SUBJECT:	**ANNUAL REPORT ON IMPLEMENTATION OF THE GENDER POLICY**
Agenda item:	A
Category:	For Information

Section A: Introduction

- This report is an update on progress made in 2017 on implementing Gavi's gender policy. It covers the programmatic, corporate, governance, communications and advocacy dimensions of Gavi's gender focused work.
- The Sustainable Development Goals (SDGs) have brought a greater focus on gender equality and women's empowerment. Gender plays an important role in immunisation and is a strong component of Gavi's commitment to equity in immunisation.
- The goal of Gavi's gender policy is to 1) increase immunisation coverage by supporting countries overcome gender-related barriers to accessing immunisation services and 2) promote equal access and utilisation for all girls and boys, women and men to immunisation and related health services that respond to their different health needs.
- In 2017, the Secretariat enhanced its focus on engagement on gender.

Section B: Facts and Data

1. Gender Policy at a glance

1.1 Gavi's gender policy calls for gender-sensitive funding and programmatic approaches, generating new data and evidence, exercising leadership and advocating for gender equality, and increasing accountability for gender related results.

1.2 Research shows that due to socio-cultural and economic factors, women tend to have lower access to available social services, including health services. **Gender-related barriers,** including education level, decision-making power and economic dependency among women are important predictors of their children's vaccination status[1].

1.3 Per available evidence, there is no significant difference at global level in immunisation coverage for boys and girls. Differences favouring either boys or girls, do exist in some regions, countries and socio-economic groups and

[1] Hilber AM, McKenzie O, Gari S et al. Project Gender and Immunisation. Qualitative Systematic Review. Geneva: STPH and WHO, 2010, 44-48.

may be masked by national or aggregated estimates. For example, district level household surveys in Haryana, a province in India, found a 5.7% difference between male and female children for full vaccination.[2]

2. Gender and Gavi Programming

2.1 Gavi's **strategic framework** for 2016-2020 calls for an increasing focus on sustainable coverage and equity of immunisation and includes **two indicators** directly related to gender equity.

2.2 The first indicator uses **education status** as a proxy for women's empowerment and tracks the differential level of coverage of third dose of diphtheria-tetanus-pertussis (DTP3) vaccine among children of mothers with secondary education or higher and mothers with no education. A key limitation of this indicator is that it relies on household survey data that is only available in 3 to 5 year intervals. The limited availability of new data points limits the utility of this indicator in monitoring changes year-on-year.

2.3 In 2017, 30% of countries for which data is available have less than 10% difference in DTP3 coverage in children of female caregivers with and without education. This is compared to the baseline of 34% in 2015, and the target of 44% for 2020. To date, special investments in data have included support to operational research with a coverage and equity focus, as well as reports and training materials on equity (including triangulation of various sources of data, geospatial mapping and supply and social-determinants). Going forward, the Alliance will invest in dedicated efforts on equity analysis for gender barriers and summarising lessons learned in order to bring these to the country level and inform policy and practice.

2.4 The second indicator monitors **sex-disaggregated coverage** for DTP3 vaccine (as measured through household surveys). In 2017, 44 out of 68 countries (65%) reported having sex-disaggregated data within the last five-year period.

2.5 **Health System Strengthening (HSS) grants** are the primary mechanism for Gavi to address gender related barriers. **Internal analysis** undertaken in 2017 of the 14 HSS proposals recommended for approval since the last analysis in 2016 found:

(a) Inadequate understanding of the distinction between gender related barriers and sex-discrepancies. Of the 14 country proposals, 7 countries (50%) mistook absence of sex discrepancies in immunisation coverage with absence of gender related barriers to immunisation.

[2] Gupta, M.et al. (2016). Effectiveness of Multiple-Strategy Community Intervention in Reducing Geographical, Socioeconomic and Gender Based Inequalities in Maternal and Child Health Outcomes in Haryana, India. PLOS ONE, 11(3), e0150537. http://dx.doi.org/10.1371/journal.pone.0150537

(b) Regardless, every country (100%) indirectly identified barriers that are defined as gendered when talking about low coverage. The commonly highlighted barriers were low health awareness of caregivers, low female empowerment, lack of community involvement in demand generation and limited skills of health workers in communicating with female caregivers.

(c) Although remedial solutions were identified by every country, only 6 of the 14 (43%) applications directly allocated budget for funding the proposed interventions.

2.6 The **Independent Review Committee** have members who are well versed with gender barriers and ensure that gender responsive interventions are targeted.

2.7 This recent analysis has triggered a new thrust with several remedial actions under way. For example, an information sheet explaining common gender related barriers and examples of interventions to tackle these barriers has been developed and included in Gavi's HSS and new vaccine support grant application guidelines.

2.8 Gavi support for human papillomavirus (HPV) and rubella vaccines is a targeted investment in women's health:

(a) **HPV**: Cervical cancer is the fourth leading cause of cancer in women, with 85% of cases occurring in low income countries where women lack access to early screening and treatment[3]. Gavi's HPV programme[4], targeting a wider age range (9 -14 years) offers a strong platform to accelerate adolescent health integration (e.g. with nutrition, menstrual hygiene, reproductive and sexual health) and reach vulnerable populations including out of school and HIV+ girls. Gavi is working on models to incentivise countries to invest in adolescent health integration using HPV delivery as a platform. The partnership with Girl Effect is using modern communications approaches to generate demand for HPV and other adolescent health interventions.

(b) **Rubella**:A pregnant woman who contracts rubella is at risk of miscarriage, stillbirth or birth defects (congenital rubella syndrome). By the end of 2016, Gavi supported measles-rubella campaigns, for the 9 months -14 year old boys and girls, helped to vaccinate 196 million children, and ensured that children are now receiving measles and rubella vaccines through routine immunisation.

2.9 **VIS 2018**: A gender equity indicator is included in the VIS 2018 to measure whether a vaccine has special benefits for women and girls, e.g. because the disease is more harmful for them (e.g. hepatitis E). The VIS list also

[3] Campos NG et al. (2016) Resources Required for Cervical Cancer Prevention in Low- and Middle-Income Countries.PLoS ONE11(10) https://doi.org/10.1371/journal.pone.0164000

[4] Till date, 9 countries(Ethiopia, Senegal, Tanzania, Zimbabwe, Kenya, Gambia, Mauritania, Malawi with a total of approx. 20 million girls to be vaccinated have been approved and 3 countries (Zambia, Solomon Islands and Lao PDR) have applied for the HPV programme.

includes several vaccines for pregnant women including some that confer protection to both mothers and neonates (maternal influenza), and others administered to pregnant women to protect the neonate (respiratory syncytial virus). Routine delivery of maternal vaccines could strengthen the antenatal care platform as has been the case with tetanus toxoid, a low cost traditional vaccine.

3. Gender and Secretariat

3.1 In 2017, Gavi's internal **Gender Working Group (GWG)** continued as the body within the Secretariat that is responsible for oversight and implementation of the gender policy. This group is composed of representatives from different teams across the Secretariat with a view to mainstreaming gender in different work streams.

3.2 There is a KPI on gender as part of the Team Performance Management (TPM). This tracks the percentage of activities in the GWG workplan that is completed on time. As of the start of November 2017, 94% of activities were on track to be completed.

3.3 Along with the existing KPI for TPM, **a new gender KPI** was developed for 2017. This called for the Secretariat to review and revamp its approach to gender to reflect new priorities. As a result, the GWG engaged in a collective effort to map gender 'touchpoints' with Gavi's programmes and proceses. Opportunities to further advance this agenda were identified and are included in Section 6.

3.4 **HR statistics on gender within the Secretariat**: Currently the Secretariat staff is 61% female, 39% male. Figure 1 shows the breakdown of gender across career levels. As seen, a disproportionate number of female staff occupy administrative categories (1-2). Although there is greater gender parity in mid- career levels (Level 4-5),male staff hold higher career levels (particularly Level 6 - 7). There is gender balance at the highest career levels (level 8 – CEO/Deputy CEO). The Secretariat will continue to pay attention to the need to enhance women's participation at decision making levels.

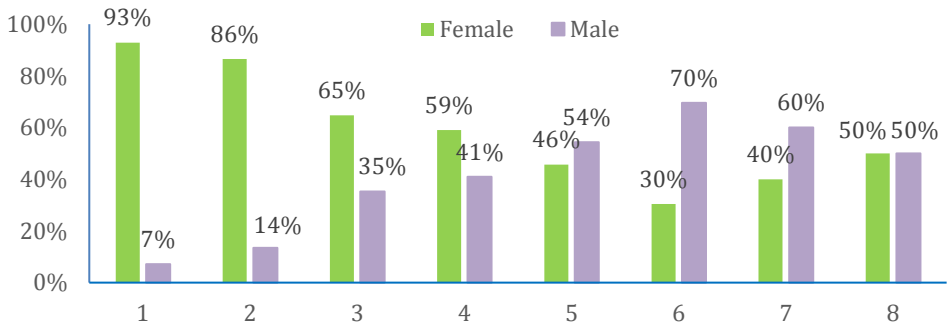

Figure 1: Gender distribution across Gavi career levels (as of Oct 2017)

4. Gender and Board

4.1 Throughout 2017, the **Gavi Board** has been partially compliant with the guidelines that no more than 60% of either gender is represented on the Board. Board Members currently comprise 50% female, 50% male while Alternate Board members are not compliant (71% male, 29% female). Based on nominations for appointment of new Board and Alternate Board members for 2018, this will significantly improve, bringing Alternate Board members into compliance at 50%/50% while Board members will remain within the compliance range at 54% male, 46% female.

4.2 Gavi KPI's now include a KPI on gender balance that extends to all Board Committees, not just the Gavi Board as prescribed in the Gender Policy. The mid-year result on this KPI was 60% male, 40% female representing compliance in aggregate across the Gavi Board and its Committees.

5. Gender and Communications/Advocacy

5.1 Throughout 2017, Gavi further strengthened its positioning on gender through a range of communication and advocacy efforts. Gavi has positioned immunisation, a public health good that disproportionately benefits the underprivileged - including girls, as a robust platform, upon which Universal Health Coverage can be built. As a result of sustained advocacy by the Secretariat for more ambitious **Sustainable Development Goal indicators**, SAGE has recommended that HPV (last dose) be included as one of the additional measures to track progress on immunisation. The Secretariat continues to position the HPV vaccine as a key scalable and cost effective preventive solution against cervical cancer and a platform to deliver other essential services to adolescent girls.

5.2 Gavi continues to engage strongly with the Organisation of African First Ladies Against HIV/AIDS (OAFLA) for advancing the immunisation agenda at continental and national levels.

5.3 The **Annual Progress Report**, Gavi's flagship publication emphasised efforts to help countries address gender-related barriers to immunisation and included a feature on Gavi's work to empower women and girls through its support to HPV vaccine. In addition, specific communication for **International Women's Day** included blogs by the CEO and Deputy CEO on links between gender and immunisation, and social media campaigns on female "vaccine heroes" and #GaviVoices. For **World Immunisation Week**, a multimedia slideshow showed two mothers living in different countries – Norway, a leading Gavi donor country and Mozambique, a key recipient of Gavi support – sharing the same perspectives on the importance of immunisation.

5.4 Reconfirmed commitment by Gavi CEO on **International Gender Champions**. This is a leadership network that brings together female and male decision workers to break down gender barriers. The leaders take the Gender Parity Pledge (which aims to strive for gender parity in all panel discussions in International Geneva).

6. Future direction

6.1 As part of Gavi's efforts to enhance engagement on gender, the following activities will be prioritised going forward:

(a) Promote gender parity and reduce gender-related barriers as a key objective in country guidance, grant programming and grant application, monitoring and review processes

(b) Ensure Gavi's corporate policies and governance practices are responsive and sensitive to gender issues

(c) Assess and monitor the impact of Gavi's policies and their implementation on gender equity in countries.

(d) Articulate and position Gavi's public policy on gender and advocacy and broader SDG context.

6.2 Examples of strategic programmatic opportunities include: strengthening advocacy for behaviour change among target populations; flexible immunisation service availability; increase in number of female front-line health workers; community outreach to minimise travel for women and out of pocket expenses.

6.3 Gavi will actively engage with Alliance partners to ensure that the programme is informed by an exchange of innovative ideas and best practices.