

The GAVI Alliance Gender Policy

Background

A GAVI Alliance gender policy has been requested by several GAVI Alliance and Fund Board members. The commitment to develop a gender policy was formalised in the 2007-10 GAVI Alliance Strategy, which set the development of a policy on gender equality in immunisation as a 2008 milestone towards the broader organisational strategic goal to increase the added value of GAVI as a public-private partnership.

Gender equality refers to the absence of discrimination on the basis of one's sex in terms of resources, benefits, services and decision-making power (see Annex 2). For the GAVI Alliance this means that girls and boys, men and women get equal access to appropriate immunisation and health services, even those services that differ by sex. A gender sensitive approach recognises the differences between men and women, boys and girls and therefore defines the appropriate interventions according to their respective needs.

While socioeconomic inequality in general is the strongest determinant of health status, gender inequality constitutes one of the most influential social determinants of health. These inequalities are shown as vulnerability to disease and ill-health; the extent to which different people's health needs and concerns are acknowledged; access to health services; quality of health care; and the very research on which health policies and decision making are based.

Development process

The GAVI Secretariat commissioned the Overseas Development Institute (ODI) to manage an interactive process with GAVI staff and partners to develop a gender policy. This process was guided by a time-limited advisory committee including GAVI Alliance partners and the GAVI Secretariat (membership listed in Annex 5). The policy development process was underpinned by an assessment of the links between gender and immunisation. The results of the assessment are presented in a GAVI Knowledge Stocktaking Report (available upon request).

Through the process it was emerged that immunisation is often perceived by many in the immunisation community as gender neutral. However, the stocktaking exercise found that: (1) sex differentials in immunisation coverage exist in a range of contexts; (2) such differentials are exacerbated in the hardest to reach populations; and (3) there are major sex differentials in the burden of disease across vaccine-preventable illnesses (please see Annex 3 for further details). However it is also clear that more analysis is needed as the evidence on the gender implications of immunisation coverage is still limited. This is partly due to the failure of the international community to uphold its commitment to support the generation, consistent reporting and analysis of age- and sex-disaggregated data.

Therefore, the goal of the GAVI Alliance Gender Policy was defined as follows: to promote increased coverage, effectiveness and efficiency of immunisation and related health services by ensuring that all girls and boys, women and men, receive equal access to these services. The policy is

grounded in existing international legal and political commitments, as well as on the conviction that gender equality is everyone's responsibility and warrants special attention and resources

Monitoring and evaluation

The GAVI Secretariat will be responsible for reporting to the GAVI Alliance board on progress towards delivery of these outcomes on an annual basis. A full external review of the Gender Policy and its implementation will be conducted in financial 2012. Based on the results, the GAVI Alliance may consider revising the policy.

Implementation and next steps

The Board is requested to approve "The GAVI Alliance Gender Policy - Towards Gender Equality in Immunisation and Related Health Services" (Annex 1) and assign the Secretariat to work together with partners to develop an implementation strategy which will set out specific objectives and activities, immediate, medium and long-term priorities, responsible parties and a monitoring plan. The implementation strategy will be presented to the Board (or board executive committee) in due course. The Board should also take note that adequate human and financial resources for gender mainstreaming are essential for the effective implementation of the Gender Policy.

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1. The GAVI Alliance Gender Policy - Towards Gender equality in immunisation and related health services
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Membership of the Gender Advisory Committee

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Towards Gender Equality in Immunisation
and Related Health Services****1. Goal and scope of the policy**

- 1.1 The goal of GAVI Alliance's Gender Policy is to promote increased coverage, effectiveness and efficiency of immunisation and related health services by ensuring that all girls and boys, women and men, receive equal access to these services.
- 1.2 Adoption of a gender policy is consistent with GAVI Alliance's mission and the GAVI Principles and is necessary for fulfilling its commitment to the Millennium Development Goals. It is also aligned with the principles of the Paris Declaration on Aid Effectiveness, and its cross-cutting issues of human rights and gender equality. The policy seeks to enable the GAVI Alliance to contribute to the scaling-up of gender mainstreaming in the health sector.
- 1.3 The policy is grounded in existing international legal and political commitments, as well as on the conviction that gender equality is everyone's responsibility and warrants special attention and resources. The policy also aims to identify, develop, use and promote creative ways to engage men and boys, as well as women and girls, as agents of change in the pursuit of gender equality.
- 1.4 The guiding principles of this policy are for the GAVI Alliance to:
 - 1.4.1 Apply a gender perspective to all its work. To realise its mission, and in line with internationally agreed-upon legal and political commitments to gender and health, the Alliance will apply a gender perspective to all relevant work.
 - 1.4.2 Complement partners' efforts to promote gender equality in health. As an Alliance and in line with the commitments made by its partners, the GAVI Alliance will strive to exercise leadership and raise awareness of, and promote coordinated international efforts towards, the realisation of existing international commitments to gender equality and health equity.
 - 1.4.3 Promote country ownership and alignment with regard to gender issues. Efforts to mainstream gender in immunisation services and support health systems will be rooted in the interest in, awareness of and capacity at country level. The GAVI Alliance can play a catalytic role in helping to ensure that countries recognise the potential and importance of addressing gender inequalities.
 - 1.4.4 Exercise strong leadership and demonstrating political will. The GAVI Alliance will play a catalytic role in promoting awareness and realisation of effective strategies to address gender inequality in the health sector. This will include the identification of existing bottlenecks about gender inequalities and their underlying causes in the field of immunisation, and the

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manner in which partners can address them through promotion and support for best practice.

2. Definitions

- 2.1 **Sex** is concerned with physiological and biological characteristics that are used to define and differentiate humans as either female or male. **Gender** is concerned with the social roles and values that are ascribed to girls and boys, women and men, and the ways in which these socio-cultural understandings of appropriate behaviour and roles for females and males are underpinned in most societies by unequal power relations. Gender roles are learned through socialisation and are changeable rather than fixed.
- 2.2 **Gender equality** refers to the absence of discrimination on the basis of one's sex in terms of resources, benefits, services, and decision-making power. Initiatives to empower girls and women are often necessary to achieve gender equality, to address unequal opportunities and access to resources.
- 2.3 **Gender sensitivity:** refers to perceptiveness and responsiveness concerning differences in gender roles, responsibilities, challenges and opportunities.
- 2.4 **Gender perspective:** is a way of analysing and interpreting situations from a viewpoint that takes into consideration gender constructs in society (i.e. notions of appropriate behaviour for men and women, which may include issues of sexual identity) and searching for solutions to overcome inequalities.

3. Rationale for a gender policy

- 3.1 To attain the MDGs, respect, protect and fulfil the human right to the highest attainable standard of health, and promote gender equality and child well-being, there is a need to redress gender inequalities and their impact on access to and use of essential health services. Gender equality is both a determinant of programming effectiveness and a prerequisite for poverty reduction and development.
- 3.2 While socioeconomic inequality is the strongest determinant of health status, gender-based relations of power that are at the root of gender inequality constitute one of the most influential social determinants of health. These inequalities are shown as vulnerability to disease and ill-health; the extent to which different people's health needs and concerns are acknowledged; access to health services; quality of health care; and the very research on which health policies and decision making are based.
- 3.3 Immunisation has often been perceived as gender neutral, however existing evidence suggests that: (1) sex differentials in immunisation coverage exist in a range of contexts; (2) such differentials are exacerbated in the hardest to reach populations; and (3) there are major

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sex differentials in the burden of disease across vaccine-preventable illnesses. However it is also clear that more evidence is needed as the evidence on the gender implications of immunisation coverage is still limited. This is partly due to the failure of the international community to uphold its commitment to support the generation, consistent reporting and analysis of age- and sex-disaggregated data¹.

4. Strategic directions

The Alliance will pursue this policy by: (1) generating, reporting and analysing new evidence; (2) ensuring gender sensitive policy and funding support, and (3) advocating for gender equality in health.

4.1 Generate, report and analyse new evidence

Developing an understanding of the gender-based implications of the evidence base on which immunisation policy and programming decisions are made is a prerequisite for achieving gender equality in immunisation services and the health system more broadly. Consequently the GAVI Alliance commits to:

- 4.1.1 Encourage routine, systematic reporting and analysis of sex-disaggregated data in all areas of GAVI support.
- 4.1.2 Conduct gender analysis of immunisation and related health services.
- 4.1.3 Strengthen linkages between immunisation and other health services to improve outcomes for all girls and boys, women and men throughout their life course.

4.2 Ensure gender sensitive funding and policies

Policymaking and funding support present central opportunities to highlight the gender dimensions of immunisation and related services. It can also leverage change across and beyond the GAVI Alliance to improve both the gendered outcomes of immunisation and development more broadly. Consequently the GAVI Alliance commits to:

- 4.2.1 Review and revise funding guidelines to ensure that countries include age- and sex-disaggregated data and gender analysis in needs assessments and that proposed targets and outcome measures incorporate a gender perspective
- 4.2.2 Incorporate a gender perspective into any new area of program and funding.

¹ ODI (2008) 'Knowledge Stocktaking Report on Gender and Immunisation', Commissioned by the GAVI Alliance.

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- 4.2.3 Promote the use of the different funding mechanisms, especially the health system strengthening (HSS) window and the support to civil society, to support pilot activities that demonstrate the effectiveness of gender sensitive approaches.
- 4.2.4 Encourage inter-agency coordination committees (ICCs) and health sector coordination committees (HSCCs) and other relevant national coordination bodies to consult with appropriate national institutions and ministries with knowledge in gender to ensure that their approach is informed by national expertise in the area.
- 4.2.5 Incorporate gender dimensions into policy development, policy formulations, new investment decisions and agenda setting.
- 4.2.6 Incorporate a gender perspective in monitoring and evaluation procedures and activities. This includes the development of gender sensitive indicators and supporting the strengthening of health information systems, in cooperation with partners.

4.3 Advocate for gender equality as a means to improve immunisation coverage and access to health services

The GAVI Alliance can have a catalytic role in advocating for gender equality as a means to improve immunization coverage and access to health. The message and communication at global, regional and national levels will be key to:

- 4.3.1 Ensure that all GAVI communications: (1) demonstrate Alliance commitment to gender mainstreaming; (2) encourage greater focus on gender mainstreaming and gender issues in immunisation; and (3) employ gender appropriate language;
- 4.3.2 Actively disseminate and promote evidence and lessons learned regarding the impact that gender mainstreaming has on immunisation service access, coverage and impact

5. Gender Sensitive Approaches within the GAVI Alliance structures

5.1 Resources

- 5.1.1 Committing adequate human and financial resources for gender mainstreaming is essential for the effective implementation of the Gender Policy.

5.2 Governance

- 5.2.1 Progress towards gender equality will be integrated into accountability outcomes at all levels. Gender balance in all areas of GAVI work should be ensured, including throughout the governance structures, to the extent possible, as well as through staffing (all levels) and consultancies.

5.3 The Role of Partners

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5.3.1 Given the GAVI Alliance's mode of operation (largely through its partners), implementation of the policy will require a clear articulation by each partner of its specific contributions to the realisation of the Gender Policy aims. Gender expertise and experience of Alliance partners should be engaged.

5.4 The Secretariat

5.4.1 Building and fostering a gender-sensitive Secretariat is a prerequisite for supporting the effective implementation of a Gender Policy and realising positive outcomes. Development of an effective gender infrastructure and organisational culture that facilitates the implementation of the policy includes:

5.4.2 Strengthen the capacity of all staff, and invest in the development of specialists in the area of gender.

5.4.3 Assess gender parity trends in the Secretariat and ensure that meaningful efforts are made to identify equal numbers of qualified female and male candidates during recruitment and promotion processes.

5.4.4 Include gender equality measures as part of performance assessments.

6. Timeline for Implementation and Review

6.1 The policy will take effect as of July 2008.

6.2 Following adoption, the Secretariat in cooperation with partners will finalise an implementation strategy that defines specific objectives and activities, immediate, medium and long-term priorities, responsible parties and a monitoring plan for presentation to the board (or board executive committee). This will include reviewing the GAVI Alliance Roadmap and Work Plan to ensure it is consistent with this policy.

6.3 The Executive Secretary will be responsible for reporting to the GAVI Alliance Board on progress towards delivery of these outcomes on an annual basis.

6.4 A full external review of the Gender Policy and its implementation will be conducted in financial year 2012. Based on the results, the GAVI Alliance may consider revising the policy.

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ANNEX 1****Selected References (indicative not comprehensive)**

- Babalola, S. and A. Adewuyi (2005) *Factors Influencing Immunisation Uptake in Nigeria: Theory-based Research in Six States*, Nigeria: PATHS.
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- WHO (2006) *Constitution of the World Health Organization*, 45th Edition, Supplement, October.
- WHO (2007) *Human Papillomavirus and HPV Vaccines: Technical Information for Policy-makers and Health Professionals*, Geneva: WHO.
- Wirth, M.E., D. Balk, E. Delamonica, A. Storeygard, E. Sacks and A. Minujin (2006) 'Setting the Stage for Equity-sensitive Monitoring of the Maternal and Child Health Millennium Development Goals', in *Bulletin of the WHO* 84: 519-27.

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Additional Gender-related Definitions

Sex is concerned with physiological and biological characteristics that are used to define and differentiate humans as either female or male. **Gender** is concerned with the social roles and values that are ascribed to girls and boys, women and men, and the ways in which these socio-cultural understandings of appropriate behaviour and roles for females and males are underpinned in most societies by unequal power relations. Gender roles are learned through socialisation and are changeable rather than fixed. However, because of the way that gender differences are embedded within education, political, economic, legislative, cultural and religious systems and practices, change often requires a long-term multifaceted approach that is based on an understanding of the context specificity of the concepts of sex and gender.²

Accordingly, in order to achieve **gender equality**, initiatives to empower girls and women are often necessary so as to address unequal opportunities and access to resources. Gender equality refers to the absence of discrimination on the basis of one's sex in terms of resources, benefits, services and decision-making power. Although in its narrowest sense gender equality can refer to equality of opportunity, here it is employed to call for equality of outcomes. Equality is preferred over **gender equity**, which usefully highlights the importance of fairness and justice in the distribution of benefits and the associated need for a transformation of gender relations, but is dependent on societal definitions of fairness and justice that in some cultural contexts may implicitly endorse power imbalances between women and men, girls and boys.

Gender sensitivity: refers to perceptiveness and responsiveness concerning differences in gender roles, responsibilities, challenges and opportunities.

Gender perspective: is a way of analysing and interpreting situations from a viewpoint that takes into consideration gender constructs in society (i.e. notions of appropriate behaviour for men and women, which may include issues of sexual identity) and searching for solutions to overcome inequalities.

Gender mainstreaming involves integrating a gender perspective into the design, implementation, monitoring and evaluation of policies, programmes, processes and institutional structures. In the context of the GAVI Alliance's work in immunisation services and health services strengthening, it entails:

- Addressing gender-based inequalities in terms of immunisation and health care access and outcomes in line with the GAVI Alliance's unique role and mandate; and
- Promoting the right to the highest attainable standard of health for all girls and boys (including the rights to survival, development and protection enshrined in the United Nations Convention on the Rights of the Child)³, women (including the broader right to a life free of discrimination enshrined in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)).

² Definitions draw on Sida (2005) and Commonwealth Secretariat (2002).

³ The right to health is central to the health-related child rights to life, survival and development.

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Gender mainstreaming necessitates a holistic approach, one ensuring that gender sensitivity is promoted in all facets of GAVI's work, including policy design, programming and planning, country support, communications and policy advocacy, fundraising, human resources and resource allocation decisions. Given the broad-based nature of such change, both human and financial resources are required, as well as the development of organisational structures that will best facilitate and support these changes, including monitoring and evaluation mechanisms to promote accountability and measure progress over time.

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Evidence⁴

The following information draws upon an analysis of the most recently available Demographic and Health Surveys (DHS) and United Nations Children's Fund (UNICEF) Multiple Indicator Cluster Surveys (MICS) data. Findings show that, while socioeconomic inequality continues to be the most significant determinant of immunisation coverage,⁵ girls and boys in different contexts experience differential access to immunisation.

Significant biases in immunisation coverage exist against girls in South and Southeast Asia.⁶

The continued norm of son preference and its negative consequences for the survival, health and education of girl children is well documented, with implications for immunisation services. This is further complicated by concerns of family balance, so that in some contexts girls with older sisters are significantly less likely to be immunised than boys.⁷

Biases against girls in immunisation coverage are not confined to Asia, but **are perpetuated in West and East Africa too.**⁸ Qualitative research on East Africa suggests that this is closely linked with maternal education levels, with higher immunisation coverage associated with higher levels of maternal schooling and vice versa.

Gender differences in immunisation not only impact girls. **Biases exist against boys in Africa.**⁹ The underlying causes of these differences have as of yet not been well investigated in the literature, but are possibly related to fears of male sterilisation.¹⁰

⁴ For further detail regarding the evidence base supporting this policy, please refer to the ODI-authored Knowledge Stocktaking Report (ODI, 2008).

⁵ On average, the rate of coverage is 25 to 30 percentage points higher among the richest quintile of the population than it is among the poor quintile (Gwatkin, D.R. and G. Deveshwar-Bahl (2001) *Immunization Coverage Inequalities: An Overview of Socio-economic and Gender Differentials in Developing Countries*, Washington, DC: World Bank).

⁶ In Pakistan, for example, there is a 7.8% differential between girls and boys in terms of complete immunisation; in Cambodia, the difference is 4.9 percentage points and in Nepal 4.3 percentage points (see Appendix E of the Background Report for full immunisation data and analysis). India has the largest gap, with a 13.4 percentage point higher full immunisation rate among boys. (DHS surveys: Pakistan 1990/91, Cambodia 2005, Nepal 2006.)

⁷ In addition to son preference, it is family balance that drives the likelihood that a girl child will be vaccinated, as girls with two or more older brothers and no older sisters are equally likely to be immunised as boys, whereas girls with two or more older sisters are significantly less likely to be immunised than boys (Pande, R. and A. Malhotra (2006) *Son Preference and Daughter Neglect in India: What Happens to Living Girls?* Washington, DC: ICRW.).

⁸ For example, in Gabon, the immunisation coverage gap between girls and boys is 7.2%, Gambia, 6.7%, Côte d'Ivoire, 4.5%, Ethiopia, 4.3% and Sierra Leone, 3.6%. (DHS surveys: Côte d'Ivoire 2000, Ethiopia 2005, Gabon 2000, Gambia 2000, Sierra Leone 2000.)

⁹ Data from Madagascar suggest a 12 percentage point lower rate of complete immunisation among boys. In Nigeria, there is a 7.9 percentage point difference and in Namibia, a 5.6 percentage point difference and in Namibia, a 5.6 percentage point difference. (DHS surveys: Madagascar 2003/04.)

¹⁰ In some contexts, such as Nigeria, these have been linked to rumours of foreign contamination of vaccinations with sterilising agents (fuelling suspicions of hidden agendas to control Muslim populations) (Babalola, S. and A. Adewuyi (2005) *Factors Influencing Immunisation Uptake in Nigeria: Theory-based Research in Six States*, Nigeria: PATHS; Science in Africa (2004) 'Nigeria: Muslim Suspicion of Polio Vaccine Lingers on', available at <http://www.scienceinAfrica.co.za/2004/march/polio.htm>).

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In addition to these differences, the aggregation of data at the national level may conceal significant gender inequalities sub-nationally, as suggested by studies highlighting interactions between gender inequality and other social stratifiers, such as ethnicity and urban/rural location,¹¹ as well as age- and sex-disaggregated data analysis by wealth quintile. Gender inequalities are often more entrenched in lower wealth quintiles, although in particular contexts (e.g. India) gender inequalities cut across wealth quintiles. In other instances, a bias against boys/girls reverses across wealth quintiles. These patterns are highly context-dependent, indicating the importance of sub-national age- and sex-disaggregated reporting and gender analysis of data. In order to fully understand how inequality functions in relation to immunisation and health systems, it is imperative that further analysis of these gender dynamics is undertaken and that such gender-sensitive evidence in turn informs policy choices.

Sex differentials in immunisation impacts

As some research has shown, there may be a differential impact of specific routine vaccinations (e.g. DPT3 and measles vaccine) on girls and boys¹², owing to possible biological differences in immune response (e.g. differential specific and non-specific immune system effects, as well as differential rates of decline in maternal antibodies – specifically measles – between female and male infants).

Gender as an underlying factor in improving immunisation and health services

Barriers to health service access as a result of gender inequalities may be heightened among most marginalised populations, resulting in powerful structural exclusions from services as follows:

- 1) **Asymmetrical intra-household access to resources and decision-making power:** As women are often the primary caretakers in developing countries, they tend to be the first to recognise and seek treatment for children's illnesses. However, they often lack a voice in household spending decisions, including those that inform health care decisions.¹³ As such, women are disproportionately affected by the effects of poverty on health care access. Out-of-pocket expenditures for health, such as user fees and transportation costs, have been shown to drive families into the 'medical poverty trap,' with adverse effects upon utilisation of preventive health services, particularly among women. Although GAVI Alliance vaccines are provided to developing countries so that beneficiaries can receive immunisation services free of charge, it is important to recognise the informal costs (e.g. extra fees requested by

¹¹ Sex was not a significant factor at the bivariate level; however, at the multivariate level, sex became a significant stratifier (Wirth, M.E., D. Balk, E. Delamonica, A. Storeygard, E. Sacks and A. Minujin (2006) 'Setting the Stage for Equity-sensitive Monitoring of the Maternal and Child Health Millennium Development Goals', in *Bulletin of the WHO* 84: 519-27).

¹² It should be noted that these research findings are under debate within the immunisation community, as these findings have yet to be endorsed by the WHO Global Advisory Committee on Vaccine Safety. However, the potential serious implications of these findings warrant a thorough, gender-sensitive investigation.

¹³ In seven out of 15 countries in sub-Saharan Africa, more than 40% of women stated that their husbands had exclusive control over their spending, including health care decisions (Nanda, P. (2002) 'Gender Dimensions of User Fees: Implications for Women's Utilization of Health Care', in *Reproductive Health Matters* 10(20): 127-34).

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health professionals) or indirect costs (e.g. transportation or childcare costs)¹⁴ potentially incurred. Moreover, in general, families have been found to 'ration' scarce resources preferentially for men and boys relative to women and girls, particularly for 'non-emergency' health services, potentially including immunisation. Addressing the transformative power of men's and fathers' involvement in health initiatives is therefore critical for improving the support for women's and children's health needs as well as addressing the power-based gender inequalities in decision making.

- 2) **Inequitable distribution of time and opportunity costs of accessing health services:** Time costs owing to poor infrastructure are often greatest amongst women. As primary caregivers, women typically spend more time contending with physical and time barriers to accessing health services, such as distance to services, weak transport links, inconvenient hours, long queues, etc. These are often exacerbated by significant opportunity costs in accessing care, such as time lost, work foregone and childcare required, any of which may constitute a significant hindrance to women's and children's access to health services.
- 3) **Health clinics as sites of unequal gender and socioeconomic relations:** Health service provision is neither gender-neutral (owing to the high proportion of male health professionals in decision-making roles – e.g. physicians), nor is it sensitive to differentials by wealth, caste and class, which are in turn often compounded by gender-based power differentials.¹⁵ Gendered experiences of health care quality are critical to understand as potential deterrents to accessing health services and improving the responsiveness of services to all.
- 4) **Burden of disease and the gender implications of immunisation investment:** Women and men, girls and boys have differential exposure and vulnerability to disease,¹⁶ resulting from a combination of sex-dependent biological health risks as well as their vulnerability to socially determined health risks and conditions. The latter may include patterns of sexual

¹⁴ Indirect costs have been shown to be a significant inhibiting factor to service utilisation, even when health services are provided free of charge. Particularly for women, who are often the primary caretakers, multiple 'costs' may pose obstacles to accessing services. Transportation costs often occur as health centres may be geographically far removed. Costs are also incurred when leaving household duties and productive labour unattended for the time it takes to bring children into health centres (particularly because of the inconvenient opening hours of clinics). Additionally, women often must utilise their social capital to ask kin or neighbours to care for other children, leaving women beholden (Sen, G., A. George and P. Östlin (2002) *Engendering International Health: The Challenge of Equity*, Cambridge, MA: MIT Press).

¹⁵ In Bangladesh, women were found to avoid immunisation services owing to a fear of humiliation from being 'scolded' by the male vaccinator for losing their child's immunisation card (Perry, H., S. Nurani, M.A. Quaiyum, S.A. Jinnah and A. Sharma (2007) *Barriers to Immunization among Women and Children Living in Slums of Zone 3 of Dhaka City, Bangladesh: A Qualitative Assessment*, Working Paper 166, ICDDR,B: Dhaka).

¹⁶ Recent analysis of the Global Burden of Disease 2002 estimates indicate that 68 out of the 126 health conditions and health risk factors have at least a 20% difference between women and men. See Appendix 3 of Sen, G. and P. Östlin (2007) 'Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health: Why it Exists and How We Can Change it', Final Report to the WHO Commission on Social Determinants of Health, Women and Gender Equity Knowledge Network.

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behaviour (including the power to control decisions about sexual interactions), poor diet and socio-cultural attitudes about health-seeking behaviours.¹⁷

In sum, the importance of gender equality is multidimensional and interlocking. Beyond gaps in immunisation coverage rates, gender-based social roles influence risk of disease and ill-health, access to health services, and the quality of health care experience.

¹⁷ For example, the risk of getting cervical cancer, although determined biologically for women, is significantly heightened by social factors such as the number of sexual partners (and power to control sexuality factors), male sexual behaviour, poor diet and inadequate access to preventative screening. This socially augmented vulnerability, owing particularly to a lack of preventative screening measures, meant that in 2005, 90% of the more than 500,000 new cases of cervical cancer were in developing countries (WHO (2007) *Human Papillomavirus and HPV Vaccines: Technical Information for Policy-makers and Health Professionals*, Geneva: WHO).

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Existing Global Commitments Regarding Gender and Health and guidance documents

GAVI will also strive to raise awareness of and promote coordinated international efforts towards the realisation of existing international commitments to gender equality and health equity goals in the course of implementing its Gender Equality Policy. These include but are not limited to:

- The achievement of the **MDGs** (especially Goals 3, 4 and 5), related Poverty Reduction Strategy (PRS) goals and the aspirations of the International Health Partnership (IHP);
- **The realisation of women's and girls' rights to equality, well-being and health** as reflected in the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the UN Beijing Platform for Action (BPfA), the World Health Organization (WHO) Constitution and the Global Immunisation Vision & Strategy (GIVS); and
- **The right to the highest attainable standard of health** enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child, and other international human rights instruments.

International agreements on gender equity

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)¹⁸. CEDAW (1979) sets out the normative framework for women's rights and gender equality and obliges (Article 3) state parties to take all appropriate measures, including legislation, to ensure the full development and advancement of women and to guarantee them equal rights and freedoms. CEDAW defines governments as responsible to take all necessary efforts in all policy sectors to realise those rights and achieve de facto gender equality, and to report regularly on the implementation of their obligations. The recommendations of the CEDAW Committee provide valuable guidance for governments and their development partners to improve their performance for women's empowerment and gender equality.

The **Beijing Platform for Action (BPfA)**¹⁹ adopted at the 4th UN Conference on Women in Beijing (1995) proved an important milestone in setting the agenda for gender mainstreaming across all fields of activity. Two strategic objectives of the BPfA are of particular relevance to GAVI's work with country partners: the BPfA obligates national governments (1) to integrate gender perspectives into all 'legislation, public policies, programmes and projects' (Strategic Objective H.2) and (2) to 'generate and disseminate gender-disaggregated data and information for planning and evaluation Actions to be taken' (Strategic Objective H.3).

The **MDGs and gender**: the UN Inter-Agency Network on Women and Gender Equality has highlighted gender as a crosscutting issue affecting the realisation of all the MDGs:
While Goal 3 reaffirms an international commitment to gender equality, the targets and indicators linked to this goal are narrowly defined. But [...] Women disproportionately suffer the burden of poverty [Goal 1], are the primary agents of child welfare [Goals 1, 2 and 4], are the victims of widespread and persistent discrimination in all areas of life, and put their lives at risk every time they become pregnant [Goal 5]. They

¹⁸ CEDAW. (1979) *Convention on the Elimination of All Forms of Discrimination Against Women*. Available at: <http://www.un.org/womenwatch/daw/cedaw/index.html>.

¹⁹ Fourth World Conference on Women. 15 Sept. 1995. *Beijing Declaration and Platform for Action*. Available at: <http://www.un.org/womenwatch/daw/beijing/beijingdeclaration.html>.

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are increasingly susceptible to HIV/AIDS and other major diseases [Goal 6], play an indispensable role in the management of natural resources [Goal 7], and have the right to gain as much as men from the benefits brought by globalisation [Goal 8]. Recognising women's contributions and realising and protecting their rights thus impacts across all eight of the MDGs. Failure to address these concerns will lead to failure in achieving the MDGs themselves.²⁰

The **Poverty Reduction Strategy Papers (PRSPs)**, mandated by the international finance institutions (IFIs), provide a national development framework designed to coordinate national government policy and supportive efforts by civil society and donors in almost all low-income countries. These are also shaped to a significant extent around the achievement of the MDGs. IFI and donor funding is typically contingent on good progress against measurable indicators linked to MDG goals and targets. In many cases, these necessitate the collection and reporting of age- and sex-disaggregated data, thus providing another opportunity for alignment and harmonisation.²¹

Through the recently established **Joint Institutional Approach (JIA 2006)**²², DFID, CIDA and Sida (2006) commit to working in partnership to support UNICEF in fulfilling its mandate to advocate for the rights of the child and help meet their basic needs, in the context of achieving the MDGs. Within the JIA, gender equality is identified as one of three key priority areas of work aimed at supporting the fulfilment of UNICEF's commitment to gender mainstreaming through a rights-based approach, including providing evidence and analysis of the situation of girls and boys, women and men.

International agreements on children's rights

The UN Convention on the Rights of the Child (CRC)²³ obliges States parties to respect, protect and fulfil the rights of the child, including the right to life, survival and development, and the right to the highest attainable standard of health. A core principle of the CRC is that of 'progressive realisation', which obliges states to ensure respect for the rights reflected in the Convention without discrimination and to undertake all appropriate means towards their implementation, within the maximum extent of their available resources – including through international cooperation and assistance. Increasingly, UNICEF and other UN agencies are supporting the capacity of national governments to collect age-disaggregated poverty, well-being and budget data so as to be able to measure progress effectively.

International agreements on the right to health

The right to the highest attainable standard of health, as well as commitments to gender equality as a component of achieving this right, is reflected in international human rights treaties, international political commitments, and other international instruments, including the following:

- The WHO Constitution (1946) states that the 'enjoyment of the highest standard of health is one of the fundamental rights of every human being'. In 2007, the World Health

²⁰ See <http://www.mdgender.net/goals/> for more details. This site is a collaborative effort of the **UN Inter-Agency Network on Women and Gender Equality**, the **OECD/DAC Network on Gender Equality**, and the **Multilateral Development Bank Working Group on Gender**.

²¹ See, for example, http://siteresources.worldbank.org/INTPRS1/Resources/Attacking-Poverty-Course/399075-1115239057864/s2_swanson.pdf.

²² DFID, CIDA and Sida. (2006) *Canada, Sweden and the UK: A Joint Institutional Approach. Working Together with UNICEF for the World's Children*, London: DFID.

²³ UN General Assembly. (12 Dec. 1989) *Convention on the Rights of the Child*.

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Assembly noted the importance of integrating gender analysis and actions into the work of the WHO.²⁴

- The International Covenant on Economic, Social and Cultural Rights²⁵ provides for ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’ (article 12) This right requires governments to put in place legislation, policies and programs which will lead to available and accessible health care for all, using the maximum available resources, including through international cooperation and assistance.
- Most recently, the International Health Partnership (IHP), formed in 2007 under the leadership of Gordon Brown, recommitted signatories from developing and developed country governments, as well as major global health agencies,²⁶ to renewed urgency in accelerating progress towards the health-related MDGs through partnership and country-led improvement in sustainable health systems (IHP, 2007)²⁷.
- In its resolution 2002/31, the UN Commission on Human Rights emphasised the importance of a gender perspective to the realisation of the right to health’ and requested the UN Special Rapporteur on the right to health to apply a gender perspective throughout his mandate²⁸.
- The Global Immunisation Vision & Strategy (GIVS) 2006-15, jointly drafted by UNICEF and the WHO (2005), which ‘aims to sustain existing levels of vaccine coverage, extend immunisation services to those who are currently unreached and to age groups beyond infancy, introduce new vaccines and technologies, and link immunisation with the delivery of other health interventions and the overall development of the health sector,’ stipulates gender equality as a guiding principle to achieving these goals.

²⁴ This commitment itself is noted as drawing upon: the ICPD Programme of Action (Cairo, 1994), the Beijing Declaration and the BfPA (Beijing, 1995), the recommendations of the Beijing+10 Conference (2005) and their reports, the Economic and Social Council’s agreed conclusions 1997/2, the UN Millennium Declaration 2000, the 2005 World Summit Outcome and Resolution WHA58.30 on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration.

²⁵ UN General Assembly. (1976) *International Covenant on Economic, Social and Cultural Rights*. Available at: http://www.unhchr.ch/html/menu3/b/a_ceschr.htm.

²⁶ Signatories include: the WHO, UNICEF, the Gates Foundation, the Global Fund to Fight AIDS, TB and Malaria, the GAVI Alliance, UNAIDS.

²⁷ IHP (2007) ‘A Global “Compact” for Achieving the Health Millennium Development Goals’, No. 10 Downing Street, London, signed 5 September.

²⁸ Hunt, P. (2008) ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health’, Human Rights Council 7th session.

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Current membership of the advisory committee (as of May 2008)

GAVI Alliance Partners and other agencies

1. Tony Measham (World Bank)
2. Noreen Khan (UNICEF)
3. Peju Olukoya (WHO)
4. Dianne Stewart (The Global Fund to fight AIDS, Tuberculosis and Malaria)
5. Rebecka Allfram (Sida)

GAVI Secretariat

6. Carol Piot (Finance)
7. Corina Luputiu (Executive Office)
8. Dirk Sellers (Private Philanthropy Team)
9. Geoff Adlide (External Relations)
10. Jorn Heldrup (Country support)
11. Lisa Oldring (Governance Special Advisor to Mary Robinson, GAVI Fund Board of Directors)
12. Nina Schwalbe (Deputy Executive Secretary, Director of Policy)
13. Sofia Östmark (Coordinator, External Relations)