment when they were captured by the Ugandan army. AYINET also collects age disaggregated data on the victims they treat (Figure H2).

Children[15] constituted 23.7% of the victims screened for treatment. Adults[16] comprised the greatest number of victims (76.3%) and presented the largest number of injuries in all categories, with the exception of cases of burns and contractions where children were double the number of adult cases. Using a generational analysis of the SADD data, AYINET believes children suffered the majority of burn injuries and contractions because during rebel attacks on IDP camps, children would instinctively run into their grass-thatched huts seeking refuge only to be caught in flames as rebels set the camps and huts on fire.

AYINET uses SADD and gender and generational analyses of the context to make sense of the significant differences in injuries experienced by females and males. The data shows that not only did people's gender and age affect the kinds of grave crimes and injuries they suffered, but it also had an influence on who was able to receive treatment. Victims presented both primary and secondary injuries, but due to financial constraints only some of the primary injuries were treated (Figure H3). Overall, the strongest influence regarding treatment was financial resources, yet even financial caps set by the international donor had an impact on women's and girls' access to life saving and life changing medical care.

One significant finding from Figure H3 is AYINET's inability to treat cases of sexual abuse

FIGURE H3



that were so severe as to need reconstructive surgery. An ongoing and considerable problem is that victims of sexual abuse are highly stigmatized throughout **Uganda**. Thus, it was only during AYINET's treatment of the other injuries listed above that their female clients gained confidence and told them of the sexual and reproductive injuries due to rape and sexual violence.

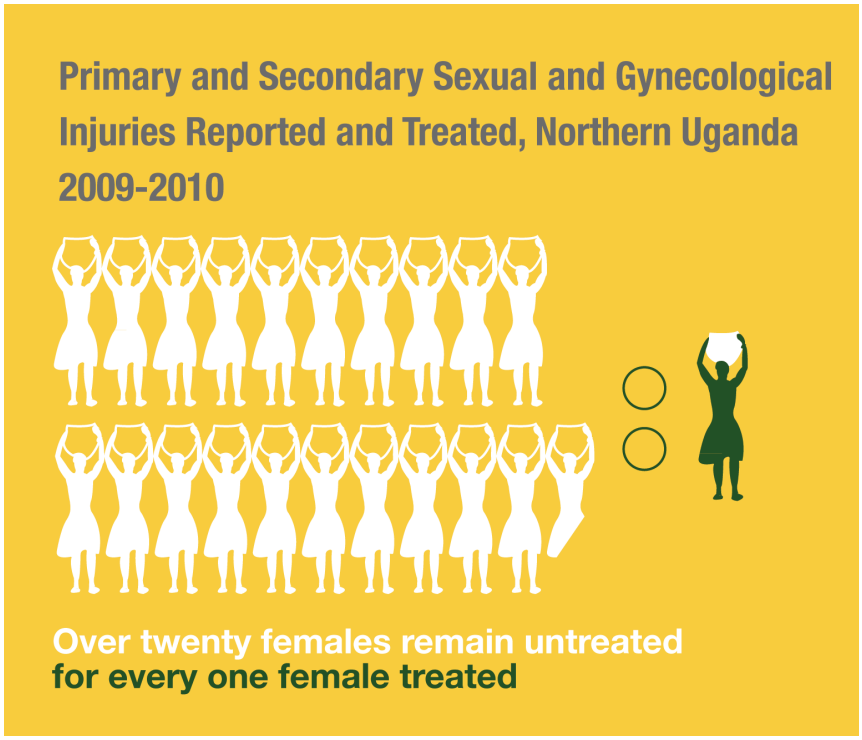
Thus, combined, 228 females reported primary and secondary injuries due to sexual violence (note that Figure H1, H2 and H3 only show primary injuries). Nearly all of these female victims had been living with ongoing pain and chronic and debilitating wounds as a result of the violence inflicted on them.

Given the high cost and need for multiple surgeries of the chronic injuries to reproductive and sexual tissues, for most all of these females AYINET could not facilitate the necessary sexual and gynecological care. However, the primarily reason was due to the fact that AYINET's international donor had set a cap on the amount of money and time a person could spend in the hospital, and sexual and reproductive surgeries surpassed both those caps. Thus in the end, of the 228 females who doctors recommended for sexual and gynecological repair, only 10 could be assisted (Figure H4).

Because they kept SADD on their patients and analyzed their data, AYINET could clearly see gaps in the needs of victims and their services. Thus, in 2011 they designed a specific reproductive and sexual health surgery project and approached different donors to try and secure resources to address the needs of the many female victims they know need critical care.

This case study illustrates that access to the medical screening teams and the kinds of injuries people suffer as a result of armed conflict can be strongly influenced by their gender and age. Gender also had an influence on who was willing to come forward to report what kinds of injuries, which injuries they initially presented, and who was actually able to receive treatment. Finally, this case study is one of the few examples we found of an organization properly collecting, managing, and analyzing SADD, using gender and generational analyses to make sense of their findings within the larger context, and then using those findings to shape response and programming and setting up a means to monitor and evaluate their response. The fact that collection and use of SADD, gender and generational analysis and evidence-based response is being done, and done well, by a victim-focused organization, run by local war affected populations, and operating on a relatively small budget is noteworthy.

FIGURE H4



*Case Study III: SADD and Older People in the Earthquake in **Haiti***

Older people have specific vulnerabilities and needs during natural disasters and armed conflicts. In particular, older people have higher rates of chronic disease which require routine medication and medical care, and yet services are often disrupted or medications unavailable. They also use devices to assist with their mobility, sight and hearing which can be damaged or lost during a crisis, particularly during flight. Because they are often less mobile, have weaker muscles, poorer eyesight and hearing, and are more susceptible to heat and cold, older people are often less able and or willing to flee quickly when a crises erupts, which can at times expose them to grave harm.[17] Their health can be negatively affected by poor nutrition. Food distribution points may be inaccessible for older people, the food aid difficult for them to eat and digest, and ration bags too heavy for them to lift and carry as occurred during early food distribution efforts in the aftermath of the earthquake in **Haiti**.[18] Numerous studies find that older people share food rations with other family members, at times even to the detriment of their own health.[19]

In the aftermath of the earthquake in **Haiti**, HelpAge International used SADD to inform its programming and response. Their surveys found that one year after the earthquake (January 2011) approximately 1 in 5 older people living in temporary camps were going hungry (Figure H5). Yet at the request of the Haitian government, food aid distribution for IDPs stopped in April 2010, and food prices continue to rise as global food prices hit record highs early in 2011. HelpAge used their findings to help target cash transfer schemes, food-for-work programs, microcredit loans, and setting up associations of older people to help ensure older people are fed.[20]

Even though older people were identified as the most vulnerable group in the aftermath of **Haiti's** earthquake, international donors continue to neglect their needs. HelpAge used a generational analysis of the 321 projects in the UN Flash Appeals for **Haiti** and found that only 5% referred to the needs of older people, and only 0.6% of the proposed projects included specific activities targeting older people. Their analysis also shows that in the end, the UN's Flash Appeals did not fund a single project that specifically targeted older people.[21]

C. When Organizations Don't Use SADD or Gender or Generational Analyses to Inform Health Response

We came across multiple cases of agencies not collection or using SADD or gender analyses to inform their health responses and report here on some of the resulting outcomes.

UNICEF reported that in the **Pakistan** earthquake response of 2005 they witnessed a situation in which the Northern Rocky Highlands were severely earthquake struck. People were cut off – buildings that were made from concrete cracked, crumbled and crushed people

FIGURE H5

to death. The **Pakistan** government was quick to mobilize helicopters to fly from the valley where medical service tents were erected,

into the mountains to extract those in need of urgent, life-saving health care. On the helicopters there were all male crews. Yet some of the areas they were flying into were where communities practiced honor killings of females, so the women victims of the earthquake thought they would be killed by their families for tarnishing their family's honor if they went on the helicopters with the all male teams. Testimonies were given by UNICEF of women who were critically injured and in terrible pain shrieking, "Don't touch me!" because the men in the helicopters were foreign men and they thought they might be killed by their families members for going with them and there was no woman there to protect their honor. In fact, it was not necessary to have a women doctor or nurse at that moment, but what was needed was a woman who could speak the language and whose presence would serve to protect the injured women's honor.[22]

In the **Democratic Republic of Congo**, all the nutrition projects submitted by UNICEF and its partner NGOs were focusing on children under 5 without collecting any sex disaggregated data. The Gender Taskforce kept asking the Health Cluster lead what was the nutritional status of girls and boys, but he had not looked at statistics by sex. When he looked at it, he saw that boys were consistently more malnourished than girls. Based on this the cluster developed minimum standards, one of them being to analyze the causes of boys' malnutrition and pay specific attention to this group of children. UNICEF then hired a gender consultant to analyze why boys were more malnourished than girls and how the programs could be modified to address this issue. In this case, the SADD was what convinced the Health Cluster lead to take action.[23]

Following increased intensity in fighting inside **Pakistan** in 2009, the IDP crises was becoming more severe and people were fleeing the area. The Health Cluster was not collecting or analyzing any SADD that was being gathered at the health clinic level. Yet one portion of the IDP population was a conservative population, which practiced purdah, and they had moved from their original higher and cooler locations to lower and very hot (50 degrees Celsius) areas. Newspapers started reporting women suffering from scabies and urinary tract infections. This was because the toilets for the IDPs were not built with enough privacy, so the women would not go out to go to toilet in daylight, and the water situation was not set up in a gender sensitive manner, so the women were not going to bathe. The Health Cluster was not collecting SADD at their clinics, so they lacked reliable data on who was coming into the health clinics or how illness or injury was affecting different sexes or ages. With the mobile clinics, the Gender Task Force advocated for accompaniers (females to be present while male doctors examine), in cases where there no women doctors or nurses available and pressed for a reworking of the toilet and water facilities.[24]

D. SADD Guidelines and Data Collection Tools for Lead Health Cluster Agencies

The updated Sphere Handbook and the lead agencies within the health cluster and WHO have produced numerous guidelines on how to conduct health sector assessments during emergencies, which state the need to collect and use SADD.

• The Sphere Handbook, presenting the standards for the Health Sector, highligts the importance of ensuring a balanced representation of women and men. Furthermore, it recommends analyzing utilization rates by sex, age, ethnic origin and disability.[25]

• In its 2010 "Guidance for health sector assessment to support the post disaster recovery process," WHO notes that "the choice of indicators needs to be reviewed and adapted based on the country context. The indicators are also to be used to assess the impact of the disaster as well as for monitoring. The indica-

tors should be disaggregated and analysed by age and sex."[26]

• In WHO's "First Needs Assessment Reporting Template" for rapid initial assessments in emergencies, SADD is recommended for demographic breakdowns of the affected populations and ADD for under 5s on health impact.[27]

• Similarly, the 2006 IASC Gender Handbook's section on Health recommends collecting and disaggregating "all data by sex and age and apply a gender analysis" and prompts some specific question that should be investigated, such as "What diseases affect women and men differently within the context of the crisis?" "What is the crude mortality rate disaggregated by sex and age? Are there disproportionate deaths among women, girls, boys and/or men? If so, what are the reasons?" The Handbook also suggests identifying local practices and beliefs about caring for sick members of the community, including through home-based care, and looking at who is more burdened by these practices, women, girls, boys or men. It highlights the importance of mapping the availability, location, capacity and functional status of health facilities and public health programmes, including sex-specific essential services for women and men (e.g., maternal and child health services and reproductive health services for men).[28]

• In March, 2010 the IASC launched an innovative online training course based on the 2006 IASC Gender Handbook-"Women, girls, boys and men, different needs-equal opportunities", to give humanitarian workers a practical tool to better understand the different health risks and issues women, men and children face, while at the same time work to ensure equal access to care."[29]

• MSF, one of the lead NGOs in the health sector, has similar suggestions in its various handbooks, stating for instance, "It is also important to know where and when different tasks are done, how much time they require and how they are usually divided between the sexes and between young and old."[30]

SADD Data Collection Tools

The WHO's 2010 "Guidance for health sector assessment to support the post disaster recovery process" focuses on two types of assessments: 1) the health sector part of the Post Disaster Needs Assessments (PDNA) and 2) the Damage and Loss Assessment (DaLA) methodology, described in detail also in the Handbook for Estimating the Socio-economic and Environmental Effects of Disasters.[31] According to WHO, "The main focus of the DaLA is to assess the financial impact of a disaster on the health sector, for example, in terms of infrastructure, equipment and furniture, medication, as well as unforeseen expenses, such as increased costs for emergency treatment of injuries, loss of revenues in health facilities and surveillance", with the objective to restore the pre-disaster situation (called the 'building back better' approach).[32]

WHO handbook proposes a framework for the PDNA that "allows a systematic analysis of the impact of a disaster on the health of communities, the identification of new risks they are exposed to, determining the post-disaster functionality of the health infrastructure and the performance of the health system building blocks."[33] WHO guidelines provide an analytical matrix which is meant to be used as a step by step assessment and analysis for the health sector. They include examples of key indicators for the assessment of the pre-disaster sub-sectors, as well as for the health system building block. These questions include a great number of SADD parameters. For instance, under "The key indicators: pre-disaster baselines and challenges, impact of crisis and monitoring," regarding nutrition it is suggested to look at the number of admissions based on SADD.[34] Under Communicable Diseases, the indicator suggested is the number "incidence rates for selected diseases relevant to the local context (by age/sex)(cholera, measles, acute

meningitis, others)."[35] Under "Sexual & Reproductive Health", it is recommended to monitor the number of "cases or incidence of sexual violence (by sex and age)."[36] Health care facilitates, run by both the local government and by WHO partners, appear to be the main source of data.

The WHO Health Cluster Guide is also a key reference tool for the health sector and contains numerous references to the need for the collection and analysis of SADD, as well as suggestions on how to collect it.[37] Similarly, the Sphere Handbook, in its annexes, presents a series of useful forms to collect SADD.

E. Core Recommendations for Health Cluster for Ensuring Good Data Collection and Gathering SADD

Phase I and Phase II Assessments

1 Work with gender specialists in country, where possible, to draw from the existing secondary data to quickly assess the status of women, girls, men, boys, older people and children prior to the crises so that when initial assessment data comes in, you have a basis from which to extrapolate.

2 Look at existing data collected prior to the disaster, where possible, to quickly assess the demographic profile of the population in order to know how many male and female older people, adults, youth and children may need assistance. And, when the initial assessment data comes in, this will allow a stronger basis from which to extrapolate.

3 Ensure that assessment team members, interviewers and translators include females.

4 Ensure that key female informants are interviewed who often have information on immediate health needs of women and girls, this may include local midwives, nurses, teachers, community leaders, and leading market women.

5 Ensure that if you are using focus groups, 50% of those focus groups are comprised of women and older girls, ideally exclusively of women and girls (given males' tendency to dominate public and mixed-sex conversations).

6 Ensure that you record the sex and age of those you are interviewing, this will enable you to:

- **a** Assess whether there are important segments of the population you have not reached who may have necessary views to inform your response;
- **b** Assess if there are important differences across gender and age in terms of needs and access to health services among the most vulnerable populations.

7 Map the availability, location, capacity and functionality of health facilities, noting essential sex-specific services like maternal and child health and reproductive health services.

- **a** Prioritize maximum protection of those facilities, including keep the area well lit and providing secure means for people to access the sites;
- **b** Carry out initial assessment using SADD to see who is able and unable to reach and use these facilities.

Phase III Assessments

1 Follow Phase 1 and 2 recommendations.

2 Gather basic SADD (i.e., their sex and age) on those who come into clinics and health camps and ensure SADD is written on their medical records and recorded in data bases that can be used for analyses. This will enable the data to be used to:

- **a** Understand who is and is not actually coming into the clinics and health camps , and hence how outreach and access need to be improved;
- **b** Understand who has what kinds

of health needs;
c Understand whose health needs the clinics and camps are meeting and whose they are not able to meet, and why, and how you might address this;
d Carry out regular reviews of the findings to ensure that response is shaped to reflect improving access, decreasing vulnerabilities, and meeting real needs.

3 Identify existing health care professionals, including those who are not working, and assess why they are not working and what needs to be done to enable their return to work.

4 Assess the availability of medical drugs and equipment for the provision of basic and life-saving health services for males and females, children, youth, adults and older people.

5 Carry out more detailed and nuanced qualitative and quantitative studies on key issues of concern, ensuring collection of SADD where relevant and gender and generational analyses to interpret findings within the context.

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IX. WASH

A. Introduction

The provision of water and sanitation to populations affected by disasters is often considered one of the most urgent and indispensable forms of aid. Gender and age shape the amount of water needed, the intended uses for it, as well as the division of the water collection tasks and the sanitation behaviors. Furthermore, "the access to adequate WASH facilities plays an important role in the protection and dignity of the population."[1] Access to clean water and adequate sanitation and exposure to certain water-borne and water-related diseases is experienced through gender and age dimensions.

While it is often assumed that everyone in a community equally benefits from a water supply system, such social cohesion is a myth. Not everyone benefits equally: some may be favoured while others are excluded. For instance, women from minority groups have been observed to be denied access to water points, while in cultures imposing seclusion on women, it may be hard, or even impossible, for women to approach and use certain public water facilities.[2] The literature stresses the urgent need to integrate socio-cultural factors as a fourth dimension in designing water supply programmes.[3] Yet, the provision of water is often seen as a mostly technical problem, disregarding the human aspects.

THE RIGHT TO WATER IS LAID OUT IN

- **UN Resolution on Right to Water and Sanitation (Document A/64/L.63/Rev.1) 28 July 2010**
- **General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant) UN Committee on Economic, Social and Cultural Rights (CESCR) 20 January 2003**

The human right to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses. An adequate amount of safe water is necessary to prevent death from dehydration, to reduce the risk of water-related disease and to provide for consumption, cooking, personal and domestic hygienic requirements. Non-Discrimination is an important aspect of this comment, as it is relevant to post conflict and post disaster settings. The right to sanitation is not covered in this provision.

- **United Nation Human Rights Council Resolution A/HRC/15/L.14**

The UN Human Rights Council affirmed that the right to water and sanitation is legally binding: "The human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity."

B. Case Studies on Use of SADD

We offer three case studies to illustrate how gender and age influence both the needs and the access to water and sanitation, and how the use of SADD and gender and generational analyses reveal findings with strong programmatic implications. The three case studies include: 1) an overview of the gender and generational impact of water-borne and water-related diseases in **Tanzania** and **Haiti**, 2) an example of sanitation related issues in the first phases of an emergency, looking at the flood in **Pakistan**, and 3) a brief overview of the complex relationship between WASH and protection in **Haiti**.

*Case Study I: Water-related Diseases: Malaria in **Tanzania** and Cholera in **Haiti***

The primary cause of indirect deaths during civil war are infectious diseases. Of these, malaria is in many countries the most deadly. Malaria is the leading cause of infant mortality in Africa, accounting for about 20 percent of the total deaths.[4] Older people are also quite vulnerable to malaria. For this reason, the malaria rates are generally kept under close watch during emergencies. Yet, the morbidity and mortality bulletins presenting the prevalence of malaria that WHO circulates generally present aggregated data only. A 2005 study conducted in the Lake Victoria region, **Tanzania**, examined the relationships between socio-economic characteristics, vulnerability, and adaptation to malaria and found an interesting correlation between age, sex and prevalence of malaria.[5]

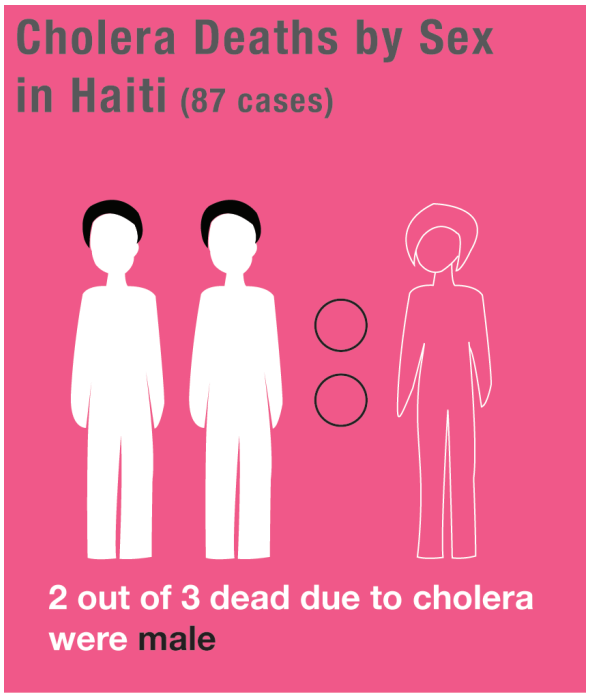
Researchers investigating the reasons for the heightened vulnerability through focus group discussions, disaggregated the data by gender and age and identified among the main reasons, 1) worse nutritional status among women and older people; 2) the fact that non-pregnant women work much harder on the farms than men, which, in addition to exposing them to more frequent mosquito bites, makes them weaker and more susceptible; and 3) that during the growing season women are more involved in weeding bean fields, an activity that exposed them, and the younger children they carried on their backs, to the bites from mosquitoes that carry malaria.

Once data on malaria mortality were disaggregated dividing the population in various age groups, a new, previously undetected pattern emerged. Looking at aggregated data for malaria mortality, the period from December to April appeared as the one with the lowest incidence. However, disaggregating the data and separating children under of age of 5, an opposite trend appeared. The figures demonstrate that children's death rate due to malaria reaches a climax between January and March. The authors attributed this to several factors, including,

> Poor nutrition for this age group, particularly between September and November, when even the breast-fed infants do not get enough milk from their mothers; (...) the fact that diarrheal disease caused by eating potatoes results in children becoming very weak and more susceptible to malaria; and the fact that many women, particularly those from poor households, spent [in those month] most of their time doing casual labour elsewhere and had little time to attend these young children.[6]

There is also widespread evidence that cholera contagion can be influenced by factors such as age and gender. For reasons that are not entirely clear, cholera is a more severe disease in pregnant women.[7] However, cholera is sometimes treated as a gender neutral disease, and as a result, data on cholera are collected in an aggregated manner. In other cases, organizations assume that in a large number of countries women have primary roles as caretakers which brings them into closer contact with contaminated individuals. Additionally,

FIGURE W1



as women often collect water for the family, cholera-prevention campaigns target women in mobilizing volunteers to raise awareness in the community and attempting to break the chain of contamination. This was the case in **Haiti**, where some organizations choose this approach. In the northwest, for instance, CARE staff and volunteers carried out cholera sensitization activities with 4,630 people in Anse-à-Foleur and Saint Louis du Nord. Of those sensitized, 61 percent were women.[8]

These approaches, however, are somewhat risky if they are not accompanied by a factual verification. In **Haiti**, for instance, the data on cholera have been stratified by department and age group (dividing those aged <5 years and all other ages), but not by gender. However, a rapid assessment of mortality from cholera was conducted in Artibonite Department in 2010, which comprises approximately 16 percent of the Haitian population and where the largest number of cholera cases were reported. The assessment team identified a total of 87 cholera deaths: among them, 58 (67 percent) were male and eight (9.2 percent) were aged 5-18 years (Figure W1).[9] The use of SADD thus challenged the assumption that adult women are the most affected and has direct implications for cholera prevention and response.

*Case Study II: Sanitation in the Early Phases of Relief in **Pakistan** Flood Response*

When the flood hit **Pakistan** in August 2010, approximately 20 million people were affected and more than 500,000 displaced. Many of the displaced needed to be temporarily hosted in camps. Given the massive logistical constrains, the first assessment data started arriving approximately one month after the flood. Even in the absence of any data, some organizations managed to respond to the different needs of women, men, girls and boys. The International Committee of the Red Cross (ICRC), for instance, took gender in consideration in different ways while setting up the camps. In terms of water and sanitation services, ICRC referred to the existing demographic national statistics, and thus inferred that the population in the affected areas was composed of 70 percent women and children.

Based on these figures, the sanitation system was built by differentiating the sanitation blocks by gender with a ratio of 1:3 (one sanitation block for males and three for women and children). This ratio is the same as the one that the 2011 Sphere Handbook recommends. The sanitation blocks for women and children were well labeled with signboards and equipped by special tap-stands and concrete slabs for washing clothes and dishes. On the hygiene promotion aspects, Pakistani Red Crescent Society female staff were delivering key messages to IDPs women on a daily bases. Moreover, community kitchens were built to facilitate the women during the cooking time and allow them to maintain their social relations.

Also, on the basis of what was known prior to the flood about Pakistani women from the affected regions and the cultural parameters around privacy, ICRC distributed plastic sheets to be installed around clusters of tents to provide additional privacy for women.[10]

Both in early and later assessments, UNHABITAT carried out detailed SADD that had clear lessons for response. For instance, in its September report on WASH work in IDP camps in **Pakistan** presented data disaggregated in four categories (Figure W2). The data showed interesting results, as the fact that latrines are built only by adult males, but managed in almost equal shares by men, women, girls and boys within the households. Despite this, women are the main target of hygiene education.

Similarly, the rapid multi cluster assessment headed by OCHA collected a wealth of SADD data directly relevant to response.[11] Figure W3, for instance, shows how the places of defeca-

FIGURE W2

Water and Sanitation Activities by Sex and Age (Ambore, Pakistan), 2010
Water
Who identifies water sources?
Who participates in the construction of the water site?
Who fetches water for family consumption?
Who consumes water?
Who stores and manages water?
25%
50%
75%
100%
Sanitation
Who manages sanitation facilities at household level?
Who constructs household latrine?
Who uses latrine?
Who manages latrine?
Who gets health and hygiene education?
Who disposes waste?
Who cleans house?
Who bathes children?
25%
50%
75%
100%
Adult Female
Girl
Adult Male
Boy

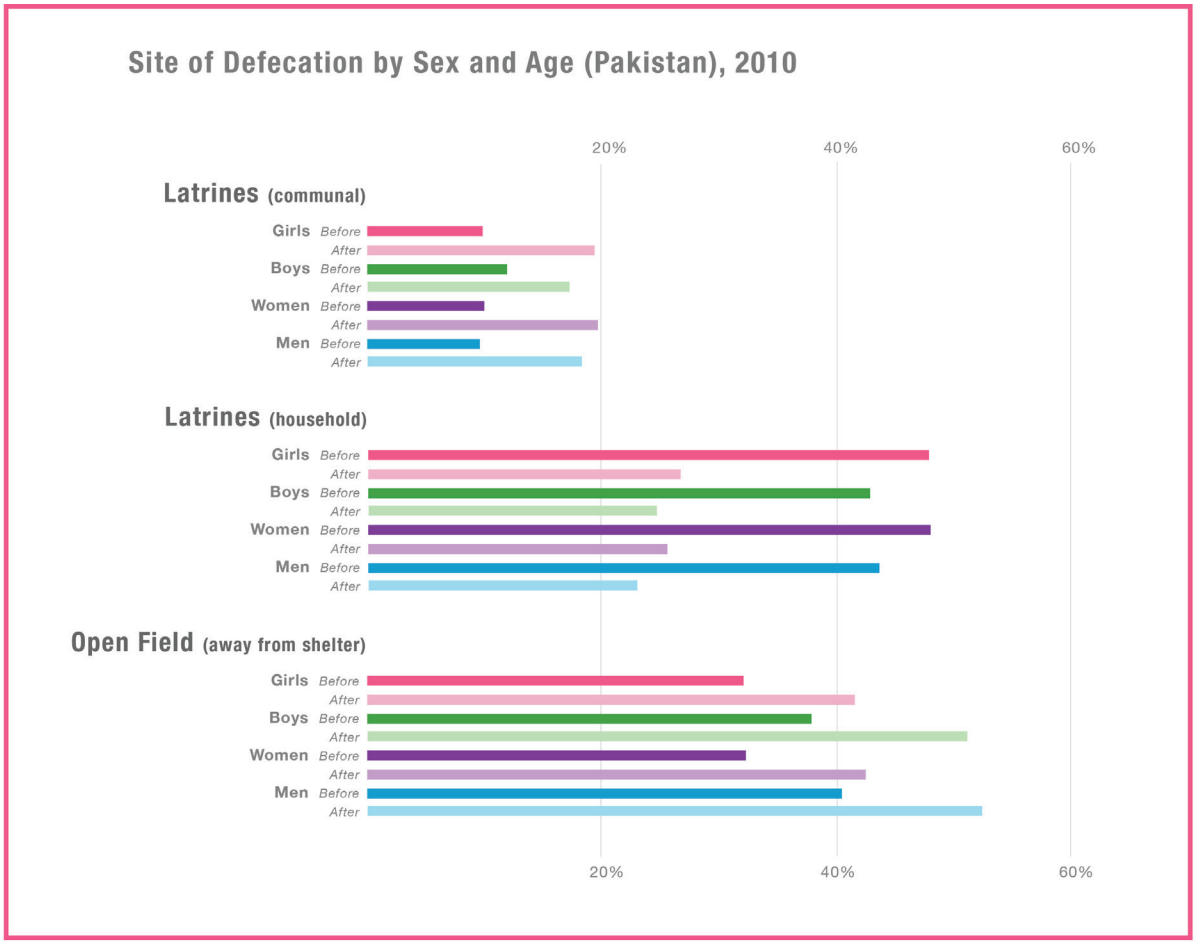
tion changed for different groups before and after the crisis. The programmatic implications are several. For instance, the fact that the greatest proportional increase in the use of communal latrines affected girls could represent an important indicator of the fact that there are potential protection risks for them in the use of latrines, and thus the locations have to be carefully considered.

*Case Study III: WASH and Protection in **Haiti***

While in the 2010 **Pakistan** flood response detailed above, the assessment phase included the collection of SADD and the resulting analysis shaped response, in the case of the **Haiti** earthquake response, which also took place in 2010, the situation was quite different.

According to the ACAPS Operations Manager[13] and two regional GenCap Gender Advisers,[14] in **Haiti** the assessment for water and sanitation needs largely overlooked the gender and cultural dimension of the population, with heavy repercussions for humanitarian response. In **Haiti** no specific questions in the **Phase I and II** rapid assessments were on gender. The ACAPS operation managed to have a Gender Focal Point for **Haiti** write up a concise report on gender issues on women and men to provide a foundation to help inform the analyses of the assessment findings. For example, the Gender Focal Point in her report looked at the full rapid assessment

FIGURE W3[12]



report for WASH and found that outside of Port au Prince, 83 percent of the latrines were not divided by sex, and 84 percent were not adequately lit, which she highlighted. However, in synthesizing the final Rapid Initial Needs Assessment report much of this gender aware data was lost, and hence did not inform programming.[15]

As a result of the lack of key gender dimensions within the published assessment data, the WASH intervention was inappropriate and led to inefficiency and ineffectiveness, including regarding the simple pit latrines built immediately after the earthquake. An assessment carried out by IOM in the camp coordination and camp management priority sites between February and March 2010, found that the latrines were insufficient in numbers, with the average of people per latrine at 411 people/latrine, with peaks from 668 people/latrine to 941 people/latrine – the Sphere standard is 20 people/latrine.[16] IOM also found that 33 percent (7/21) of the sites had no latrines. However, the main concerns emerged around the accessibility of latrines. Respondents complained that latrines were not separated by gender and granted insufficient privacy, they were too far away, they were not lit, they lacked locks, and they were culturally inappropriate (i.e., people could not sit down). Key protection issues emerged as sexual violence was reported in 29 percent (6/21) of the sites.

Furthermore, according to IOM's data, 33 percent of all latrines built were not used, and 57 percent were only occasionally used. The reasons, as detailed above, were almost entirely gender related. This case study clearly shows how SADD is a crucial element to ensure effectiveness and cost efficiency of relief: a gender and generational analysis can ensure at the same time that both more lives are saved, people's integrity and dignity is preserved, and basic human rights are reinforced.

C. When Organizations Don't Use SADD or Gender or Generational Analyses to Inform WASH Response

In 2003, a UN Task Force on Gender and Water[17] was created with the objective to promote gender mainstreaming in the implementation of the Millennium Development Goals (MDGs) related to water and sanitation and the Johannesburg Plan of Implementation (JPOI) at the global, regional, national, local and utility levels. In December 2008, and again in 2009, an Expert Group Meeting was held to address the question of gender disaggregated data in Water and Sanitation. Yet, in general there is a stark absence of gender disaggregated WASH data.

In March 2010 the GenCap published its 9th Experience Document, entitled "Demistifying Gender Programming in Water, Sanitation and Hygiene", which focused on the GenCap experience in the **Democratic Republic of Congo**. According to the author,

> Empirical field observation and exchanges with INGOs [showed that] the different responsibilities of girls, boys, women and men with regard to hygiene maintenance, water management and sanitation were not adequately analyzed. For instance, the hygiene promotion initiatives were gender blind, not fully acknowledging the fact that women and girls are primarily responsible for household and community hygiene maintenance.[18]

According to the GenCap Status Report #3, the WASH Cluster is the second sector (after Protection), in which GenCap Advis-

ers are most frequently requested to work. However, the report notes that the WASH sector, along with the health and agriculture and the food distribution sectors, have shown the least ability to include SADD in data collection and gender and generational analyses.

The examples presented in this chapter, however, clearly demonstrate how SADD is a prerequisite for the provision of an effective, life-saving assistance, and the cost of neglecting is not only ineffective but puts people at risk.

D. SADD Guidelines and Data Collection Tools for Lead WASH Agencies

SADD GUIDELINES

The 2011 Sphere Handbook and UNICEF, the lead agency within the WASH cluster, in partnership with the lead sectoral organizations have produced several guidelines on how to best collect and use SADD.

- The Sphere Handbook pays particular attention to gender in relation to WASH. For instance, concerning toilets it recommends that "Disaggregated population data are used to plan the number of women's cubicles to men's using an approximate ration of 3:1, and it underlines the need to ensure safety in the toilets by providing light and locks.[19]

- Among the principles of UNICEF's Core Commitments for Children in Humanitarian Action is that, "Gender analysis informs decisions based on the different needs and capacities of girls, boys, women and men."[20]

- The Draft Water, Coordination and Hygiene Cluster Coordination Handbook published by the Global WASH Cluster in 2009 states that, "Within one week of a rapid onset disaster (…) A Flash Appeal will need to be prepared. In order to do this, a minimum level of disaggregated assessment data is needed to help inform [among other things], the nature and scale of the emergency and its impact.; (…) the size, location, and characteristics of the affected populations, (…) their immediate needs and priorities, the information gaps that need to be filled and the Principle stakeholders and information sources."[21]

- The Handbook also has pragmatic recommendations on how to include gender considerations in programming, for example, "Adequate numbers of well lit, lockable latrines for each sex are available within camp settings."[22]

- In the IASC Gender Handbook for WASH, the suggestions include collecting SADD data on the number of households and the number of households members, and verifying whether "water points, toilets and bathing facilities are located and designed to ensure privacy and security", if users (especially women and children) can access them safely."[23]

- In March 2010 the GenCap published its 9th Experience Document, entitled "Demistifying Gender Programming in Water, Sanitation and Hygiene" which provides a series of gender sensitive recommendations for WASH.[24] The majority of these recommendations have now been included in the 2011 Edition of the Sphere Handbook.

SADD DATA COLLECTION TOOLS

In the Draft Water, Coordination and Hy-

giene Cluster Coordination Handbook Published by the Global WASH Cluster the assessment guidelines are clearly divided in the different phases. During **Phase I**, it is noted that data will normally be gathered through a rapid assessment process, which may be an inter-Cluster assessment coordinated by the HC / UNOCHA, or a rapid assessment within the WASH Cluster based largely on meta-analysis of disaggregated assessment information provided by WASH Cluster actors.[25]

Concerning **Phase II**, the Handbook notes that, "Within 2-4 weeks of a rapid onset disaster… Many WASH agencies will be undertaking their own comprehensive WASH sector- specific assessments, and the emphasis of the WCC role is in getting a coordinated approach to how the assessments are carried out, e.g. common indicators, what data is shared, a process for central analysis, including identification of duplication and gaps, and reporting of that data."[26] This coordinated process for comprehensive assessments is likely to take 4-6 weeks, and includes a phase of preparation of the assessments, one of data collection, one of data analysis and one to produce the final reports.

Concerning **Phase III**, the Handbook notes that, from one week to six months after a rapid onset disaster, "there will be an on-going process of assessment, and situation and progress monitoring. During this process there may be a range of detailed assessments within different Clusters, and joint assessments coordinated by the HC /UNOCHA. Ongoing monitoring and assessment will remain focused at field level and should inform a continuous process of reviewing the WASH Cluster response plans."[27]

So, it is apparent that SADD can, and should, be included in all these different phases.

There is a number of existing assessment tools that are routinely used. On top of the Global WASH Cluster Assessment Tools there are organization specific ones; Oxfam, for instance, one of the main NGOs in the WASH sector, has its own Oxfam Public Health Assessment Tool, that includes principles as the obligation to undertake mainstreaming gender and protection in WASH assessment and programmes.[28]

E. Core Recommendations for WASH Cluster for Ensuring Good Data Collection and Gathering SADD

During Phase I Assessments

1 Ensure to include SADD into the design of baselines, tools and indicators;

2 Ensure to include women as assessors and translators on the team and brief and train the assessment teams on SADD considerations;

3 Ensure to include women among the principle stakeholders and information sources. This may include local midwives, nurses, teachers, community leaders, and leading market women.

During Phase II Assessments

1 Ensure that if you are using focus groups, 50% of those focus groups are comprised of women and older girls, ideally exclusively of women and girls (given males' tendency to dominate public and mixed-sex conversations);

2 If separate focus groups are not an op-

tion, the facilitators of the interviews should be prepared handle male dominance in discussions and generally create a protected space where women can both participate and express their needs and opinions;

3 Ensure that you record the sex and age of those you are interviewing, this will enable you to:

a Assess whether there are important segments of the population you have not reached who may have necessary views to inform your response;

b Assess if there are important differences across gender and age in terms of needs and access to health services among the most vulnerable populations.

c Rather than thinking in the abstract of "gender sensitive WASH" it is important to think about practical implications, such as lights and locks for safety, placement, distance and exposure in relation to reducing risks of sexual and gender based violence, and cultural issues of form and use.

During Phase III Assessments

1 Gather basic SADD (sex and age) on those who come into IDP and refugees camps, so to decide the ratio of latrines accordingly;

2 Gather basic SADD (sex and age) on those who collect water and use latrines and showers, and when. This will enable:

a Understanding of who is and is not actually using latrines and showers, and hence how outreach and access need to be improved;

b Understanding of whose water and sanitation needs are being met and whose are not being met, and why, and how this might be addressed;

c The carrying out of regular reviews of the findings to ensure that response is shaped to reflect improving access, decreasing vulnerabilities, and meeting real needs.

3 Schedule and conduct assessment and focus group discussions in different hours of the day, making sure that relevant groups are invited in times when they are relatively free from other duties to attend;

4 Carry out more detailed and nuanced qualitative and quantitative studies on key issues of concern, ensuring collection of SADD where relevant and gender and generational analyses to interpret findings within the context.

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X. If Sex/Gender and Age Matter For Response, Why Don't We Systematically Collect SADD?

A. Realities on the Ground

Interviews conducted by the authors with people knowledgeable about gender and generational analysis and SADD in natural disaster and armed conflict found that all persons interviewed believed that collecting SADD and using gender and generational analysis was essential to improve programming and response. Interviews with people admittedly less knowledgeable about SADD, gender and or generational analysis in natural disaster and armed conflict found only a handful of these people believed that SADD, gender and generational analysis was not necessary and would not have any impact improving programming and response. We have found, furthermore, that almost all the major standards, handbooks and guidelines require the collection and analysis of SADD.

During our study, we have found extremely limited, ad hoc, sporadic use of SADD in **Phase I and II**, and only marginally better use in **Phase III** assessments by the clusters. The notable exceptions here are the Education and Shelter Clusters, in which SADD and gender analysis are incorporated throughout their assessment tools and in their programming. Other senior officials within the clusters admitted that their use of evidence-based programming derived from assessments was weak, and that SADD was collected extremely rarely and then only on an ad hoc basis, though many were trying to change that.

It was noted, particularly by the ACAPS team, that there is a lack of understanding among users as to what can realistically be collected in **Phase I and II** and how much it could influence programming. Nearly everyone agreed that the key to deep understanding via assessments was in **Phase III**. Nonetheless, it was agreed that in **Phase I and II** some aspects of sex, gender and age for framing methods and gender and generational analysis were necessary and could improve the understanding of the situation for people in the crises.

Notably, when SADD is collected, it was noted by most all persons interviewed that field offices don't necessarily know what to do with it. Therefore, simply the presence of SADD guidelines or even SADD does not necessarily or reliably indicate more gender sensitive approaches, programming or better results. Interviewees reported that field teams/clusters may have the data but because they don't know how to carry out a larger, contextual gender and or generational analysis, they don't know how to interpret the data beyond what it tells them at face value. Nor do they necessary know how to understand it in a larger context of the society and what the situation was like before the crises.

At this point, most interviewees said it would be essential to have gender specialists as part of the teams so that by using secondary literature and employing a broader contextual understanding, they could help the assessment teams (especially in **Phase II and III**) make sense of the data collected. In the rare cases where gender specialists were available and where SADD was collected, properly analyzed, and applied in programming (several in-

A 2009, IASC Gender Sub-Working Group Report on SADD in Emergency Response Found:

1. Gender awareness, understanding, and knowledge transfer requires constant reinforcement at all levels to ensure the consistent collection of SADD.

There exists a broad understanding and acceptance of the importance of collecting SADD to appropriately inform decision-making. This is quite evident at the Global Cluster level, but is less clear at the country and regional levels. The data collection tools used depends largely on the preferences of the country team. The importance of SADD is not well reinforced at the higher levels and there is often a lack of statistical expertise within the teams to transform data into meaningful information. Knowledge transfer from the global level to the country level therefore needs to be strengthened.

2. There is no harmonization of age data, no definition of children and very little information is collected on the older person.

The cluster program objectives determine the extent to which age-disaggregated data are compiled. There is no harmonized definition as to what age range constitutes a "child", but most programs at least distinguish children's needs from those of adults. Data is not usually disaggregated by single years of age, and age groupings are often not comprehensive. This limits the data's usefulness across programs. Data to support the needs of older persons is not a priority.

3. Strengthening information management is an important step towards the improved collection of SADD.

The consensus of cluster representatives is that, while there has been a great deal of technical advancement around information management, the cluster approach has not kept up. More work is needed to harmonize concepts, influence data collection standards, and strengthen data interpretation skills.

4. Having the right data at the right time is critical in emergency settings.

At each stage of an emergency, it is important to put relevant, reliable data into the hands of those who need it.

5. SADD collection and analysis must be grounded in statistical methodologies that follow standard procedures

During the early phases of initial assessments, data collection exercises do not collect disaggregated data on sex and age. This must be distinguished from the issue of being able to collect the data. The challenges of early emergency settings, combined with political and security issues, can complicate and delay data collection. However, there is no evidence to suggest that such issues should prevent the collection of SADD. The breadth and depth of data collected increase as the emergency setting stabilizes. There are a variety of data collection tools being used with little or no harmonization of methodologies, strategies, or conceptualization.

6. Information about sex/gender and age is not being used to its full potential.

Even when data are collected, there is often a weak link between the data analysis and interpretation. Aggregated data is often the most practical to use because disaggregated data requires specialized knowledge and expertise for its interpretation. For example, SADD interpretation requires the expertise of gender specialists and statisticians. These skills are not readily found in the field of humanitarian actors. It takes time and skilled resources to collect and interpret findings to support program decision-making.

Inter-Agency Standing Committee Gender Sub-Working Group. Sex and Age Disaggregated Data in Humanitarian Action: SADD Project. IASC: New York (May 2009).

terviewees referred to some work around the **Pakistan** earthquake response), interviewees noted positive outcomes for the affected populations (although M&E was not necessarily carried out).

We found almost no cases in which SADD was collected, gender and or generational analysis was used to understand those data in context, those findings clearly influenced programming, and then proper monitoring and evaluations were done to determine if programming was enhanced. If we reflect on numerous years of studies in the academic literature, which clearly demonstrate that sex, gender and age effect people's experiences of disaster and armed conflict and their access to services, we should logically be working under the assumption that it does matter and hence should be taken into account. Therefore, it is the authors' opinion that the emphasis should be put on better understanding where SADD and gender and generational analysis matter and can contribute; how to ensure proper data collection and analysis that feeds into programming; and how to carry out proper monitoring and evaluation to determine affects.

B. Why Aren't Agencies Collecting SADD and Using Gender and Generational Analyses in Assessments during Crises?

Throughout our interviews, the authors ask why agencies were not more routinely collecting SADD and using gender and generational analyses in their assessments during crises. The following points present the most frequent responses:

- Overall, the response by the humanitarian system is not evidence-driven.

- There is no harmonized way to collect, manage and analyze the data and use it to inform programming.

- The cluster leads lack training and understanding of the need for and how to collect, analyze and translate SADD into programming. Because cluster leads and donor agencies do not show strong interest in or understanding of the value of SADD, the field does not collect it.

- Cluster leads at headquarters and in field may not be aware of the IASC, Women, Girls, Boys and Men: Different Needs – Equal Opportunities: Gender Handbook in Humanitarian Action as a resource for assessments and analysis during emergencies.

- Clusters have guidelines for assessments that include some SADD elements, but rarely implement them in the field.

- SADD and gender and generational analyses are being used to show there are problems, but ***not*** to inform programming.

- Agencies fear that SADD and gender and generational analyses will make them accountable for things they don't want to be accountable for.

- SADD is central to gender equality. However this confuses some people who then see SADD as about gender sensitivity and training. They don't understand SADD is actually about helping them understand and meet people's needs.

- Some agencies refuse or believe it is not possible for them to integrate SADD into their databases which were designed without SADD.

- A misunderstanding among some agencies regarding the scope of what SADD and gender and generational analyses can encompass, so that if their programs include all women or men they don't need SADD.

- Difficulty in finding qualified local, female employees who are willing to travel, and the difficulty in accepting the idea of hiring non-technical staff.

- People don't realize the value of SADD and gender and generational analyses, they don't

recognize that programming will be deeper and more relevant and that actors will do their jobs better and more responsibly if they have it.

C. The Way Forward

All 11 clusters are mandated to ensure gender equality in their humanitarian response, and are informed on the need to collect and use SADD by numerous guidelines and handbooks tailored to their cluster. It appears that the lack of implementation of these guidelines and hence the inability to fully reach their mandates has more to do with lack of awareness, knowledge and skills around SADD and gender and generational analysis then any other reason.

Hence, the solution to addressing these issues is clear: strengthening the clusters' awareness, knowledge and skills around the collection and use of SADD and gender and generational analysis to interpret that data. Logically, the cluster leads need to take the lead in working within their clusters on issues of SADD and gender and generational analysis, supported by GenCaps advisors as necessary.

XI. Conclusion

In order to ensure vulnerabilities, needs and access to life-saving services are best understood and responded too, it is important to have information on different segments of society. Having information gaps related to sex/gender and age restricts and hinders critical decision-making in humanitarian response in all phases of an emergency. Proper collection, analysis and use of SADD allows operational agencies to target assistance more efficiently, to provide programming that is more specific and effective, and to more fully integrate protection concerns into their programming response.

1 Our research concludes that there is no sufficient intellectual, logistical or financial justification for not collecting SADD and using gender and generational analyses to interpret that data to inform humanitarian response. Nor is there any such justification for not modifying existing data collection and monitoring systems that presently do not include SADD. While the methods of data collection used will look different in each phase, we find that it is not only possible, but also necessary to collect SADD in all phases of an emergency to inform response. We have provided detailed recommendations on how to ensure SADD can be collected during each phase of an emergency and within each of the five sectors, and those recommendations are adaptable to all 11 clusters.

2 Data without analysis is useless. To understand SADD, those analyzing it need to know how to carry out gender and generational analyses, which are contextually-based, in order to better inform the response that is generated from the evidence. Though GenCaps is an excellent resource, they cannot carry out all the analyses needed. If agencies want their programs and response to be evidence-based, then they must invest in training and/or hire staff that can collect and analyze SADD.

3 Cluster leads should spearhead the effort to help their clusters become more evidence-based, so that humanitarian responses is more effective and efficient in saving lives and livelihoods. Hence, they should train, as necessary, on the collection and analysis of SADD, and the difference it can make in programming. They should also take a lead in encouraging agencies within their clusters to collect, analyze and use SADD, and make available resources that already exist (and which we highlight in this report) on the mandates and tools to collect SADD within their clusters in all phases of an emergency.

4 Donors are also responsible for ensuring agencies they support are basing their response on evidence of actual needs of the most vulnerable populations. This means they must require and ensure that those agencies are collecting and using SADD and gender and generational analyses to inform their humanitarian response. There are many ways to collect SADD, so there is no need to be overly prescriptive and what is possible and useful varies based on the phase of the emergency (as detailed in this report).

5 In all evaluations of major humanitarian responses, donors should require those evaluations contain analysis of the collection, analysis and use of SADD to inform programming. Donors should also require evidence of SADD and gender and generational analysis in monitoring and evaluating humanitarian assistance efforts receiving their support, with an emphasis on how SADD is informing programming.

6 Finally, emphasis should be put on better understanding within each sector and during each phase of an emergency where SADD and gender and generational analysis matter and can contribute; how to ensure proper data collection and analysis is used to shaped programming; and how to carry out proper monitoring and evaluation to determine effects.

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