

# Gender Analysis and Action Plan

*Increasing resilience to the health risks of climate change in the Federated States of  
Micronesia (FSM)*

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## Background

The proposed project *Increasing resilience to the health risks of climate change in the Federated States of Micronesia (FSM)* is intended to transform the current situation of high vulnerability to vector-borne disease (VBD), water-borne disease (WBD), and food-borne disease (FBD) risks related to climate change by developing a climate-resilient health system, as outlined in the National Climate Change and Health Action Plan (NCCHAP) and implementing tangible human health adaptation activities at the community level. The project is organized around three main result areas or outcomes:

1. Outcome 1: Relevant policies, systems, processes and guidelines are institutionalized in the FSM for effective adaptation response to climate change-related vector-, water- and food-borne diseases;
2. Outcome 2: The Health Information Early Warning System becomes effective in supporting timely planning and responding to climate change sensitive diseases in FSM; and
3. Outcome 3: Communities have increased resilience to climate-related FBDs, WBDs and VBDs as well as capacity to manage associated health burdens.

The different activities have been developed taking into account recommendations from the NCCHAP and the joint external evaluation of International Health Regulations core capacities of FSM from the World Health Organization (WHO).<sup>1</sup>

An integral part of the project development process has been the undertaking of the following gender analysis to better understand gender roles generally across FSM and more specifically within the health sector. Data on gender issues as well as the overall situation analysis is included as part of the following Gender Analysis and Action Plan (GAAP). The gender and social inclusion action plan (GAP) details the work undertaken to ensure the project progresses gender equality; presents the targets and design features, included in the project to address gender concerns and ensure tangible benefits to women and men, especially from vulnerable groups; and presents gender sensitive monitoring and evaluation targets and indicators.

## Purpose and Methodology

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<sup>1</sup>[World Health Organization \(2019\), Joint external evaluation of International Health Regulations core capacities of the Federated States of Micronesia: mission report: 13-17 August 2018](#)

The gender analysis and gender action plan (GAAP) is based on a desk study as well as several stakeholder consultations that took place from November 2021 through March 2022. The stakeholder meetings included consultations associated with the development of the concept note, an inception workshop, as well as individual consultations with gender focal points in the FSM government and representatives from local women's groups. Representatives from each State of FSM's four States were consulted. These included consultations with the Pohnpei Women's Council; Yap State Gender Support Officer representing Yap women's groups; Kosrae Women's Association and Chuuk Women's Council (see Appendix 1 for a summary of stakeholder consultations that took place with government focal points and women's group representatives).

A total of 51 participants from the national government as well as across the four FSM States were consulted during the initial stakeholder workshop. Out of these, 26 of the participants were women and 25 were men, with representatives from government agencies, NGOs, and State agencies participated including the Chuuk Conservation Society (CSS), Kosrae's Women's Association, and Yap Protected Area Network.

Consultations at the state level also took place to inform the design process (4 March and 8 March 2022). Accordingly, the states of Kosrae, Pohnpei, Chuuk and Yap were involved. The first session was conducted in Pohnpei, with the stakeholders in Kosrae attending via Zoom. The second session was conducted in both Yap and Chuuk. Across the four states there were 46 participants (26 women and 20 men.) In attendance during the consultations were representatives from state and municipal governments, traditional leaders, religious leaders, as well as CSOs and NGOs. This included the Pedie Women's Organization (Pohnpei), Yap Women's Association, the Neighboring Islands Women's Association (Yap) and the Kosrae Women's Association.

Through these discussions, participants specifically requested that women's groups be included as part of project implementation and provided feedback on the specific activities of the proposed project. Once developed, the GAAP was disseminated to government gender focal points and women's groups for review, feedback, and validation.

## **Gender Assessment and Analysis**

**FSM Legislative Policy and Planning Frameworks** The Constitution of the FSM states that no law shall be enacted in the Trust Territory which discriminates against any person on the basis of race, sex, language, or religion, nor shall the equal protection of the laws be denied. Although there is no national legislation criminalizing sexual assault, FSM has legislation criminalizing both sexual assault with penetration and sexual intercourse with girls under the age of thirteen. At state level,

two governments have passed Family Protection Acts including Pohnpei (2017)<sup>2</sup> and Kosrae (2014)<sup>3</sup>. Chuuk and Yap States have yet to pass family protection legislation.<sup>4</sup>

### International Commitments

The FSM has ratified a range of international human rights conventions including, amongst others: Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW - 2004)<sup>5</sup> and the [Optional Protocol on the Involvement of Children in Armed Conflict](#); the [Convention for the Suppression of the Traffic in Persons and Exploitation of the Prostitution of Others](#); the Convention on the Rights of the Child (CRC - 1993) and the Optional Protocol on Sale of Children, Child Prostitution and Child Pornography; and has signed the Convention on the Rights of People with Disabilities (CDRP - 2017). FSM renewed its commitment to CEDAW through the Pacific Leaders Genders Equality Declaration (PLEGD) (2012 and re-affirmed in 2015)<sup>6</sup>.

Further, FSM is a signatory to the United Nations Framework Convention on Climate Change (UNFCCC), ratified the Paris Agreement and submitted its Intended Nationally Determined Contribution in November 2015. In line with the Paris Agreement, which states that climate change actions need to “be guided by respect for human rights, gender equality and the empowerment of women,” and follow “a country-driven, gender-responsive, participatory and fully transparent approach,” successive UNFCCC National Communications have addressed the impacts of climate change on women and other vulnerable groups, including the need for increased focus on social components such as gender and social inclusion (GSI) issues.

This need to increase attention to GSI issues is also stressed in the UNFCCC GAP, adopted by world leaders at COP23. Five critical actions to achieve gender objectives are outlined in this GAP, including: 1) Capacity building, knowledge sharing and communication; 2) gender balance, participation and women’s leadership; 3) coherence consistent implementation of gender-related mandates and activities; 4) gender-responsive implementation and means of implementation, and 5) monitoring and reporting.

The fourteenth Triennial Conference of Pacific Women (Triennial) and the 7th Ministers for Women Meeting, was held from 27 to 29 April 2021, and the fourth of May respectively, and

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<sup>2</sup> [Domestic Violence Act of 2017](#). Title 53 of the Pohnpei Code relative to Domestic Issues. Inserting a new Chapter 1 relating to Domestic Violence; and amending 59 PC 4-101 of the Pohnpei Code to provide consistency. The policy states: “It is therefore declared to be the public policy of the state of Pohnpei to preserve and promote harmonious relationships in domestic affairs and to prevent the perpetration of acts of violence within the families of Pohnpei State.” See also: [Amendment to Section 5-142 of Title 61](#) of the Pohnpei Code relating to the age of consent.

<sup>3</sup> [Title 16 of the Kosrae State Code, Part III. Establishing the Kosrae State Family Protection Act of 2012](#). The Act provides protection and safety of those persons who, by reason of their **sex**, age, marital status, physical or mental disability, or other condition are subject to physical or mental abuse occurring within, or as a consequence of their domestic interpersonal relationship with the abuser or abusers.

<sup>4</sup> <https://pacificwomen.org/wp-content/uploads/2019/01/FSM-Pacific-Women-country-plan-summary-Jan-2019.pdf>

<sup>5</sup> While the CEDAW was ratified, a 2004 review by UN Women found that FSM was non-compliant on 61% of the recognized indicators of legal compliance.

<sup>6</sup> <https://www.aidsdatahub.org/sites/default/files/resource/pacific-leaders-gender-equality-declaration-2016.pdf>

focused on three priority areas: (i) women’s economic empowerment, (ii) gender-based violence, and (iii) gender-responsive climate justice; and four cross-cutting themes: (i) women in leadership and decision-making; (ii) crises and disasters; (iii) sex-, age- and disability-disaggregated data (SADDD) and statistics; and (iv) intergenerational dialogue to ensure the perspectives of Pacific youth are heard.<sup>7</sup> As part of the Ministerial meeting FSM in May 2021 endorsed the outcomes and recommendations from the 14th Triennial Conference of Pacific Women, which included the priority area of gender-responsive climate justice, with an agreement that Governments should strengthen coordination and capacity-building on gender and human rights, including the integration of gender into Climate Change and natural disaster-related policies.<sup>8</sup>

### National Strategic Development Plan

The FSM Strategic Development Plan (SDP) 2004 – 2023 highlights seven specific goals aimed at improving gender equity and social inclusion.<sup>9</sup> These include:

- **Strategic Goal 1:** Enhance and promote the cultural, economic, legal, political and social development of women and children throughout their life cycles
- **Strategic Goal 2:** Enhance the leadership capacity and roles of women
- **Strategic Goal 3:** Mainstream gender issues into decision-making, policies and strategic development plans
- **Strategic Goal 4:** Maximize women’s contribution to and participation in democratic and, development processes by creating opportunities for women’s active involvement
- **Strategic Goal 5:** Strengthen the institutional capacity of the women’s programs in FSM
- **Strategic Goal 6:** Strengthen the institutional capacity, effectiveness and impact of youth organizations
- **Strategic Goal 7:** Strengthen youth development through social, economic and political participation.

### National Gender Policy

The National Gender Policy (NGP) 2018 – 2023, endorsed by the FSM Government in May 2018 is intended to “promote gender equity, equality, social justice and sustainable development in the country”<sup>10</sup>. The NGP is aligned with: the goals and objectives of the National Strategic

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<sup>7</sup> [https://www.forumsec.org/wp-content/uploads/2021/07/Economic-Empowerment-of-Women\\_Final.pdf](https://www.forumsec.org/wp-content/uploads/2021/07/Economic-Empowerment-of-Women_Final.pdf)

<sup>8</sup> <https://www.spc.int/sites/default/files/documents/14th%20Triennial%20Conference%20of%20Pacific%20Women%20Eng.pdf>

<sup>9</sup> FSM National Strategic Development Plan 2004 – 2023, Government of the FSM.

<sup>10</sup> Twentieth Congress of the Federated States of Micronesia Fourth Regular Session, 2018. C.R. NO. 20-102.

Development Plan 2004-2023; the Pacific Leaders Genders Equality Declaration (PLEGD); the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Convention on the Rights of People with Disabilities, and the mandate of the Department of Health and Social Affairs (DHSA) and State Offices responsible for Social Services.

The NGP commits the FSM Government to take action in the following six areas:

1. Women's advancement
2. Gender mainstreaming
3. Strengthening women's programming
4. Strengthening youth organizations programming and leadership
5. Establishing social inclusion and social services for the elderly, and
6. Addressing the economic, political, social and legal needs of people with disabilities and those with special needs.

The NGP is expected to ensure high-level accountability across national and state governments, working in collaboration with local Women's Council and Associations, to achieve identified gender outcomes. It is also expected that organizations serving youth and people with disabilities (PWD) will collaborate to achieve social inclusion objectives.

Overall, FSM National Government's role is to mobilize funds and resources while implementation is undertaken at the State-level, this includes in areas of social services. Figure 1 below provides an overview of the different laws and services at the State and National level that establish areas to advance Gender and Social Inclusion (GSI). The national gender focal point coordinates FSM gender activities, deals with international and regional issues and is responsible for disseminating information and providing advice and assistance to the various state women's development offices. In all cases, the national and state women's offices/programmes were consulted.<sup>11</sup>

*Figure 1: National and State Laws and Services to Advance GSI (Source: FSM Gender Stock Take<sup>12</sup>)*

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<sup>11</sup> [https://www.spc.int/sites/default/files/wordpresscontent/wp-content/uploads/2017/03/web\\_2-FSM\\_gender\\_stocktake.pdf](https://www.spc.int/sites/default/files/wordpresscontent/wp-content/uploads/2017/03/web_2-FSM_gender_stocktake.pdf)

<sup>12</sup> *Ibid.*

	Chuuk	Kosrae	Pohnpei	Yap	FSM
<b>No. staff responsible for GSI policy and programs</b>	One in governor's office	No visible focal point	Social services Team of 3 in health:	At least 3 staff	3 staff plus one external advisor (social affairs DHSA)
<b>Domestic violence laws</b>	No	Yes	Yes	No	
<b>Accessibility law</b>	No	Yes	Yes	Yes	
<b>Social services provided in addition to health and education</b>	Some federal programs and others accessed to provide support to states, typically through education and health services. No state social programs such as victim support or child protection services. Personal loans for housing through FSM Development Bank, United States Department of Agriculture rural development and housing authorities. Variable levels of program activity by NGOs in different states.				
<b>Financial support for NGOs</b>	Several NGOs have accessed funding for buildings. Yap state provides funding support for key NGOs. Congress initiates FSM government grants to NGOs.				
<b>Engagement with civil society or traditional leadership</b>	Not systematic	Annual, broad-based engagement	Regular consultation with traditional leaders	Traditional leader councils have veto rights	Departments have varying models for engaging with states

## Framework for Sustainable Health

A Framework for Sustainable Health Development in the Federated States of Micronesia 2014–2024 was developed to ensure that people and communities are healthy and enjoy universal access to quality health services. The strategic framework sets out six goals: ensure accountability, sustainability and quality of health service delivery; achieve universal access to an essential package of health-cares services; increase financial sustainability and ensure universal access to essential health services; improve availability, accessibility, quality and use of health information for evidence based decision-making across the health sector; reduce morbidity and mortality; and ensure supportive and sustainable social and physical environments to improve health.<sup>13</sup>

The framework does not include any differentiation based on gender or other specific vulnerabilities.

## FSM Gender Policy Coordination and Implementation

<sup>13</sup> <file:///Users/administrator/Downloads/WPRO-2017-DPM-013-fsm-eng.pdf>

The DHSA hosts the Gender Development Office (GDO) as the focal point for gender issues in FSM, and the CEDAW Committee, with the Stocktake Assessment<sup>14</sup> highlighted critical challenges, including:

- GDO is not strategically located within the central government structure to influence the integration of gender across the policy, programming and resource allocation spectra.
- GDO has few resources and no process to facilitate the mainstreaming of gender and women's human rights across the whole of government.
- GDO lacks expertise and experience in gender and human rights analysis and integration, particularly when it comes to research and statistical support, gender-related planning and analysis, sub-grant management, information management and dissemination and evaluation.

Further it should be noted that in addition to the GDO, FSM National government funds some gender positions, with Pohnpei and Yap having state funded 'women's interest officers' (or equivalent), but gender equality work in Chuuk and Kosrae is largely the responsibility of CSOs including the state women's umbrella organizations. These CSOs and women's organizations will be engaged throughout the project implementation.

Since the Stocktake Report, the DHSA and GDO have made significant progress including:

- Actively engaging in policy, programming and resourcing spectra to incorporate gender equality considerations in national government processes (for example the SDGs and the Voluntary National Review (VNR)),
- Increased budget allocation for gender equality
- The National Ending Violence Against Women Policy and State Action Plans (action plans not yet endorsed)
- Mobilized resources to support women's economic empowerment, sexual reproductive health rights and ending violence against women
- At the State-level:
  - Chuuk State passed the Chuuk State Disability Act (February 2022), which aims to provide accessible services to promote and protect the rights of people with disabilities. The Act mandates the Governor's office to oversee its implementation.<sup>15</sup>
  - Kosrae's Sate Legislature passed the Kosrae Disability Act (Bill 191) on 3 December 2021.<sup>16</sup>

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<sup>14</sup> Stocktake of the gender mainstreaming capacity of Pacific Island governments – FSM: Available at:

[https://www.spc.int/sites/default/files/wordpresscontent/wp-content/uploads/2017/03/web\\_2-FSM\\_gender\\_stocktake.pdf](https://www.spc.int/sites/default/files/wordpresscontent/wp-content/uploads/2017/03/web_2-FSM_gender_stocktake.pdf)

<sup>15</sup> <https://www.spc.int/updates/blog/2022/05/influencing-legal-frameworks-to-promote-the-rights-of-people-with-disabilities>

<sup>16</sup> <https://www.spc.int/updates/blog/2022/02/new-disability-law-for-kosrae-state-to-enhance-protection-of-persons-with>

The Pacific Women Country Plan for FSM highlighted some progress in addressing these gaps, but many of them still remain significant barriers for FSM mainstreaming gender.<sup>17</sup>

The FSM Women's Council comprises office bearers from the four State women's councils or associations, umbrella groups for all the women's groups in the state: Chuuk Women's Council (CWC), Kosrae Women's Association (KWA), Pohnpei Women's Council (PWC) and Yap Women's Association (YWA). These women's councils are key players in advocating for gender equality in their own states to support the six strategic goals in the NGP as well as implementing projects and programs identified by members. At the 2014 National Women's Conference in Pohnpei, the women's councils resolved to form an FSM Women's Council. That body was legally established prior to the 2016 conference in Yap. The Women's Councils completed the process to formally establish the FSM Women's Council in January 2018 and is now the coordinating body or national voice for women; and has received funding support from National Government through the GDO. The 2020 conference in Kosrae was postponed during the time of restricted travel movement and COVID-19 lockdown period between March 2020 to July 2022. The 9th FSM Women's Conference was convened by the FSM Department for Health & Social Affairs (DHSA) in Kosrae State at the end of November 2023, with the endorsement of the FSM Women's Council Strategic Plan as a key outcome of the meeting.

The VNR notes that “it is in the civil society sector where women have an outsized impact on the collective consciousness and development of the many islands in FSM. More organized support and public-private and private-private partnerships should be sought as a matter of policy.”

As noted above in the methodology section, women's groups have been consulted in the development of the GAP and will continue to be part of the stakeholder engagement process as they are an integral part of communities across FSM.

The current SAP Health project will include dedicated gender capacity support during implementation to ensure the action plan is carried out as well as ensure women's groups and government gender officials are fully incorporated and engaged throughout the life of project.

## Overview Gender Inequality

The poverty profile for FSM highlights that at the national level about one-fifth of the population lives in female-headed households (17.8%-20.7% range across the states). These female-headed households are also on average larger and have more children across all states except Yap. Further,

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<sup>17</sup> Pacific Women FSM Country Plan Summary; Available at: <https://pacificwomen.org/key-pacific-women-resources/fsm-country-plan-summary/https://pacificwomen.org/key-pacific-women-resources/fsm-country-plan-summary/>

at the national level over half of female-headed households live in poverty compared to 40% of male-headed households (Table 1).<sup>18</sup>

**Table 1: Male vs. Female-Headed Households Summary 2013/2014 HIES**

Household Type	Percent of Population					Poverty Incidence				
	Yap	Chuuk	Pohnpei	Kosrae	Total	Yap	Chuuk	Pohnpei	Kosrae	Total
<b>Male Headed</b>	79.3	82.2	78.7	81.7	80.6	37.3	43.3	36.7	18.8	38.9
<b>Female Headed</b>	20.7	17.8	21.3	18.3	19.4	47.3	55.9	48.2	31.3	50.5
<b>Overall</b>	100	100	100	100	100	39.4	45.5	39.2	21	41.2
Household Type	Average Household Size					Average No. of Children under 15				
	Yap	Chuuk	Pohnpei	Kosrae	Total	Yap	Chuuk	Pohnpei	Kosrae	Total
<b>Male Headed</b>	7.4	8.5	7.7	6.7	8.5	2.6	3.5	2.7	2.7	3.1
<b>Female Headed</b>	6.3	10.3	8.5	8.8	9	2.1	4	2.9	3.3	3.3
<b>Overall</b>	7.2	9.7	7.9	7.1	8.6	2.5	3.6	2.7	2.8	3.1

In 2013/2014, male-headed households across all states had higher average annual income than female-headed households. At the national level, female-headed households earned 9% less on average than male-headed households, but that differential varied significantly across states with male-headed households in Kosrae earning 2% more than female-headed households compared to a 42% differential in Chuuk. Breaking this down by income groups there isn't much of a difference between male- and female-headed households earning less than \$5,000 (37.4% of male households and 36.7% of female households), but the distribution of high-income households (>\$30,000) shows higher percentage of male-headed households (10.2% vs. 6.7%) (Table 2).<sup>19</sup>

**Table 2: Average Annual Income Males vs. Females HIES 2013/2014**

State	Average annual income
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<sup>18</sup> HIES Poverty Profile 2013/14; Available at: [https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2013\\_FSM\\_Poverty\\_Profile.pdf](https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2013_FSM_Poverty_Profile.pdf). The latest HIES was conducted in 2023, but the data are not currently available.

<sup>19</sup> HIES Main Analysis Report 2013/14; Available at: [https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2013\\_FSM\\_Poverty\\_Profile.pdf](https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2013_FSM_Poverty_Profile.pdf)

	Male (USD)	Female (USD)	Difference (USD)	Difference (%)
Yap	16,103	15,085	1,018	7%
Chuuk	8,858	6,197	2,661	43%
Pohnpei	17,033	15,517	1,516	10%
Kosrae	15,190	14,896	2,94	2%
FSM	13,311	12,208	1,103	9%

Source of income across male and female headed households is consistent for the most part, with the major differences being that male-headed households are on average 11% more based on cash income and female headed households saved 9% more than male headed households.<sup>20</sup> While the expenditures breakdowns for male- and female-headed households is pretty similar with food and non-alcoholic beverages accounting for 34.4% and 34.5% of monthly expenditures, respectively, there is a substantial difference in the level of expenditures with male-headed households spending on average 12% more than female-headed households.<sup>21</sup>

In the workforce, similar disparities exist. Across the States, 62.7% (Chuuk) to 70.3% (Pohnpei) of the male population 15+ years old were in the workforce with 51% of that labor force engaged in formal work and 48% engaged in home-based work (45% subsistence, 54% market-oriented). For females, only 43.3% (Chuuk) to 65.7% (Yap) of the population 15+ years old were in the workforce with 42% of that labor force engaged in formal work and 57% engaged in home-based work (58% subsistence, 41% market). Roughly a quarter of male and female households were employed in agriculture, but nearly 30% of females were employed in private households compared to just 10% of males. The other major differences are that 14% of males were employed in fishing compared to just 2% of females and 15% of males were employed in public administration compared to 9% of females. These differences highlight that income opportunities for females in FSM are limited compared to those for men, and the income activities available to women tend to be more home-based work, particularly for subsistence.<sup>22</sup>

The gender differentials in labor force preparticipation are further evident in the FSM Social Security Administration statistics. In 2016, women represented 39% of Social Security contributors in FSM, and on average women social security contributors had 11% lower annual average gross earnings than their male counterparts. While this ‘gender earnings gap’ has reduced substantially over the last 20 years (19% since 1997), it still highlights a significant issue to be

<sup>20</sup> HIES Main Analysis Report 2013/14 ; Available at: [https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2013\\_HIES\\_Main\\_Analysis\\_Report.pdf](https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2013_HIES_Main_Analysis_Report.pdf)

<sup>21</sup> Census 2010, Basic Tables; Available at: <https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2010-Basic-Tables.xlsx>

<sup>22</sup> Census 2010, Basic Tables; Available at: <https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2010-Basic-Tables.xlsx>

addressed for gender equality. At the state level, Chuuk social security contributors were 40% female and the earnings gap was about 14%. For Pohnpei, 38% women and an 8% gap; for Yap, 43% women and an 11% gap; and for Kosrae 36% women and 16% gap. The VNR noted that women are leading transformative change through civil society. In the civil society sector, the FSM Social Security data shows that women's participation is the same as men, and in addition they earn substantially more, on average, than men.

For education, women in FSM have significantly lower educational attainment than men. At the elementary school level 69% of females over 25 years and over in FSM have completed at least elementary school compared to 75% of males, but this differential is more pronounced in Yap and Kosrae where 90.2% and 90.9% of males, respectively have completed elementary school compared to only 68.5% and 78.8% of females, respectively. Overall, about 40% of males have graduate high school compared to just 31% of females, but that differential is also more drastic in Yap and Kosrae where 72.9% and 68.2% of men had graduated high school, respectively compared to 46.1% and 42.1% of women. The proportion of men with bachelor's degrees (5.3%) is also about double the proportion of women with bachelor's degrees (2.8%) at the national level (Table 3).

Further the 2012 Fertility Monograph for FSM further documents issues for gender inequality in FSM. In 2012, about 6% of women aged 15-19 years had given birth, a relatively high rate of teenage fertility. Overall, almost 100 births to women younger than 15 years of age were registered during the period 2000-2010, and another 1,061 births of women aged 15-17 years. The census data show that only a small proportion of teenage women who gave birth attended school which creates additional hardships and lack of income potential in the future for the young women.<sup>2324</sup>

In the 2016 Agricultural Census, most of the people aged 15 and over in households with land used for agriculture had not graduated from high school – 58 percent of males and 59 percent of females. Twenty percent of males and 21 percent of females reported that they had graduated from high school, and 12 percent of males and 11 percent of females reported some college but no degree.<sup>25</sup>

The FSM Education indicators Report for 2018/2019 highlights that in 2019, net enrollment in FSM schools is 82% in elementary level, whereas it is only 65% in ECE and 46% Secondary level and while boys' and girls' net enrollment is almost equal in elementary level, boys' NER is higher in ECE and girls' NER is higher in secondary level. In grade 1, gross intake rate is slightly higher for male students compared to female students, whereas in grade 8 female gross intake rate is substantially higher than male gross intake rate. Possible reasons for this variation by gender could be associated with late entry of male in grade 1, whereas higher GIR for females in grade 8 could be associated with repetition in elementary level. Most primary school survival rates throughout

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<sup>23</sup> Census 2010, Basic Tables; Available at: <https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2010-Basic-Tables.xlsx>

<sup>24</sup> Fertility Monograph 2012, Available at: [https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2012-Fertility\\_Monograph.pdf](https://www.fsmstatistics.fm/wp-content/uploads/2019/02/2012-Fertility_Monograph.pdf)

<sup>25</sup> FSM 2016 Agriculture Census; Available at: [http://www.fsmrd.fm/wp-content/uploads/2020/06/200120\\_FSM\\_IAC\\_2016.pdf](http://www.fsmrd.fm/wp-content/uploads/2020/06/200120_FSM_IAC_2016.pdf)

FSM are considered low with female students having slightly higher survival rates than male students. The data shows roughly ~45% (39% Male/50% Female) survival rate of cohort starting in Grade 1 and reaching Grade 8 and that same cohort starting in Grade 1 and reaching Grade 12 is very low at about ~20% (17% Male/25% Female).<sup>26</sup> These education gaps lead to less opportunities in the workforce for women as well as limited leadership/politics roles for women. For the specific project, it indicates that stakeholder engagement needs to be actively aware of and addressing these inequities in designing outreach, communications, and other strategies for the project. Further, women's interest groups, community groups, and civil society might require additional support, capacity development and coaching and mentoring to be able to fully and actively engage in the envisioned climate adaptation sub-projects.

*Table 3: Comparison of Educational Attainment 2010 Census<sup>27</sup>*

Group	Category	Total	Yap	Chuuk	Pohnpei	Kosrae
Male	Percent elementary school graduates	75.7	90.2	70.4	74.7	90.9
	Percent high school graduates	40.6	72.9	30.3	37.8	68.2
	Percent bachelor's degree	5.3	7.3	2.5	7.4	9.2
Female	Percent elementary school graduates	69.6	68.5	65.8	73.1	78.8
	Percent high school graduates	31.4	46.1	25.3	31.6	42.1
	Percent bachelor's degree	2.8	4	1.1	4.4	2.8
Overall	Percent elementary school graduates	72.6	78.9	68.1	73.9	84.8
	Percent high school graduates	36	58.9	27.8	34.7	55.1
	Percent bachelor's degree	4	5.6	1.8	5.9	6

<sup>26</sup> FSM Education Indicators 2018/2019; <http://national.doe.fm/index.php/ndoe-public/education-statistics/education-indicators/532-fsm-education-indicators-18-19>

<sup>27</sup> The 2020 census was not completed (likely due to the onset of the COVID-10 pandemic. Latest data is available on FSM Statistics website: <https://www.fsmstatistics.fm/social/population-statistics/>

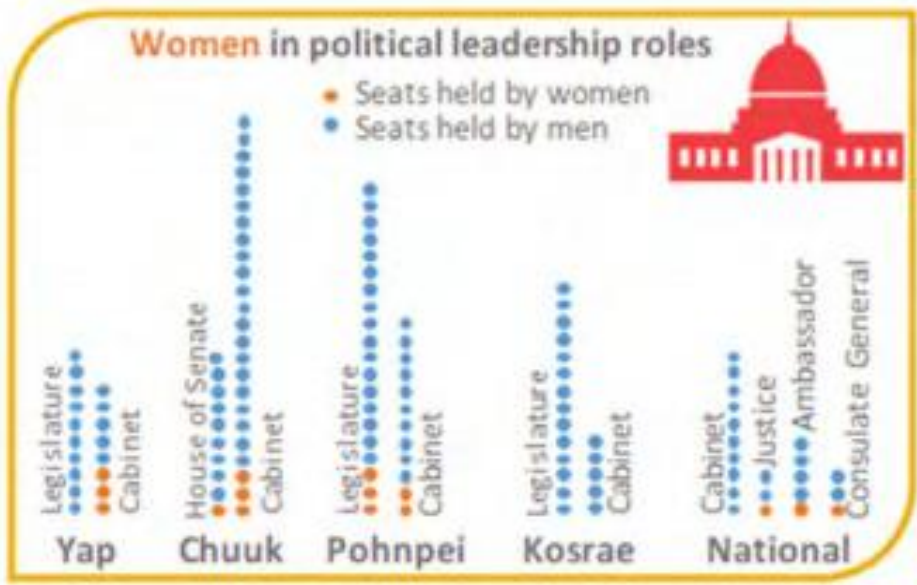
The SAP health project should recognize the prevalence of discrimination and unequal participation of females in technical and vocational education and training (TVET), and ensure women and girls are equitably represented in project activities and are recognized for their unique perspectives on the health and well-being of their families.

### Women in Public Life and Decision-Making

Until recently, women in FSM have been totally absent from the legislative and executive levels of government and continue to be significantly under-represented in civic affairs today. In 2020, there were three women serving as legislators in the Pohnpei State Legislature, and in Chuuk, there were two State female senators.

In the public service, some women have achieved seniority and are able to influence government policies and programs. Statistics show that of all the major formal work sectors (national and state government, private sector and civil society), it is civil society where women actually earn more on average than men.

**Table 4: Women in Political Leadership Positions in FSM States, 2020 Data**



Source: VNR Report, 2020

There are no legal barriers to women’s representation in government, but there are significant socio-cultural restrictions. Traditionally, matrilineal societies enable women to actively participate in decision-making processes related to family, community and natural resource matters, but for the speaker of the family is male, usually an uncle or brother. This SAP health project will ensure

the participation of women in the decision-making process for the project through representation on the project steering committee and by ensuring capacity support is provided to both women and men. The active participation of women is embedded in the Gender Action Plan (GAP) below as well as in the project's Stakeholder Engagement Plan (Annex 7).

### *Violence Against Women*

In October 2014, FSM conducted a National Family Health and Safety Study<sup>28</sup> which highlighted the major issue of violence against women in FSM including the following significant findings:

- Almost one in three ever-partnered women in the FSM (32.8%) have experienced physical and/or sexual violence by a partner at least once in their life and slightly over 18% of ever-partnered women have experienced sexual violence by a partner in their lifetime.
- Nearly one in four ever-partnered women (24.1%) experienced physical and/or sexual violence by a partner in the 12 months preceding the interview.
- Two in five women who ever experienced partner violence (41%) were injured at least once in their lifetime due to the violence.
- More than one in three ever-abused women (35%) never told anyone about the violence. Those who did disclose it mostly confided in family members and friends. 89% of ever-abused women never went to formal services or authorities, such as health centers or police, for support. The most common reason for not seeking support from formal services or authorities was that respondents thought the violence was normal or not serious.
- Almost 10% of all interviewed women experienced physical violence by a non-partner and the most common perpetrators were parents and other relatives.
- Children of women who experienced partner violence were almost three times more likely to have stopped or dropped out of school than children of women who never experienced partner violence.

Some key recommendations for FSM included that national and state level actions are implementing are to:

- Promote a multi-sectoral coordination between the health system and other public agencies (e.g., legislature, judiciary, public safety, social services) and private organizations (e.g., women's groups, NGOs, private health centers) to address VAW in a comprehensive manner.

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<sup>28</sup> FSM National Health and Safety Report; Available at: <https://pacific.unfpa.org/sites/default/files/pub-pdf/FSMFHSSReportweb.pdf>

- Create shelters and other social services institutions with health, counseling, and security staff adequately trained to serve abused women and children. Locate those shelters close by a respected local leader to provide further security to abused women and children from the abusers.
- Develop workshops for parents about parent-children relationships, gender roles, and gender equality.
- Promote the passing of the Family Protection Act in Chuuk, and Yap.
- Give funding priority to existing government programs aimed at addressing violence against women, such as the Domestic Violence Unit and the training program for police officers on domestic violence.

### *Sexual Exploitation Abuse and Harassment (SEAH)*

Given the current baseline in FSM, women are at greater risk for experiencing sexual exploitation, abuse and harassment (SEAH) within the workplace in particular.

While the overall risk of SEAH in FSM is higher than other countries, within the context of the proposed project, the overall level of risk pertaining to violence against women and gender-based violence (GBV) during project implementation has been assessed to be low. Supporting communities to increase their resilience to climate-related FBDs, WBDs and VBDs as well as building their capacity to manage associated health burdens the specific interventions of the project will help to decrease the overall risk of GBV and SEAH for women living in the targeted communities. The project has also established a number of provisions to mitigate any such risks as well as to support survivors of both GBV and SEAH resulting from or related to the project. These are integrated in the gender action plan (see section below) and outlined here.

First, the project will establish a robust grievance and redress mechanism that will be managed by SPC as the AE and is in line with SPC's policies to prevent sexual harassment and assault in the workplace (<https://bit.ly/3IXfHvL>). The grievance mechanism will allow victims of SEAH and GBV to anonymously report their claim and experiences. The grievance and redress mechanism will include both access to the GCF's independent redress mechanism, as well as one that is specific for the project. Its development will be informed and advised by the GESS expert to ensure that there are provisions and procedures in place for diligent accounting for and follow-up regarding GBV and SEAH-specific grievances. More detailed information regarding the project's grievance mechanism can be found in Annex 12.

To address issues of women's disenfranchisement and empowerment in the workplace (which contributes to SEAH specifically), the project plans to allocate a specific number of women-only and women-specific training opportunities. This will help to ensure that they are actively engaged

in project implementation and viewed as equals by both the project implementation team, as well as the target beneficiaries and communities, thereby reducing their risk of experiencing GBV.

Finally, as part of SPC's policies training on SEAH will be mandatory for all project staff, contractors, and consultants.

### *Comparison to the Region*

Compared to other nations in the Pacific, FSM is lagging in many gender indicators (as collected by the SPC NMDI initiative<sup>29</sup>), particularly representation of women in parliament, female participation in the labor force, and proportion of women employed in a non-agriculture sector (Table 5).<sup>30</sup>

*Table 5: Overview Comparison of Gender Indicators for Pacific Island Countries*

Indicator	Cook	FSM	Fiji	Kiribati	RMI	Nauru	Niue	Palau	PNG	Samoa	Solomons	Tokelau	Tonga	Tuvalu	Vanuatu
Women Representation in Parliament HD-GEN-1.1 MDG.3.3	17 2014	0 2016	16 2016	7 2016	9.1 2016	5.3 2016	10 2016	0 2016	2.8 2014	10 2016	2 2016	15 2011	3.6 2016	7 2016	0 2016
Govt Budget Allocated to Women's Department (% Recurrent) HD-GEN-1.4	0.3 2011-12	0 2004	0.1 2014	0.1 2014	0 2015	0.1 2010-11	0.1 2011-12	0 2014		2 2013-14	0.7 2014		0.1 2014-15	0.7 2014	0.7 2010
Tertiary Education Completion Rate HD-GEN-1.7	13.1 2016	9.1 2013		4 2015	2.3 1999	3 2013	3.3 2001	16.2 2015		13.9 2013	6 2015	19.8 2016	17.5 2016	13.7 2016	4.7 2013
Female Labor Participation Rate HD-GEN-1.8	58.4 2016	36.2 2013	37.4 2017	55.8 2015	35.4 1999	52.7 2013	63 2016	74.3 2015	60.5 2011	43.5 2013	71 2013	63.2 2016	41.9 2016	35.4 2016	85.7 2016
Female-Male Labor Participation Ratio HD-GEN-1.9	0.8 2016	0.6 2013	0.5 2017	0.8 2015	0.5 1999	0.7 2013	0.8 2016	0.9 2015	1 2011	0.6 2013	0.9 2013	0.8 2016	0.8 2016	0.6 2016	1 2016
Female-Male Employment Ratio HD-GEN-1.10	0.8 2016	0.5 2013		0.7 2015		0.6 2013	0.8 2016	0.8 2015	1 2011	0.6 2013	0.8 2013	0.7 2016	0.5 2016	0.5 2016	0.6 2016
Women Employed in a Non-Ag Sector HD-GEN-1.11 MDG.3.2	48.8 2016	33.1 2013	34 2007	44.7 2015	36.7 2011	37.4 2013	49.3 2016	48.7 2015	32.1 2000	38.5 2013	65.5 2015	44.5 2016	46.3 2016	36.4 2016	41.3 2009
Prevalence of Violence Against Women HD-GEN-1.12	33 2014	33 2014	64 2013	68 2010	51 2014			25 2014	65 2010	65 2006	64 2009		40 2012	45 2007	60 2011
Attitudes VAW HD-GEN-1.13				76 2010	56.5 2007					55.7 2009	65.8 2015		26.4 2012	71 2007	59.8 2013

<sup>29</sup> SPC NMDI Initiative; Available at: <http://www.spc.int/nmdi/gender>

<sup>30</sup> Not all of the indicators align with other reported numbers utilized in the baseline for FSM, but the standardized numbers across countries provide a good framework for regional comparison.

## *Gender, Health, Climate and Water, Food, & Vector-Borne Diseases*

FSM developed a National Climate Change and Health Action Plan (NCCHAP). Developed in 2012, with support from the World Health Organization, this action plan details climate sensitive health risks in FSM, along with related climate change and health needs and adaptation strategies. While being quite comprehensive, it is unclear whether any progress-reporting has been undertaken on this plan since its development. A gap analysis of some of the policy, human capacity, interdisciplinary collaboration and health information systems and associated recommendations from stakeholder consultations and in-country documentation is included as part of the NCCHAP.<sup>31</sup> As part of that gap analysis, one of the identified gaps was that “Gender-sensitivity and disability inclusiveness is not currently being addressed adequately in climate change programs, projects and activities that focus on the health impacts of climate change due to VBD, WBD and FBD.” The recommendation was to better coordinate with women’s groups and contact points for persons with disabilities to determine the projects to alleviate the health impacts of climate change due to VBD, WBD and FBD.

Climate conditions affect the rates of diseases from unclean water and food including through rising temperatures, changes in rainfall patterns, and availability of water, all of which are likely to shift and lengthen the periods during which vector-borne diseases are spread.<sup>32</sup> The impact of these diseases on women and men is likely to be different. For instance, the risk of malaria will increase with rising temperatures due to climate change, and risk of malaria infection for pregnant women doubles due to their changed physiology, which makes them more susceptible to mosquitoes.<sup>33</sup> Maternal malaria can cause miscarriage, stillbirth, premature birth, and low birth weight.<sup>34</sup> Dengue virus is also associated with increased risk of caesarean delivery, eclampsia and growth restriction.<sup>35</sup>

Through heavier precipitation and increased drought incidents, climate change also increases the risk of WBDs. Water scarcity forces the provision of water from sources that may be biologically and toxicologically contaminated, resulting in bacterial, viral and protozoan infections as well as exposure to toxins. Those most at risk of severe illness and death from WBDs include infants, young children, pregnant women, older adults, and people with chronic disease and/or weakened immune systems.<sup>36</sup>

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<sup>31</sup> Annex E: Climate Change and Health Needs and Adaptation Strategies for FSM, from the NCCHAP, pgs. 21-25.

<sup>32</sup> FAO, 2008. [Climate Change and Food Security in Pacific island Countries](#). Last Accessed 19 Feb. 22

<sup>33</sup> *Ibid.*

<sup>34</sup> WHO, 2011. [Gender, Climate Change, and Health](#). Last Accessed 19 Feb. 22

<sup>35</sup> Pouliot, S. H., Xiong, X., Harville, E., Paz-Soldan, V., Tomashek, K. M., Breart, G., & Buekens, P. (2010). Maternal dengue and pregnancy outcomes: A systematic review. *Obstetrical & Gynecological Survey*, 65(2), 107–118. <https://pubmed.ncbi.nlm.nih.gov/20100360/> Last Accessed 19 Feb. 22

<sup>36</sup> Centers for Disease Control (CDC), 2020. <https://www.cdc.gov/healthywater/global/WASH.html> Last Accessed 19 February 2022.

## *Stakeholder Feedback on Gender Aspects*

Stakeholder consultations solicited feedback on gender dimensions related to the health sector across FSM. Participants were asked *inter alia* questions about primary caregivers within households, to provide information on informal health providers within communities such as traditional caregivers, and to provide input on the women's groups and organizations serving youth and PWDs that should be consulted as part of the project development process. From the discussions across the four States, a number of relevant women's groups were identified to further discuss gender issues as they relate to the proposed project. These include four women's groups, one from each State: Chuuk Women Council, Kosrae Women Association, Pohnpei Women Council and Yap Women Association. These groups were included in the State-level stakeholder discussions and were reached out to through consultations in the development of the full project proposal. Feedback from stakeholders made it clear that women, youth, and other marginalized groups should be prioritized to the extent possible through the activities that target communities, most notably those activities associated with outputs 3.2 and 3.3 of the current proposal.

Elements identified by stakeholders include the following:

- Local government and NGO's should work with State agencies for adaptation projects to prevent project duplication and to collaborate but not compete with each other.
- Projects specifically targeting gender have been ongoing in FSM and the capacity for undertaking gender-specific work can be built upon by the SAP Health project. Examples of such projects include the following:
  - The Australian Government, through *Pacific Women*, has committed approximately USD 1.4 M over 10 years (2012–2022) on initiatives to support women's empowerment in FSM.<sup>37</sup> The funding provided has enhanced the capacity of key organizations that the current proposal can build upon including the Chuuk Women's Council as well as the FSM government and support for growing women's micro-enterprises.
  - The Indian Government has funded a USD 1 M project (2020-2023), implemented by UNDP, to *Strengthen the Gender Machinery of FSM*.<sup>38</sup> The project aims to mainstream gender in sectoral plans and to build the capacity of the government to manage and monitor gender responsive policies/legislation. The current proposal should coordinate with this project to utilize and support further strengthening of capacity generated around gender.

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<sup>37</sup> <https://pacificwomen.org/our-work/locations/federated-states-of-micronesia/>

<sup>38</sup> <https://info.undp.org/docs/pdc/Documents/H04/FSM%20strengthening%20gender%20machinery.pdf>

- Women, mothers in the communities, youth groups, senior citizens, LGBTQ+ groups, outer island communities, persons with disability, and low-income households should be incorporated into project implementation.
- NGOs to engage include the Pohnpei Women's Council, Chuuk's Women's Council, Yap Women's Association, Neighboring Islands Women's Association, Tamil Women's Association, and the Kosrae Women's Association.

### *Gender Analysis and Recommendations*

The examples provided in the last section, demonstrate the ways in which climate change could impact human health based on gender as well as impacts on other vulnerable groups. The relationships between these issues are highly relevant for the Pacific region, including for FSM. Long-term social and economic development will neither be effective nor sustainable unless measures to address climate change, and health problems include clear strategies for promoting gender equality and women's empowerment.<sup>39</sup>

The vulnerabilities that different and diverse groups of women in the FSM face are intersectional. For instance, elderly women and persons with disability, particularly those living in remote, rural, and/or coastal areas (compared to those based in urban communities) are far more likely to be at risk from exposure to vector-borne, food-borne, and/or water-borne diseases; are far less likely to have access to quality and sufficient health services to prevent and/or mitigate exposure to V/F/WBDs; and due to underlying socioeconomic conditions and barriers, are overall less likely able to access resources (e.g. mosquito nets, rainwater tanks, equipment to enhance individual and/or community protection to disease, etc.). Sociocultural norms such as gender-specific caste systems within some of the FSM States present an additional layer of complexity, as these are valued customs and traditions within which women must navigate their lived experiences. Implications on limited access to climate- and health-related resources, information, and/or services vary along these differentiated lines. A more detailed intersectional gender analysis expounding on this preliminary assessment will be reflected in the Vulnerability and Capacity Assessment (VCA), taking into account per-State contexts.

It is also evident that in addition to health data being outdated, the data that does exist does not include demographic distinctions. Moving forward, it will be important to ensure that any data collection or system to track specific health metrics includes a tagging system for disaggregating indicators by sex, age, and other vulnerability markers.

The project aims to ensure that Pacific women in all their diversity are meaningfully engaged in technical training in F/V/WBD prevention and, as much as possible, represented and able to participate in decision-making in climate and health decisions that affect their own lives. This

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<sup>39</sup> UN Women, 2015. [Climate change, Gender, and health in the Pacific](#). Last Accessed 19 Feb. 22.

approach of non-tokenistic involvement is designed to allow women to advocate for their overall access – to healthcare services, to relevant preventative information on F/V/WBD, in their own spheres of influence. In the same way, the project adopts and applies an intersectional analysis to its design and implementation, recognising that the outcome (or, ‘burden’) of change is not solely dependent on women and is facilitated through holistic structural and/or systemic change.

Recommendations for the FSM’s SAP health project include the following:

- Through the research that will lay the groundwork for developing a Health National Adaptation Plan (HNAP) – the research undertaken should include the need to understand how climate change is impacting women’s and men’s health to ensure any policy formation addresses the needs of all members of society (Activities 1.1.1, 1.1.2, and 1.2.1).
- Given the unique situation of Pacific regional realities, the collection of new data should be disaggregated by sex, age and disability status, location and analysed to promote research and policies related to disease incidence and patterns. This information can be used to improve planning and response for the likely health impacts of climate change (across all three components).
- Additional resources should be put into the water and sanitation needs of FSM, which will be increasingly affected by droughts, flooding and rising sea levels. This is particularly true for the smaller, low-lying, atolls. As proposed by stakeholders, women, mothers in the communities, youth groups, senior citizens, LGBTQ+ groups, outer island communities, persons with disability, and low-income households should be consulted and considered, to ensure these investments equally benefit women, men, youth and other vulnerable groups (Outcome 3).
- Women in the Pacific generally and FSM specifically, have intimate knowledge of their environment and are often caregivers for their families and the sick. Women should therefore be an integral part of all decision-making on health system strengthening, and responses to emerging diseases and health issues resulting from climate change (across all three outcomes).
- Increasing illnesses erupt due to unusual weather events that are related to the effects of overall climate change (slowly increasing temperatures, rising sea levels and king tide events, heightened incidences of drought) in addition to seasonal communicable disease incidence patterns. Baseline data disaggregated by gender, age and other vulnerability categories for climate-related disease categories is lacking. The current proposal has a critical role to play in collecting this information through its stakeholder engagement and coordination with other past projects. Establishing more effective baselines for gender

inequality will help to better target interventions going forward and support the sustainability of gender-balanced results (Outcomes 2 and 3).

- Women can provide critical inputs to effectively tailor, mitigate and manage climate-related VDBs, WBDs and FBDs. The project must therefore empower women to contribute their skills and knowledge through direct consultation and forums to ensure their knowledge can be successfully integrated (across all three outcomes).

Both the ability to access information and the ways in which information is accessed are likely to be different for women (i.e., access to mobile communication), so in designing dissemination systems for HIEWS, the project will need to ensure that women have an equal pathway to utilizing the available information (Outcome 2). These recommendations will be integrated into the project's overall logical framework, implementation arrangements, and stakeholder engagement processes through all relevant parts of the proposal including the full proposal and associated annexes.

## Gender Action Plan

The following GAP works proactively to address the recommendations and baseline inequities highlighted in the above sections. It contains specific gender-responsive elements to be considered in the project design and during the implementation of its activities, in order to ensure effective gender and equity outcomes related to health risks due to climate change. The GAP is closely aligned to the outputs of the logical framework and proposed activities. The GAP also complements the Environment and Social Safeguards - Annex 12, which highlights the project as being Risk Category C.

Gender expertise will be provided throughout project implementation in cooperation with SPC as the accredited entity. In particular, the project will work closely with FSM DHSA's GDO. The Project Management Unit (PMU) will be responsible for ensuring this engagement and the project will include a Gender and Environmental and Social Safeguard (GESS) Officer. The National Project Steering Committee (NPSC) will engage gender expertise through the GESS Officer and can make use of SPC's in-house gender expertise (funded through co-finance from SPC). Specific discussions on the gender dimension of different activities of the project will be part of the NPSC's meeting agenda and the NPSC will review periodically progress against the GAP.

As mentioned above, the project will include dedicated gender capacity support during implementation to properly carryout and monitor the GAP. The dedicated support, throughout the life of the project, will also be provided to women's groups and government gender officials to incorporate a gender-lens in the decision-making processes and design of policies and strategies that respond to the emerging diseases and health issues resulting from climate change. The GESS Officer is the dedicated resource for consultation under GRA 2.1.1. Supplementary in-house technical capacity in GESI is also available within SPC – as Accredited Entity (AE), SPC's Climate Change and Environmental Sustainability Division employs a GESI and ESS Adviser within the Climate Finance Unit; as Executing Entity (EE), SPC's Public Health Division employs a GESI and Health Adviser; finally, SPC's Human Rights and Social Development Division provides GEDSI surge support upon request.

While the risk of increased gender-based violence (GBV) and sexual exploitation, abuse and harassment (SEAH) is low, the project will strictly adhere to SPC's zero tolerance policy for sexual harassment, all project personnel, contractors, and contracts for any hired consultants will include provisions on SEAH as well as training to deal and mitigate SEAH and GBV issues. The project will also include a robust grievance and redress mechanism that includes specific provisions for reporting SEAH and will be managed by SPC as the AE and is in line with SPC's Whistle-blower Protection Policy and Procedure (see Annex 12 for details). To address issues of women's disenfranchisement and empowerment in the workplace

(which contributes to SEAH specifically), the project will allocate women-only and women-specific training opportunities (see below). This will help to ensure that they are actively engaged in project implementation and viewed as equals by both the project implementation team, as well as the target beneficiaries and communities, thereby reducing their risk of experiencing GBV and SEAH.

### ***Implementing Roles and Responsibilities for Gender Mainstreaming***

The various entities involved in the SAP Health project are all responsible for ensuring gender mainstreaming and the effective execution of the gender action plan, but each has unique and complementary roles and responsibilities as summarized below:

- **SPC Accredited Entity (AE):** the AE functions will be undertaken by the Climate Change and Environment Sustainability Programme (CCES), which hosts the Climate Finance Unit (CFU) which is SPC's focal point to the GCF. SPC as the AE is responsible for overall compliance with SPC policies towards social and environmental responsibility, GCF Revised Environmental and Social Policy and any required monitoring/reporting to GCF. SPC will also issue tenders for any needed technical support from contractors and will ensure that contractors have appropriate gender and environmental and social expertise. SPC has in-house gender expertise that will be used as needed to support implementation and ensure the GAP is followed. SPC is ultimately responsible for ensuring that the project is implemented in alignment with FSM's national and state gender strategies and the GCF Gender Policy.
- **FSM Department of Health and Social Affairs (DHSA)** – DHSA will be the national government focal point for the project and house the PMU (see below). The GDO as part of the DHSA will be actively consulted during implementation.
- **SPC Public Health Division: (PHD):** Executing entity (EE) for the project.
- **SPC Micronesia Regional Office (MRO):** The SPC MRO will support the recruitment of staff. The PMU will be recruited by the SPC MRO and will be embedded in the FSM DHSA.
- **National Project Steering Committee (NPSC):** – The NPSC will oversee project implementation and review annual work plans and project reports. This will include ensuring that the GAP is being followed and implemented. The NPSC will ensure gender balance and will include a representative for each of the four FSM states to reinforce the country-driven, federal approach. The NPSC will be supported by the GESS officer and can seek support from SPC's in-house gender expertise as needed.

- **Project Management Unit (PMU)** – The PMU will be recruited by SPC MRO and ensure that the project consults and interact with Sate-level gender groups/community groups, which have a strong track record across FSM. The PMU will be supported by the GESS officer and as with the NPSC can request support from SPC’s in-house gender expertise as needed.
- **Gender and Environmental and Social Safeguard (GESS) Officer:** The GESS will be responsible for implementing the gender action plan and will provide oversight and quality review to ensure gender elements are integrated into all studies, assessments, policy development, and training. The GESS officer has been budgeted within the following activities of the project log frame: 1.1.1, 1.1.2, 1.2.1, 1.2.3, 2.1.2. 2.1.3, 3.1.1. 3.1.2, 3.2.1.

The overall gender action plan for the SAP Health project is detailed in Table 6 below.

**Table 6: Project Gender Action Plan**

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
<b>Impact Statement:</b> To increase the resilience of women, men and other vulnerable groups in FSM to the increased risks of vector-, water-, and food-borne diseases due to climate change						
Gender balanced representation and participation in NSC and across decision making throughout implementation  <i>All Outcomes</i>	Equally involve men and women government staff, NGO representatives, policymakers, staff, and health service providers in decision making processes	Number of men and women government staff, NGO representatives, policymakers, staff, and health service providers involved in decision making	<b>Baseline:</b> N/A  <b>Target:</b> 50% men and 50% women representation/ participation; and 50% women/men reporting they feel they have meaningfully	Year 1	<u>Parties:</u> SPC, PMU GESS Officer, PMU, GDO  <u>Means of Verification:</u> Meeting roster list and minutes, reports from GESS Officer	No additional cost implications

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
			participated in decision making			
<b>Outcome 1: 1. Relevant policies, systems, processes and guidelines are institutionalized in the FSM for effective adaptation response to climate change-related vector-, water- and food-borne diseases</b>						
<u>Output 1.1</u> The relevant stakeholders are informed of baseline situation of climate change vulnerability on health and adaptation response capacity of the four states of FSM (from logframe Annex 2a)	1.1. Vulnerability and capacity assessment process include gender and marginalized group-specific projections/ impacts	1.1.1 Baseline assessments updated with gender- and socially marginalized group projections/impacts	<p><b>Baseline:</b> gender- and socially marginalized group assessments not integrated into vulnerability and capacity assessment processes</p> <p><b>Target:</b> Gender and socially marginalized group- specific assessments integrated into vulnerability and capacity assessment processes</p>	Year 1 and ongoing	<p><u>Parties:</u> SPC, GESS Officer, GDO, Health service professionals</p> <p><u>Means of Verification:</u> GESS Officer review of vulnerability and capacity assessments to ensure integration of gender in preparation phase</p>	Costs included in costs for policy development (ToR to include specific consideration of gender & marginalized group projects)
<u>Output 1.2:</u> FSM's health sector has access to recommended policy papers and enhanced technical capacity to effectively manage	1.2.1 Analysis of gender impacts to manage FBDs, VDBs, and WBDs undertaken and incorporated	1.2.1 Health impacts based on gender and other vulnerable groups identified	<p><b>Baseline 1.2.1:</b> N/A</p> <p><b>Target 1.2.1:</b> Gender and age disaggregated data and information collected and available</p>	Year 1 and ongoing	<p><u>Parties:</u> SPC, GESS Officer, GDO, Health service professionals</p> <p><u>Means of Verification:</u> Drafts of reports, minutes/roster from</p>	Included in cost for development and implementation of training (ToRs to include development of

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
FDBs, VDBs, and WBDs (from logframe Annex 2a)					consultations, review report from GESS, pre- and post-training surveys	gender module and analysis of gender impacts)
<u>Output 1.2:</u> FSM's health sector has access to recommended policy papers and enhanced technical capacity to effectively manage FDBs, VDBs, and WBDs (from logframe Annex 2a)	1.2.2 Incorporate gender mainstreaming module into trainings	1.2.2 Gender module incorporated into trainings and workshops	<b>Baseline 1.2.2:</b> 0 <b>Target 1.2.2:</b> 1 gender module developed and given with technical trainings	Year 1 and ongoing	<u>Parties:</u> SPC, GESS Officer, GDO, Health service professionals  <u>Means of Verification:</u> Drafts of reports, minutes/roster from consultations, review report from GESS, pre- and post-training surveys	Included in cost for development and implementation of training (ToRs to include development of gender module and analysis of gender impacts)
<u>Output 1.2:</u> FSM's health sector has access to recommended policy papers and enhanced technical capacity to effectively manage FDBs, VDBs, and WBDs (from logframe Annex 2a)	1.2.3 Ensure gender-balanced participation and opportunities in sensitization workshops trainings (Activity 1.2.3 in logframe)	1.2.3.1. Number of men and women trained in training and sensitization workshops to increase operational readiness of health and climate change policies and action plans at national	<b>Baseline 1.2.3:</b> 0 <b>Target 1.2.3:</b> 50% women and 50% men trained <sup>40</sup>	Year 1 and ongoing	<u>Parties:</u> SPC, GESS Officer, GDO, Health service professionals  <u>Means of Verification:</u> Drafts of reports, minutes/roster from consultations, review report from GESS, pre- and post-training surveys	Included in cost for development and implementation of training (ToRs to include development of gender module and analysis of gender impacts)

<sup>40</sup> For sensitization workshops nurses, doctors and other technicians in the medical field will be trained. The number of men and women working in these positions is closer to a 50/50 breakdown than other areas. While men make up the majority of doctors, women make up the majority of nurses.

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
		and state level (Activity 1.2.3)  1.2.3.2. Number of health service personnel reported better understanding of the VCA processes				
<u>Output 1.2:</u> FSM's health sector has access to recommended policy papers and enhanced technical capacity to effectively manage FDBs, VDBs, and WBDs (from logframe Annex 2a)	1.2.4 Opportunities for women-only training provided	1.2.4 Provide women-only training	<b>Baseline 1.2.4:</b> 0  <b>Target 1.2.4:</b> At least 1 women-only sensitization training provided	Year 1 and ongoing	<u>Parties:</u> SPC, GESS Officer, GDO, Health service professionals  <u>Means of Verification:</u> Drafts of reports, minutes/roster from consultations, review report from GESS, pre- and post-training surveys	Included in cost for development and implementation of training (ToRs to include development of gender module and analysis of gender impacts)
<b>Outcome 2: The Health Information Early Warning System becomes effective in supporting timely planning and responding to climate change sensitive diseases in FSM.</b>						
<u>Output 2.1:</u> Technologies, Procedures, and Capacities for an Effective and Timely	2.1.1 Consult with gender experts, relevant policy makers and women's groups on design of data systems and needs for	2.1.1 Number of consultations with relevant policy makers, gender	<b>Baseline:</b> N/A  <b>Target:</b> at least 4 consultations; 2 prior to development and 2 for validation of HIEWS	Year 1 and ongoing	<u>Parties:</u> SPC, PMU GESS Officer, GDO, Women's groups	GESS Officer (Total: USD 182,500)

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
HIEWS Operation Established	gender and age disaggregated data	experts, and women's groups			<u>Means of Verification:</u> Data platform, metadata, review report from GESS Officer, pre- and post-training surveys	
<u>Output 2.1:</u> Technologies, Procedures, and Capacities for an Effective and Timely HIEWS Operation Established	2.1.2 Integrate gender and age disaggregated data streams into HIEWS	2.1.2 Gender and age disaggregated indicators and data streams available	<b>Baseline:</b> Gender and age disaggregated data streams for HIEWS not currently available  <b>Target:</b> Gender and age disaggregated data and information collected and available.	Year 1 and ongoing	<u>Parties:</u> SPC, PMU GESS Officer, GDO, Women's groups  <u>Means of Verification:</u> Data platform, metadata, review report from GESS Officer, pre- and post-training surveys	GESS Officer (included under Output 2.1)
<u>Output 2.1:</u> Technologies, Procedures, and Capacities for an Effective and Timely HIEWS Operation Established	2.1.3 Ensure gender-balanced participation and opportunities on operational and technical aspects of the HIEWS	2.1.3.1. Number of men and women trained on operational and technical aspects of the HIEWS on a national and state level (Activity 2.1.3)	<b>Baseline:</b> 0  <b>Target:</b> 40% women and 60% men trained <sup>41</sup>	Year 1 and ongoing	<u>Parties:</u> SPC, PMU GESS Officer, GDO, Women's groups  <u>Means of Verification:</u> Data platform, metadata, review report from GESS Officer,	GESS Officer (included under Output 2.1)

<sup>41</sup> Through stakeholder consultations (see Summary Annex I) the number of men in the field of the health sector in general is close to 70% versus 30% women. The project will therefore oversample women to ensure a larger proportion of women gain technical knowledge in this area.

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
		2.1.3.2. Number of women and men reported better understanding of operational and technical aspects of the HIEWS on a national and state level			pre- and post-training surveys	
<b>Component 3: Communities have increased resilience to climate-related vector-, water- and food-borne as well as capacity to manage associated health burdens</b>						
Output 3.1: Adaptation interventions to prevent the spread of FDBs, VBDs and WBDs implemented in selected communities	3.1.1 Ensure gender-balanced participation for selected adaptation interventions	3.1.1 Number of female-headed households (HHs) with installed adaptation interventions	<b>Baseline:</b> N/A  <b>Target:</b> at least 30% of selected HHs are female-headed <sup>42</sup>  VCA research methods evaluated (1-3 in terms of effective gender-specific considerations. <sup>43</sup> )	Year 3 and ongoing	<b>Parties:</b> SPC, PMU, GESS Officer, GDO, Health services professionals  <b>Means of Verification:</b> Tracking of beneficiaries	Cost incorporated into cost of installing adaptation interventions

<sup>42</sup> As indicated in table 1 of the gender analysis above 20% of total HHs across FSM are female-headed. The project will therefore oversample female headed HHs as they tend to be more vulnerable and suffer from greater incidence of poverty.

<sup>43</sup> 1 = not effective; 2= partially effective; 3= fully effective

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
Output 3.1: Adaptation interventions to prevent the spread of FDBs, VBDs and WBDs implemented in selected communities	3.1.2. Conduct operation and maintenance training for local water committees (e.g. plumbing + water committee training) and handover ceremony	3.1.2. Percentage of total key personnel of local water committees trained that are women	Baseline: N/A  Target: 50% of total key personnel of local water committees trained are women	Year 3 and ongoing	<u>Parties:</u> SPC, PMU, GESS Officer, GDO, Health services professionals  <u>Means of Verification:</u> Tracking of beneficiaries	Cost incorporated into cost of installing adaptation interventions
Output 3.2: Community awareness and prevention communications consolidated and distributed among key community stakeholders	3.2.1 Assess means in which women and men access or could access health information to enable ease-of-use for both genders, taking into account social norms that may be reflected in institutional settings	3.2.1 Gender assessment conducted with recommendation of concrete actions to ensure that the information products, education and communications materials integrated as part of output 3.3 are gender responsive.	<b>Baseline:</b> 0  <b>Target:</b> 1 gender assessment conducted	Year 3 and ongoing	<u>Parties:</u> SPC, GESS Officer, PMU  <u>Means of Verification:</u> GESS notes/report, pre- and post-training surveys	Costs incorporated into public awareness campaigns and trainings

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
Output 3.2: Community awareness and prevention communications consolidated and distributed among key community stakeholders	3.2.2 Level of gender integration in information products, and various information, education, and communications materials. Information products and information, education and communications materials will be gender-responsive and tailored to the varying needs and capacities of different end-users (e.g., language requirements, literacy levels, level of access to communications assets, etc.).	3.2.2 Extent/level of integration	<b>Baseline:</b> 0  <b>Target:</b> Gender-sensitive design criteria are fully integrated into (scale of 1-3) <sup>44</sup>	Year 3 and ongoing	<u>Parties:</u> SPC, GESS Officer, PMU  <u>Means of Verification:</u> GESS notes/report, pre- and post-training surveys	Costs incorporated into public awareness campaigns and trainings
Output 3.2: Community awareness and prevention	3.2.3 Ensure gender-balanced participation and opportunities in	3.2.3.1. Number of women and men	<b>Baseline:</b> 0	Year 3 and ongoing	<u>Parties:</u> SPC, GESS Officer, PMU	Costs incorporated into public awareness

<sup>44</sup> 1 = not integrated; 2= partially integrated; 3= fully integrated

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
communications consolidated and distributed among key community stakeholders	training to vulnerable communities for prevention and response (Activity 3.2.1 logframe)	<p>trained for prevention and response</p> <p>3.2.3.2. Number of women and men reported better understanding of prevention and response for climate-sensitive diseases</p> <p>3.2.3.3. Women-only training provided</p>	<p><b>Target:</b> 50% women and 50% men trained</p> <p><b>Baseline:</b> N/A</p> <p><b>Target:</b> At least 1 women-only training provided</p>		<p><u>Means of Verification:</u> GESS notes/report, pre- and post-training surveys</p>	campaigns and trainings
Output 3.3. Monitoring, Evaluation, and Learning (MEL) framework established, and lessons learned disseminated to enhance climate-sensitive disease management.	3.3.1 MEL protocol includes procedures for monitoring and evaluating GAP	<p>3.3.1.1 Procedures for tracking GAP implementation included in MEL</p> <p>3.3.1.2 Evaluation includes an assessment of gender integration</p>	<p>Baseline: NA</p> <p>Target: 1 MEL framework with procedures for tracking GAP included</p> <p>Baseline: NA</p> <p>Target: 1 ToR for evaluation (mid-term and final) with an</p>	Year 1 and ongoing	<p><u>Parties:</u> SPC, GESS Officer, PMU</p> <p><u>Means of Verification:</u> Review of MEL</p>	Costs incorporated into MEL protocol design

Objective (related log-frame activities)	Gender-Responsive Action	Gender-Responsive Indicators	Baseline and Targets	Timeline	Responsible Parties and Means of Verification	Allocated Budget (USD)
			assessment of the project's quality of gender integration			
<b>Project Management:</b> Strengthen the technical and institutional capacities of the project team on the gender dimension and conduct SEAH training						
Technical and institutional capacities of the project team on gender dimensions of health are increased	Recruit a gender and environmental and social expert	A gender specialist recruited as soon as possible, at project inception	<b>Baseline:</b> N/A <b>Target:</b> 1 GESS Officer hired	Year 1	SPC, PMU	GESS Officer (Total: USD 182,500)
Project staff and key stakeholders all trained in SEAH	SEAH training for all personnel associated with programme	# of persons trained	<b>Baseline:</b> N/A <b>Target:</b> Percentage of project personnel , contactors, consultants and oversight committees (i.e. NPSC) that completed PSEAH training that are women	Year 1 and ongoing	SPC, PMU, GESS Officer	GESS Officer (Total: USD 182,500)

## Annex I – Summary Consultations

### Inception Workshop Consultations

An inception workshop convened on November 2, 2021, commenced the consultation and engagement process with stakeholder agencies. The workshop was conducted by SPC, E Co. and Palikir Consultants and involved the participation of key players including the FSM GCF National Designated Authority (NDA), DHSA, DECEM, FSM Overseas Development Assistance (ODA), World Health Organization (WHO), SPC, United States Agency for International Development (USAID) as well as state government representatives. The workshop was facilitated by Palikir Consultants – with two working groups one on co-financing and the second on stakeholder mapping. For the working groups, discussions were held separately for State-level focal points and the national government and international partners. There was a considerable amount of overlap in the responses, which demonstrates cohesion across the country in-terms of the stakeholders that should be targeted for the Health-SAP.

In terms of the stakeholders, who will be affected by the project, all groups noted that this project will affect citizens at the community level. They specifically listed Municipal Governments, Women's Groups, Youth Groups, Church Groups, Farmers and Fishers (producers), Consumer Organizations (disabled persons groups), Private Sector/Business Community, State Governments, and Traditional Leaders.

With regards to stakeholders that may influence the project, the State-level focal points identified the following groups: traditional leaders, landowners, elected officials (government), project partners, private sector entities, NGOs and other development partners. In addition to these, participants also listed schools, Civil Society Organizations, state legislatures, youth groups, church and women's groups, and local communities as people who might be useful project partners even though the project may also be implemented without their contributions.

Groups that were identified to be prioritized through project implementation were: women, mothers in the target communities, youth groups, schools, LGBTQ+ groups, outer island communities, persons with disability children, senior citizens and low-income households.

The stakeholder consultations **included questions designed to solicit feedback on gender dimensions related to the health sector across FSM. Participants were asked inter alia questions about primary caregivers within households, to provide information on informal health providers within communities such as traditional caregivers and to give the names of women's groups or women in the health care sector who should be consulted as part of the project development process. From the response to these questions across the four States, a number of relevant women's groups were identified to further discuss gender issues as they**

relate to the proposed project. It was also clear that women, youth and other marginalized groups should be prioritized to the extent possible throughout project implementation.

*Working Group 2 from Inception Workshop (stakeholder mapping and engagement):  
Summary of Discussions (11/02/2021)*

### Q1: Which groups or individuals might be affected by the project?

**National:** Communities, women's groups, senior citizens, dispensaries, schools, DPOs, FBOs NGOs, state and municipal governments, EPAs, health departments and hospitals.

**Pohnpei:** Communities; Municipal Governments; Women's Groups; Youth Groups; Church Groups; Farmers & Fishers (producers); Consumer Organizations; Private Sector/Business Community; State Governments; Traditional Leaders/Kousapws

**Kosrae:** Everyone (government, municipal, and community groups) - most affected would be those with limited access to health services

**Yap:** Everyone will be affected by the project

**Chuuk:** Most communities in Chuuk, especially remote communities; Places without proper solid waste management

### Q2: Which groups or individuals might affect the project?

**National:** Traditional leaders, municipal governments, landowners, government officials (elected), NGOs, implementing entities, project partners

**Pohnpei:** Traditional Leaders; Other Development Partners: EPA and Health (main implementers); Office of Statistics; Weather Station

**Kosrae:** Government; Private Sector; NGOS; Landowners

**Yap:** Government officials, landowners, implementing dept./agency,

**Chuuk:** Programs/entities with major implementation roles in the project; Co-financing partners (i.e., private sector); Implementation partners (i.e., CSOs); Landowners and other state and community stakeholders

### Q3: Who might become useful project partners even though the project may also be implemented without their contribution?

### *National*

Schools, traditional leaders, elected officials, private sector, PIHOA, NGOs, CSOs

### *Pohnpei*

Everyone will be useful partners for the project, including the State Legislature, Traditional Leaders (Mwoalen Wahu), etc.

### *Kosrae*

MCRS-Kosrae Chapter

CHC

IOM

Youth

Schools

Community groups

### *Yap*

Traditional leaders, community groups: youth, church, women

Embassies – diplomatic missions, PIHOA

### *Chuuk*

Local Communities, Traditional and Religious leadership, Women and Youth groups

## **Q4: Who might perceive the project as a potential threat to their role and interests?**

### *National*

Private sector, utilities, elected officials, health care workers, livestock owners

### *Pohnpei*

This project will take a collaborative, whole-of-country approach where all stakeholders have a role. We do not envision anyone perceiving any aspect of this project as a ‘threat’.

### *Kosrae*

Business sector

Landowners

Church

*Yap*

Yap State Public Service Corporation (YSPSC), FSM Petroleum Company (FSMPC), Private Sector, elected government leaders influenced by their constituents who may not be in favour of project and related activities

*Chuuk*

State and local partners should there be a lack of transparency across the board

**Q5: Who will anyway be involved in the project?**

*National*

Impacts everyone – media/broadcast people, social media, outside international partners, health sector/EPA and utilities

*Pohnpei*

Redundant question. (All stakeholders)

*Kosrae*

KBA

Facebook users

Church

*Yap*

GCF, SPC, National Gov't, State Gov't, Health Sector, Environmental Sector, local Stakeholders (traditional chiefs, local communities), Utilities, Communication...

*Chuuk*

Everyone

**Q6: Which interest groups can we prioritise (such as women or caregivers in the communities) through this project?**

***National***

*Women, mothers in the communities, youth groups, schools, LGBTQ+ groups, outer island communities, persons with disability.*

***Pohnpei***

*Women, Persons with Disabilities, children, coastal communities, Outer Island and rural communities, and low-income households.*

***Kosrae***

*Disabled, senior citizens, women, youth*

***Yap***

*NGOs (Yap Women's Association, Neighbouring Islands Women's Association, Tamil Women's*

*Association, Disability Organization)*

*Marginalized groups – disabled, remote island inhabitants, low-income households: Gender Support Office*

***Chuuk***

*Project should be need based through understanding community circumstances.*

*Women and youth*

## State-level Gender Consultations

Given the proposed project is introducing community-level interventions, additional State level consultations were conducted in the states of Kosrae, Pohnpei, Chuuk and Yap. The state consultations were conducted in two days, March 6<sup>th</sup> and March 8<sup>th</sup>. The first session was conducted in Pohnpei, with the stakeholders in Kosrae attending via Zoom. The second session was conducted in both Yap and Chuuk, with Palikir Consultants co-facilitating via Zoom and state focal points co-facilitating on the ground. In attendance during the consultations were representatives from state and municipal governments, traditional leaders, religious leaders, as well as CSOs and NGOs.

Consultations at the state and community level followed a structured, workshop type approach beginning with a project briefing, followed by stakeholder feedback with worksheets and a survey, a discussion of the SEP and a discussion of the GRM. The stakeholders engaged were provided ample time for questions and clarifications from after each presentation. Below is a summary of the gender and scoping responses by State.

### ***Chuuk: Gender and Scoping Assessment***

Attendees:

<b>Chuuk</b>	
Morim Mori	CYC/UNICEF
Joyee Sewell	EPA
Skenson U. Erwin	ODA
Clarice Graham	Island Pride/Ship Hoops
Jowell Petrus	ODA
Elden Paul Rain	EPA
Justin Fritz	CDEOC
Kris Kanemoto	R2R/PCS
Leah Akapita	CDEOC
Ken Airus	CDEOC

<i>Questions and Responses:</i>	
Q1: At the community level, who within households are the primary caregivers for those who fall ill or suffer from disabilities?	A1: Mother and Father in the household (HH); mothers are usually the ones who children and other HH members go to
Q2: Are there any informal health providers within communities? Are there any traditional care givers outside of the formal medical system?	A2: Yes
Q3: In the health care sector, what is the approximate breakdown in terms of male vs female health providers? (i.e., physicians, nurses, technicians, etc.)	A3: there is an equal breakdown between the number of male and female, but most midwives are female
Q4: Are there other women's groups or women in the health care sector who should be consulted as part of the project development process?	A4: Yes, Chuuk Women's Council
Q5: The feasibility study gives a good overview of climate affected disease cases. Would you kindly let us know if there is information on health costs associated with this? Health costs per person?	A5: ed-evac: \$40K per person per trip (The cost is for a trip out to the outer islands of Chuuk to charter one of the vessels approximately \$300 for lagoon residents)
Q6: Is there any data related to the number of deaths on a yearly basis associated with climate induced diseases?	A6: There are data gaps and sometimes hard to access what existing data there is
Q7: Would you kindly provide us with the description and details of investments/adaptation measures that are envisaged by the project? How do they link to reducing risks of climate affected diseases?	A7: Project should improve surface water/rooftop surfaces (tanks, pipes, etc) project should implement this in a way that it does not create risks/hazards

### ***Kosrae: Gender and Scoping Assessment***

Attendees:

Kosrae	
Andy George	Kosrae Conservation and Safety Organization
Evelyn Palik	Kosrae Women Association
Mary Livaie	Kosrae Women Association
Norlin Livaie	Sanitation, Dept. Health and Social Affairs
Grant Ismael	Dept. of Health and Social Affairs
Roxanne Charley	Div. Agriculture and Land, DREA
Shiro Sigrah	Dept. Health and Social Affairs
Joemson Nithan	Dept. of Health and Social Affairs
Senolyn joe	ODA Office, DOFA
Wilson Mackwelung	Dept. of Health and Social Affairs
Derick Joseph	FSM Health
Isaac Isaac	Dept. of Health and Social Affairs

<i>Questions and Responses:</i>
<p>Q1: At the community level, who within households are the primary caregivers for those who fall ill or suffer from disabilities?</p> <p>A1: mothers and sisters</p>
<p>Q2: Are there any informal health providers within communities? Are there any traditional care givers outside of the formal medical system?</p> <p>A2: home bound caregivers, cancer survivor groups, breastfeeding groups, traditional caregivers (local/traditional doctors)</p>
<p>Q3: In the health care sector, what is the approximate breakdown in terms of male vs female health providers? (i.e., physicians, nurses, technicians, etc.)</p> <p>A3: Kosrae Dept. of Health</p> <p>(i): Physicians- 4 females and 8 male</p>

<p>(ii): Nurses- 26 female and 9 male</p> <p>(iii): Technicians- 4 female and 8 male</p> <p>Total: 59 total health care professionals (57% female)</p>
<p>Q4: Are there other women's groups or women in the health care sector who should be consulted as part of the project development process?</p> <p>A4: The main and active groups are already represented in this workshop.</p>
<p>Q5: The feasibility study gives a good overview of climate affected disease cases. Would you kindly let us know if there is information on health costs associated with this? Health costs per person?</p> <p>A5: Est cost to cure someone with climate affected disease i.e. diarrhoea- \$310. Cost is based on cost to stay in hospital for 1 week with IV injection.</p>

### ***Pohnpei: Gender and Scoping Assessment***

Attendees:

<b>Pohnpei</b>	
<b>Name</b>	<b>Organization/Position</b>
Nethleen Marlik	Pedie Women's Org
Christina Elenei	PSG
Keye Asher	National Health Food Lab
Jude Andon	EPA
Elson Elias	EPA
Norton D. Snatos	EPA
Eden Skilling	WSO, Pohnpei
Misila Marek	SMK
Paul Bartolon	SMG

Altrin Ligor	EPA
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<i>Questions and Responses:</i>	
Q1: At the community level, who within households are the primary caregivers for those who fall ill or suffer from disabilities?	A1: Mothers, sisters – basically all women in the households (HH). These specific populations need to be part of a fuller discussion. For example, how will the project affect men and women differently due to various socio-economic factors?
Q2: Are there any informal health providers within communities? Are there any traditional care givers outside of the formal medical system?	A2: Yes. Every community has local healers and traditional practitioners.
Q3: In the health care sector, what is the approximate breakdown in terms of male vs female health providers? (i.e., physicians, nurses, technicians, etc.).	A3: Generally speaking, there are a higher number of female nurses than male nurses. Also, more male doctors than female doctors. See the Annual Report for 2020 – Pohnpei State of the State report.
Q4: Are there other women’s groups or women in the health care sector who should be consulted as part of the project development process?	A4: Yes. All women’s groups, the various lab specialists and technicians in other departments (EPA), as well as the Health Aides/Assistants in the OI dispensaries.
Q5: The feasibility study gives a good overview of climate affected disease cases. Would you kindly let us know if there is information on health costs associated with this? Health costs per person would suffice.	A5: Currently we are not tracking this information, so this information is not available. This project will develop the baseline information that this question seeks.
Q6: Is there any data related to the number of deaths on a yearly basis associated with climate induced diseases?	A6: Generally, climate related deaths are not tracked on an ongoing basis and so it is hard to answer this question. This is the entire point of this project.

Q7: Would you kindly provide us with the description and details of investments/adaptation measures (activities) that are envisaged by the project? How do they link to reducing risks of climate affected diseases?

A7: All of the currently proposed activities are supported.

Capacity training and community awareness.

Improved infrastructure – expand labs for VBD, WBD and FBDs and improved sanitation infrastructure for HHs.

Surveillance needs to be tied to climate related diseases and data.

### ***Yap: Gender and Scoping Assessment***

Attendees:

Yap	
Leelkan Southwick	OPB
Charlene Laamtal	DHS/EPINET
John Lubuw Marson	DHS/Environmental Health
Maxshelton Talimelipiy	DHS/Environmental Health
Santus Bugomal	DHS/Admin
Jordan Mautaman	EPA
Jacquelyn Lefagoyal	DHS
Anastasia Perogolo	EPA
Joelyne Tiron	EPA
James Limar	Council of Pilung
Julius Chosemal	Council of Tamol
Erica Ruwepin	Yap Women's Association
Genista Gimen	Yap Women's Association
Anna L. Itimal	Neighboring Islands Women's Association

*Questions and Responses:*

Q1: At the community level, who within households are the primary caregivers for those who fall ill or suffer from disabilities?

A1: Women in the households are the primary caregivers

Q2: Are there any informal health providers within communities? Are there any traditional care givers outside of the formal medical system?

A2: Traditional healers (herbal healers, local massage)

Q3: In the health care sector, what is the approximate breakdown in terms of male vs female health providers? (i.e., physicians, nurses, technicians, etc.).

A3: Physicians: 90:10 (male vs female)

- Nurses: 90:10 (female vs male)
- Lab Technicians: 50:50 (male vs female)
- Pharmacy Tech: 60:40 (male vs female)
- Maintenance Tech: 100 (all male)
- Radiology Tech: 90:10 (male vs female)

Q4: Are there other women's groups or women in the health care sector who should be consulted as part of the project development process?

A4: Yap Women's Association (YWA), Neighbouring Islands Women's Association (NIWA)

Interview National Government  
January 17, 2022

Mr. Stuard Penias, Assistant Secretary of Social Affairs (FSM Department of Health and Social Affairs)

Mr. John Curley, Women's Development Project Officer -

- (1) What is the mandate of your office? And how does it fit within the structure of the government?

*Response:* The Division of Health is one of the two main divisions of the Department of Health and Social Affairs. This is where the health portfolio of the Department is housed and managed through various technical and administrative units with specific program activities and mandates.

- (2) Is there a list of other gender-focused projects that are being implemented in FSM? If not a comprehensive list – any additional projects that come to mind would be helpful.

*Response:* Australian Government, through *Pacific Women*, has committed approximately USD 1.4 M over 10 years (2012–2022) on initiatives to support women's empowerment in FSM (<https://pacificwomen.org/our-work/locations/federated-states-of-micronesia/>) Funding enhanced the capacity of key organizations including the Chuuk Women's Council as well as the FSM government and support for growing women's micro-enterprises; Indian Government has funded a USD 1 M project (2020-2023), implemented by UNDP, to *Strengthen the Gender Machinery of FSM* (<https://info.undp.org/docs/pdc/Documents/H04/FSM%20strengthening%20gender%20machinery.pdf>) The current proposal should coordinate with this project to utilize and support further strengthening of capacity generated around gender.

- (3) Can you provide a link to the new gender policy or if a public link isn't available a copy of the new gender policy itself (endorsed in 2018)? *No Response*

- (4) Health Care sector:

- a. At the community level, who within households are the primary caregivers for those who fall ill or suffer from disabilities? *Response:* Mostly women/mothers
- b. Are there any informal health providers within communities? Are there any traditional care givers outside of the formal medical system? *Response:* There are traditional healers in communities.
- c. In the health care sector, what is the approximate breakdown in terms of male vs female health providers? (i.e. physicians, nurses, technicians, etc) *Response:* higher proportion of male physicians and a higher proportion of female nurses

Both the concept note and draft gender annex were shared in March 2022 with Mr. Penias and Mr. Curley for comments and inputs April 4, 2022.

## Interview Yap State

April 4, 2022

Linda Teteth (Yap State) Women's Liaison Officer

Paula Mitmow newly appointed Gender Support Officer/Women's Interest Officer

- (1) What is the mandate of your office? And how does it fit within the structure of the government? – *Response:* State level government, stepping stone to women's group, work with a lot of women's groups, NGOs, communities, open since 2002 – segregate NGOs vs policies, regulations, gender issues
- (2) What is the relationship between the Yap State office and the national office? Are these parallel State-level departments/agencies?  
*Response:* coordinate with DoH but under department of youth and civic affairs;
- (3) Health Care sector:
  - a. At the community level, who within households are the primary caregivers for those who fall ill or suffer from disabilities? *Response:* Women take care of the children, taro patches near house; women are primarily taking care of anyone who gets sick
  - b. Are there any informal health providers within communities? Are there any traditional care givers outside of the formal medical system? *Response:* The way we live, now westernized; existing people who ask for local medicine, therapists, people still do go to those people to seek help
  - c. In the health care sector, what is the approximate breakdown in terms of male vs female health providers? (i.e., physicians, nurses, technicians, etc) balance –  
*Response:* government employees 2 -years ago did a survey; half of govt employees are women – balance with health services
- (4) Are there other women's groups or women in the health care sector who should be consulted as part of the project development process? Or be integrated into the project implementation

*Response:* Have an established list of groups – 10 groups – always interested but down the line lose interest, don't have enough technical support; collaboration of the entire village - Momentum in all areas – women should be involved; communities;

*Additional Discussion Points:* Umbrella group, Yap Women's Association (new officers) – have a new building, women's shelter housed there; plan in place to get funding where they can set-up programs for women (training, awareness can take place at the center); start something around women's health; and YWA would be the best entry point as the umbrella for other groups. Each village has their own women's group and reaching out to ask which groups would be most interested in such a project.

Outer island settlements (4-5) in Yap – they don't land on the main island – come to mainland to work; don't have big area in comparison to the people living → groups that are in most needs are those on outer island; Yap lacks a lot of access to information. Sometimes outbreaks of dengue, amoeba (amebiasis), are the areas where there are the biggest outbreaks. When ships come to

Yap – they bring contamination women manage the HH area cleaning, taking care of gardens – women and children are at bigger risk.

Chuuk and Kosrae – don't have state level because the women's groups were so active, they took over duties. Chuuk Women's Council and Kosrae Women's Association. Funding for awareness raising for women's groups/communities.

## **Annex II – Indicative Gender-Related Content of the Vulnerability and Capacity Assessment (VCA)**

*Below is an indicative list of gender-related content and/or issues that must be reflected in the Vulnerability and Capacity Assessment (VCA). This is not a separate output, ensure that content is incorporated in the design and primary data collection.*

### **Analysis**

- Analysis of the roles that women and men play in food preparation and handling, vector management and other interventions that are associated with preventing FBD, VBD and WBD
- Is there information on the differences of VBD, FBD and WBD incidence between women and men? What factors, other than reproductive, contribute to gender differences in the incidence of disease?
- What roles do women and men play in community health care, including employment in the health service sector?
- How do women and men explain common diseases and health problems?
- What associated health services (water supply and sanitation improvement, other disease control measures) do women and men in the client population have access to? To what extent do these affect the incidence of VBD, WBD and FBD?
- What formal health delivery systems are available to the client population, both clinical and nonclinical? To what extent do women use them? What is the ratio of female users to male users?
- Are there existing challenges faced by vulnerable groups such as the elderly and people living with disabilities? Are such groups vulnerable to contracting VBD, FBD and WBD?

### **Methodology**

- Application of context-specific Pacific or indigenous methodology in data collection and analysis, and the lens of culture as an enabler, to ensure that the project contributes to gender equality and women's empowerment