

FAQs: GENDER & POLIO ERADICATION



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What is gender and how does it relate to immunization?

Gender refers to the expected behaviour, roles and activities of women and men in societies. It is a social construction that intersects with different socio-economic determinants such as age, ethnicity and economic status. Gender roles and relations vary from society to society and are underpinned by power relations, leading to different opportunities, limitations, challenges, needs and vulnerabilities for women, girls, boys and men. Gender differs from sex in that it is social and cultural rather than biological.

Gender roles and norms are powerful determinants of health outcomes. Gender-related barriers to immunization operate at multiple levels, from the individual to the household and the community, and gender impacts both the access to and the provision of vaccines. For instance, caregivers are critical decision-makers allowing vaccination but the power to make decisions and the available resources people have to act on those decisions are influenced by gender. Similarly, house-to-house polio vaccination is heavily influenced by gender dynamics in many contexts, for instance in areas where only female vaccinators are allowed to enter households and interact with female caregivers. The Global Polio Eradication Initiative's Gender Technical Brief (2018) contains a thorough analysis of the different gendered aspects of polio eradication.

What is gender analysis?

A gender analysis identifies disparities, examines why such disparities exist and looks at how these disparities could be addressed. It identifies, assesses and informs actions to address inequality that stems from gender norms, roles and relations and unequal power relations. Gender analysis is used to identify and understand the different roles, opportunities and power dynamics that exist between

women and men in a specific context. Gender analysis in health can highlight differences in e.g. risk factors and vulnerability, access to health services and decision-making processes related to health.

What is gender mainstreaming?

Gender mainstreaming is a strategy for assessing the implications for both men and women of any planned actions, policies or programmes in all areas at all levels. It is about making women's and men's concerns and experiences a key dimension of the design, implementation, monitoring and evaluation of policies and programmes so that women and men benefit equally and inequality is not perpetrated. The ultimate goal of gender mainstreaming is to achieve gender equality. Gender mainstreaming is a process and a means to an end, not a goal in itself. Gender mainstreaming does not exclude interventions that focus only on women or only on men. Sometimes, gender analysis can reveal inequalities and discrepancies that call for sex-specific interventions.

Does gender just mean the same as women and women's issues?

No. Gender is not just about women and girls – it is about the relations between women and men with different roles, responsibilities, expectations, norms and unequal exercise of power. Gender analysis and gender mainstreaming considers the needs, experiences and challenges of both women and men in a given context and seeks to ensure that all interventions have a more equitable effect on those affected. However, women and girls continue to be the focus of many tailored initiatives in many settings because they still suffer from discriminatory practices and pervasive gender inequality.

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Is there a difference between gender equality and equity?

Yes. Gender equality is about giving the same opportunities to women and men to access and benefit from resources. Gender equity goes beyond equality of opportunity as it acknowledges that women and men have different needs, experiences, vulnerabilities and challenges. This implies that different strategies are needed to ensure equality of opportunity. For example, women and men might formally have the equal chance to attend a polio-specific training. However, just having the equal opportunity to join the training may not result in women taking advantage of this opportunity due to multiple challenges, e.g. in some contexts women might need a permission from a male household member to attend, or someone to accompany her, women might not have access to household income, transportation or other resources that hinder their participation. It is not enough to give women and men equal access to resources and opportunities but they should also be given the means and tools to be able to fully benefit from these.

How does the polio programme ensure that girls and boys are equally reached during vaccination campaigns?

Multiple studies have shown that a child's sex does not have a significant influence on immunization status and coverage worldwide. Nevertheless, there are notable variations where immunization coverage is higher for girls in some countries and higher for boys in others. This is why the polio programme regularly collects sex-disaggregated data to enable it to track gender-related discrepancies and take swift corrective action. Overall it is important to note that data from the polio-endemic countries (Afghanistan, Nigeria and Pakistan) in the past two years shows that girls and boys have been equally reached in house-to-house vaccination campaigns. For instance, in Afghanistan, out of all girls surveyed after vaccination campaigns in 2017, 92.6% were recorded as vaccinated, compared to 92.5% of boys. This high level of coverage is the tangible result of targeted and context-specific communications for awareness raising and behaviour change activities, combined with well-trained health workers recruited from local communities.

What is the GPEI doing to recruit more women as polio workers in the endemic countries?

An integral part of reaching every last child with repeated vaccination has been the increased role of women at different levels of the polio eradication programme. Hiring women in traditional contexts is imperative as in many areas, only female health workers have access to the households and can build trust and convince mothers to vaccinate their children. Female health workers have been featured increasingly as the true heroes of the

polio eradication programme. The GPEI has continually developed or adapted local strategies to engage women in the critical moment of the caregiver's decision on whether to vaccinate children against polio.

The GPEI is committed to increasing the number of female front-line workers, while providing them with the tools, training and protection they need to conduct their work effectively. In some of Pakistan's highest-risk areas, for instance, more than 90% of vaccinators are women, while in Afghanistan's highest-risk areas, women now account for 37% of social mobilizers – up from 6% during 18 months.

How many women are working in the polio programme?

Female health workers and social mobilizers are instrumental in building trust in their communities and encouraging vaccination, and the GPEI is committed to recruiting more women for the programme. In Pakistan, women currently (2017) make up more than 56% of front-line workers nationally, and in Nigeria, over 90%. In Afghanistan, where insecurity and strict gender roles in many areas restrict women's work and movement outside the home, currently 40% of front-line workers in urban areas are women. Pakistan and Nigeria have committed to ensuring that at least 80% of all front-line workers are women while Afghanistan has committed to having women comprise at least 50% of polio workers in urban areas by the end of 2018. The GPEI continuously monitors countries' performance in engaging more women as polio workers and reports on progress in its semi-annual status reports.

How does GPEI ensure gender equality is integrated in its activities and monitor gender-indicators?

The GPEI recognizes that gender is a powerful determinant of health and is committed to identifying and addressing gender-related barriers in its immunization, communication and surveillance activities. The GPEI has recently developed gender-sensitive indicators which it regularly tracks and reports on bi-annually. These gender-sensitive indicators measure the equal reach of girls and boys in vaccination campaigns, the doses of polio vaccine girls and boys have received, the timeliness of disease surveillance for girls and boys and women's participation as front-line workers in polio-endemic countries. The GPEI constantly collects sex-disaggregated data in order to track progress and adjust the programme when any gender-related discrepancies are found. The GPEI is currently developing a Gender Strategy to further guide its work towards strengthening gender mainstreaming across the programme at different levels.

What are the polio programme's indicators for measuring and tracking gender-related issues?

There are currently four indicators the GPEI is tracking and monitoring on a regular basis, and the programme reports on these indicators for endemic, outbreak and high-risk countries in its [semi-annual Status Reports](#). These are:

- 1) **Girls and boys reached in vaccination campaigns** – Measuring whether boys and girls receive equal immunization coverage in endemic countries with ongoing house-to-house vaccination campaigns
- 2) **Total doses of polio vaccine received by girls and boys** – Similar to the first indicator, this measures immunization coverage for girls and boys, measured as the percentage of girls and boys with zero doses and with three or more doses, as well as the median number of doses for girls and boys. This indicator is particularly useful in conveying information on whether we are missing significantly more girls or boys in a given context
- 3) **Timeliness of disease surveillance** – This indicator intends to measure caregivers' health-seeking behaviours and whether there are any delays in disease notification due to a child's sex
- 4) **Women's participation in immunization activities** – This indicator measures the participation of women as front-line workers in polio-endemic countries as vaccinators and social mobilizers

Are there any gender differences in terms of children's vulnerability to contracting polio?

Sex is a risk factor for polio, with a slight predominance found in males, who are more at risk for developing paralytic polio. Adult females are also at risk if they are pregnant. In addition to biological factors, social factors and power dynamics around gender that shape girls' and boys' opportunities and vulnerabilities are also crucial. Immune deficiency and malnutrition, risk factors for polio, are influenced by gender. Physical activity, which is heavily regulated by gender roles and norms, is a risk factor associated with the severity of paralysis. For example, in societies where boys are more valued than girls, boys are more likely to receive better nutrition, timely medical attention, vaccines and other opportunities to advance their health and well-being.

What has the GPEI done on gender issues in the past and why is it focusing on gender now?

In its efforts to eradicate polio and reach every last child, the GPEI has continuously worked to ensure that all children, girls and boys, are vaccinated against polio and protected from the paralyzing virus. The programme has collected sex-disaggregated data as part of its data collection processes. The GPEI has also continuously sought ways to increase women's role at different levels of the programme. However, in the past these efforts have not been systematically documented, tracked and monitored. The initial gender analysis included in the GPEI Gender Technical Brief is an important first step towards strengthening gender aspects of the programme, and the GPEI will continue to work towards systematically mainstreaming gender in its activities and interventions, with a gender strategy to be developed during 2018 to further guide this work.

What are the key results of the GPEI analysis of its new gender-sensitive indicators?

The data the GPEI has analysed and statistically tested from 2016-2017 does not show significant differences in terms of gender for most countries, either for children reached in vaccination campaigns or for surveillance data. However, data from the second half of 2017 in Syria shows that the percentage of 0 doses was 27% for girls while it was 15% for boys, and similarly, 72% of boys surveyed had received three or more doses, compared to only 32% of girls. For Central African Republic (CAR), 96% of boys surveyed had received three or more doses, compared to only 74% of girls during the second half of 2017. In CAR, disease notification within 3 days was 24% for girls, compared to 38% of boys. Gender differences in the timeliness of surveillance were also noted in Cote d'Ivoire, Ukraine, Sierra Leone and Mali. The programme continues to closely monitor the data for these countries and investigate significant findings to guide its work.

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