

SUBJECT: ANNUAL REPORT ON IMPLEMENTATION OF THE GENDER POLICY

Agenda item: A

Category: For Information

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Section A: Overview

1. Executive Summary

1.1 This report aims to update the Gavi Board on progress in 2016 in implementing the Gavi Gender Policy, which spans programmatic, corporate, and governance dimensions of Gavi's work.

2. Recommendations

2.1 This report is for information only.

Section B: Content

3. Context

3.1 The purpose of Gavi's Gender Policy is to support countries to increase coverage by overcoming gender-related barriers to accessing immunisation services by promoting equal access and utilisation for all boys and girls.

3.2 **Gender-related barriers** are obstacles to the access and utilisation of health services that are related to social and cultural norms about men and women's roles. Mothers tend to be the primary caretakers of children and in societies where women have low status, their children – both girls and boys – are less likely to be immunised. When women are empowered, immunisation coverage increases.

3.3 Gender is one of the core components of Gavi's commitment to equity in immunisation, and it cuts across all aspects of equity and health. Evidence shows that gender gaps remain and disparities increase when gender is combined with poverty and other drivers behind exclusion.

3.4 Gender sensitive or transformative approaches¹ are therefore important to improve and sustain immunisation coverage. Strategic and catalytic interventions targeting women, men, families and communities can help countries overcome gender-related barriers to accessing immunisation services, improving coverage and reaching the unreached.

3.5 **Sex discrepancies in immunisation.** Evidence shows that at a global aggregate level there are no significant differences in immunisation coverage between boys and girls. However, differences, favouring either boys or girls, do exist in some regions, countries and socio-economic groups. In addition, evidence confirms that national aggregate and/or survey data may hide sex discrepancies. This suggests that countries should be encouraged to regularly review coverage at the sub-national level.

4. Gender and Gavi programming

4.1 The **strategic framework** for the Vaccine Alliance for the period 2016-2020 calls for an increasing focus on sustainable coverage and equity of immunisation. Inequities in immunisation can arise from a number of country-specific factors, including geography, wealth, marginalised populations, and gender-related barriers. The latter might include women's empowerment, control of household resources or decision-making power.

4.2 Gavi measures **two indicators** directly related to gender equity under the new strategic framework:

(a) The first indicator uses **education status** as a proxy of women's empowerment and tracks the differential level of coverage between children of women with no education and women with secondary or higher education. In 2016, the first year of the new strategic period, just 13 of 38 countries that carried out a survey in 2011-2015 (34%) had a differential level of coverage of less than 10 percentage points.

(b) Gavi also monitors **sex-disaggregated coverage** for three doses of the pentavalent vaccine (as measured through household surveys). This has also been included as a core indicator in Gavi's new grant performance frameworks. In 2016, 42 out of 68 Gavi countries (62%) reported having sex-disaggregated data within the last five-year period.

4.3 The primary mechanism for Gavi to address gender-related barriers to accessing immunisation is through its **health system strengthening** (HSS) grants.

¹ Gender transformative refers to goals and objectives that attempt to re-define women's and men's gender roles and relations. These programmes seek to transform equal gender relations to promote shared power, control of resources, decision-making, and support for women's empowerment.

² Gender sensitivity refers to perceptiveness and responsiveness to differences in gender roles, challenges and opportunities. Gender sensitive programmes significantly improve women's and girls' or men and boys' access to protection, treatment or care. By themselves, they do little to change the larger contextual issues that lie at the root of gender inequities.

- 4.4 **HSS guidelines** require country applicants to conduct a gender analysis and to identify gender-related barriers to accessing vaccination.
- 4.5 An **internal analysis** undertaken in 2016 of the 12 HSS proposals recommended for approval since the last analysis in 2015 found that:
- (a) Seven HSS proposals (58%) identified gender-related barriers (as compared to 13 (62%) of the 21 recommended in 2014-2015);
 - (b) Seven proposals (58%) included at least one gender-related activity (as compared to 11 (52%) in 2014-2015);
 - (c) All countries are now required to include sex-disaggregated and gender-related indicators as core indicators in their Performance Frameworks (PFs), so all PFs (100%) included the following indicators (as compared to 18 proposals (86%) in 2014-2015 and ten proposals (37%) in 2011-2013):
 - i. Penta3 coverage difference between the children of educated and uneducated mothers/care-takers; and
 - ii. Penta3 coverage difference between males and females; and
 - (d) The vast majority of gender-related activities in 2016 were related to improving health information systems (HIS) for reporting sex-disaggregated data (95%).
- 4.6 In 2016, a review was undertaken of countries that had conducted a detailed gender analysis and then translated this analysis into a budgeted gender component in their HSS proposals. This review resulted in a **case study** of Afghanistan (see Appendix 1).
- 4.7 Gavi continues to provide support for **Human papillamovirus (HPV)** and **rubella** vaccines, which focus particularly on the needs of women.
- (a) **HPV:** HPV is the primary cause of cervical cancer, a disease which results in 266,000 deaths annually.² To date, 23 countries have implemented a demonstration programme and three countries have introduced HPV vaccination in their national immunisation programmes. Overall, Gavi has achieved its goal to vaccinate one million girls by 2015. At this meeting, the Board will consider a new programme design that is intended to accelerate HPV vaccine introduction in Gavi-eligible countries.
 - (b) **Rubella:** Every year, 90,000 babies in Gavi countries are born with severe birth defects known as congenital rubella syndrome because their mothers were infected with rubella during pregnancy. The combined measles-rubella vaccine, which Gavi supports, can help prevent this devastating disease. By the end of 2015, Gavi-funded measles-rubella catch-up campaigns, targeting the next generation of

² GLOBOCAN 2012

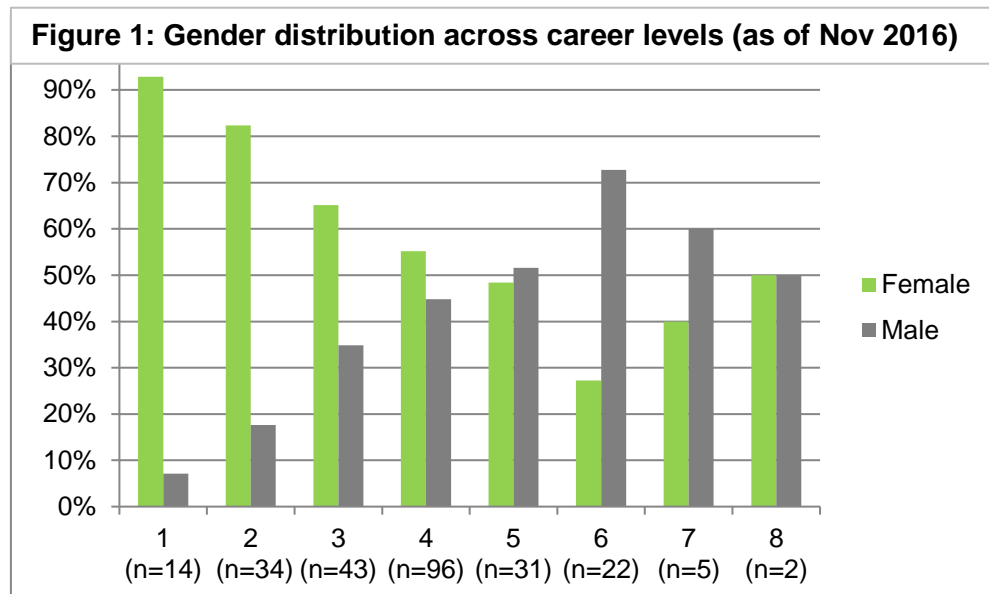
mothers and children aged 9 months to 14 years, had reached 164 million people.³

- 4.8 The guidelines for Gavi's **Joint Appraisals (JAs)** state that countries should include 'results from any equity analyses that showed any socioeconomic, geographic, gender or other barriers to access, utilisation, and delivery of essential health services.' However, out of 50 JAs conducted thus far in 2016, only 19 countries (38%) included an equity assessment or analysis that included gender. Nine (18%) of the 50 specifically referenced gender-related barriers, mostly in the form of analysing maternal education. As JAs become an increasingly important tool for Gavi programming, the guidelines will need to be strengthened to ensure gender-related barriers are included in each equity analysis.

5. Gender and the Secretariat

- 5.1 In 2016, 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. The focus of the GWG work plan in 2016 has been on integrating gender into key developing work streams (eg, Country Engagement Framework, Partners' Engagement Framework, new Strategic Focus Areas) and tracking the new strategy indicators.
- 5.2 A **Key Performance Indicator (KPI)** on gender was included as part of the Team Performance Management metrics. The indicator tracks the percentage of activities in the Gender Working Group plan that are on track or completed on time. As of July 2016, this KPI showed 92% of activities were on track/completed on time.
- 5.3 The Human Resources team monitors **statistics on gender** within the Secretariat. Currently the Secretariat staff is 59% female and 41% male. The breakdown of gender across career levels is also monitored (Figure 1).
- (a) As in recent years, the Secretariat continues to reflect some **typical patterns**; eg a disproportionate number of female staff occupy administrative categories (1-2) and an increasing proportion of male staff hold higher career levels.
 - (b) However, the Secretariat continues to have an **atypical and very good gender balance** at the two highest career levels (level 7 – Managing Director and level 8 – CEO/Deputy CEO), and an improving balance on level 6 (Director).

3 WHO/UNICEF 2016



6. Gender and the Gavi Alliance Board

- 6.1 The **Guidelines on Board gender balance**, approved in 2010, requires that for Board members and Alternate Members, no more than 60% of either gender is represented. Throughout 2016, the Gavi Board has been **partially compliant** with the guidelines: the composition is currently compliant for Board Members with a ratio of 58/42% of male/female members, but not compliant for Board Alternates with a ratio of 67/33% for male/female alternates.
- 6.2 **Gavi KPIs** include a KPI on gender balance that extends beyond the requirements of the Board Guidelines to include the membership of all Board Committees. The mid-year result on this KPI was 63% male and 37% female.

Appendix 1: Case study on Afghanistan

Country context: Traditionally, men and women in Afghanistan have held distinct roles in society: men for the most part were leaders and protectors of the family, with women regarded as the property and responsibility of male family members.¹ These arrangements have created restrictive codes of behaviour, gender segregation, and strong ties between female virtue and family honour.¹ While all Afghans have suffered during the last 30 years of conflict, women have suffered in numerous ways for reasons linked to extreme interpretations of such cultural and traditional associations (eg, rape, physical insecurity due to gender, forced and early marriage and denial of the right to education, involvement in public and social spaces and health care).²

When reconstruction of the country began in 2002, the country's health indicators ranked among the worst in the world for women's reproductive and child health: there was an under-five mortality rate of 257, an estimated maternal mortality rate of 1,600 per 100,000 live births and very high rates of disability due to polio, cerebral palsy, and conflict (including landmines).³ Among children, diarrhoea, acute respiratory infections and vaccine-preventable illnesses accounted for 60% of deaths.³ The health sector painted a picture of a largely under-served rural population, where, for example in 2005, the ratio of basic health centres to population ranged from approximately one per 40,000 people in the central and eastern regions to approximately one per 200,000 in the south.³ Nineteen districts had no health facilities at all.³

Over the past decade, progress has been made by the government in strengthening women's rights and equality. For instance, following the Bonn Agreement in 2001, a Ministry of Women's Affairs (MOWA) was established with provincial-level Departments for Women's Affairs (DOWAs).⁴ The Afghanistan National Development Strategy (ANDS 2008-2013) contains a Gender Equity Cross Cutting Strategy (AGE- CCS), and the government has adopted a National Action Plan for Women of Afghanistan (NAPWA 2008-2018).⁴ However, Afghanistan has a Gender Inequality Index (GII) value of 0.693 and places 171 out of 188 countries in the 2015 index.⁵

Gavi health system and immunisation support (HSIS): By 2020, Gavi HSIS investment in Afghanistan will have totalled US\$ 89.9 million. In its three applications for HSIS, Afghanistan has made great efforts to identify gender-related barriers to immunisation. As described in its first proposal (June 2007), it was not uncommon for Afghan women to face socio-cultural obstacles preventing them from accessing basic health services.

With the prevailing deep-rooted social norms posing numerous gender barriers, an analysis was undertaken to identify:

- 1) existing barriers to women and children for seeking health care;
- 2) the reach of key health services for women;
- 3) the gender balance of the workforce;
- 4) potential gender-responsive health interventions;
- 5) an enabling policy environment for women to participate in education, work and seek care.

Major barriers included very low female literacy rates and limited female involvement in family decision-making. Due to security problems that posed a substantial risk to community health workers (CHWs), movement of beneficiaries, particularly women and children, and their access to healthcare was limited. Despite the expansion of the primary healthcare system and the employment of many more female staff, only 30% of mothers received prenatal care during their previous pregnancy (AHS 2006). While this represented an improvement from the 5% prenatal care coverage found in 2003 (MICS), physical access – in addition to socio-cultural and political obstacles – remained a critical bottleneck given Afghanistan's difficult and mountainous geography. Based on an analysis done by the Ministry of Health in 2015, a population of 2.5 million live in provinces with less than 20% coverage.

Activities were proposed to address the identified gender-related barriers. For instance, a major source of gender inequity can be partly traced to the lack of human resources for women -- such as qualified female health workers -- in remote areas and their unequal distribution over various provinces. Thus, as described in Afghanistan's HSS2 proposal (May 2012), community midwives and community nurses were introduced as new cadres in the health workforce. The curricula of both cadres prepare them to contribute to EPI services.

Efforts to improve access to human resources continue in Afghanistan's HSS3 proposal, where it was noted during the bottleneck analysis workshop that there is currently a 3:1 ratio of male-to-female vaccinators. This data is important as it is most often vaccinators who are the direct source for vaccinations in low-resource health settings. A planned activity for the HSS3 proposal is to train more female vaccinators. Another intervention included in the HSS3 proposal intended to improve overall coverage is the establishment of 310 new EPI centers to increase the availability of service delivery points. In addition, plans have been made to establish gender-sensitive training for health workers and demand generation activities. Of the 2,878 villages with no available health services, permanent community vaccination teams will be established with a fixed female team member. These teams will be given induction training to recruit as vaccinators. There are 30,000 identified community health workers in the country who will be trained on mobilisation for vaccination.

According to Afghanistan's 2015 annual progress report (APR), which reported on 2014 activities, the country was able to successfully complete training of 250 CHWs (125 male and 125 female) in the provinces of Baghlan, Badghis, Kapisa, Khost and Paktia. Training included health education to raise awareness on key health issues as well as provision of basic health services. It is encouraging to see that since the country's first submission in 2007 – when DTP3 coverage was 63% -- coverage has risen to 78% in 2015 (WUENIC) – its highest ever.

Despite these results, gender-related obstacles remain that prevent women from reaching basic health services. In the country's first Demographic and Health Survey (DHS, 2015), only 59% of women who had a live birth in the five years preceding the survey received antenatal care from a skilled provider. According to the HSS3 proposal, the literacy rate is estimated at 17% for females and 45% for males with high discrepancies between rural and urban areas, and even higher among certain groups. As gender-related barriers to immunisation persist in the country, it will be important to monitor how implementation of planned HSS activities improve gender inequities by 2020 and beyond.

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