

GENDER AND IMMUNISATION ABRIDGED REPORT

**A Knowledge Stocktaking Exercise and an Independent Assessment
of the GAVI Alliance**

A Report Commissioned by the GAVI Alliance Secretariat

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BPfA	Beijing Platform for Action
CAR	Central African Republic
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIDA	Canadian International Development Agency
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
CSS	Civil Society Support
DAC	Development Assistance Committee (OECD)
DALY	Disability-adjusted Life Year
DFID	UK Department for International Development
DHS	Demographic and Health Surveys (USAID)
DRC	Democratic Republic of Congo
F/M MR	Female/Male Mortality Ratio
GAVI	Global Alliance for Vaccines and Immunisation
GEGA	Global Equity Gauge Alliance
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
GHP	Global Health Partnership
GIVS	Global Immunisation Vision & Strategy
HEG	Health Equity Gauge (WHO supported)
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HR	Human Resources
HSS	Health Systems Strengthening
HTMV	High-titre Measles Vaccine
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IFI	International Finance Institution
IFFIm	International Finance Facility for Immunisation
IHP	International Health Partnership
INS	Injection safety support
IPA	International Paediatric Association
IRC	Independent Review Committee
ISS	Immunisation Services Support
JIA	Joint Institutional Approach
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Surveys (UNICEF)
MMR	Measles, Mumps and Rubella
Norad	Norwegian Agency for Development Cooperation
NVS	New and Underused Vaccine Support
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
R&D	Research and Development
Sida	Swedish International Development Cooperation Agency
SMT	Senior Management Team
TB	Tuberculosis
TT	Tetanus Toxoid
UDHR	Universal Declaration of Human Rights
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNCRC	United Nations Convention on the Rights of the Child

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

Gender-related Definitions¹

Sex: is concerned with the 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

Gender equality: 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 equity: refers to fairness and justice in the distribution of benefits, but is dependent on the definition of fairness and justice endorsed by different societies. Gender equity can mean calling for a transformation of gender relations in that it recognises that equality of opportunity with men within the *status quo* is not necessarily desirable, it also runs the risk of accepting culturally ascribed gender roles that are seen as fair and just in a particular society, but that implicitly endorse power imbalances between women and men.

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:

- Striving towards 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
- Eventually achieving the right to health and well-being for all girls and boys, women and men.

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.

¹ Definitions adapted from Commonwealth Secretariat (1999; 2002).

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

Gender analysis: is the critical examination of a problem, issue or situation in order to understand the root causes of gender inequality or discrimination as it affects women and men in the development process.

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 women and men, which may include issues of sexual identity) and searching for solutions to overcome the gaps.

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

Son preference:³ a phenomenon underpinned by economic, religious, social and emotional desires and norms that favour male children and make females less desirable in family units, resulting in well documented effects such as skewed population sex ratios, female feticide and higher female child mortality rates.

Women's time poverty: owing to gender-based social roles and responsibilities (including non-market, labour-intensive work of subsistence agriculture, processing food, gathering water and firewood and caring for the young, elderly and sick) and owing to the need to balance multiple roles simultaneously, women's and girls' labour time and flexibility are often much more constrained than men's and boys'. These competing claims on limited time result in a situation of 'time poverty.'

³ This definition is adapted from Pande and Malhotra (2006).

Table of Contents

Executive Summary	viii
1. Introduction	1
1.1 Objectives and methods.....	1
1.2 Caveats.....	1
2. Gender Matters: Gathering the Evidence	3
2.1 Gender and health	3
2.2 Immunisation coverage: an example of gender equality?	4
2.3 Gender as a factor in reaching the most marginalised populations	6
2.5 Age- and sex-disaggregated data: gaps in the knowledge base	8
2.6 Gender as a factor in accessing immunisation and other health services	10
2.7 Burden of disease: gender implications of immunisation investment.....	12
3. Assessing the GAVI Alliance Secretariat from a Gender Perspective	14
3.1 Assessment of the GAVI Alliance windows of support	14
4. Assessing the GAVI Alliance’s Country Partners’ Work from a Gender Perspective	20
4.1 An overview of gender frameworks and mainstreaming approaches	20
4.2 Country partners	22
4.3 Opportunities for donor harmonisation and leveraging off existing commitments...	23
5. Strategy Development Entry Points	26
5.1 Evidence base	26
5.2 Public-private partnership business model	26
5.3 Policy, programming and funding support	28
5.4 Donor harmonisation.....	28
5.5 Communication.....	29

List of Tables

Table 1: Gender Equality Policy Development Assessment Tools	2
Table 2: Full and No Immunisation Coverage, Female to Male Coverage Rate Ratio	7
Table 3: Assessing Capacity of Multilaterals to Address Gender Issues, GAVI Results.....	16
Table 4: Evolution of Approaches to Gender and Development	21
Table 5: International Agreements on Gender Equity, Children’s Rights and the Right to Health.....	24

List of Figures

Figure 1: Timeline: Gender Equality Policy Development in the Context of GAVI Alliance Strategic History.....	15
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Executive Summary

This report seeks to document the ways and extent to which issues of gender equality are incorporated into policy dialogues, programme design and implementation of immunisation services and related health services, including an independent assessment of the current state of attention to gender within the GAVI Alliance. It was undertaken as part of a broader process initiated by the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation) to develop an evidence-informed Gender Equality Policy. This document draws on and presents the knowledge base from which the policy (recently approved by the GAVI Alliance Board in June 2008) and the plan for its implementation were developed.

The abridged version of the report comprises: (1) a review of the academic literature, (2) an assessment of the policies of the GAVI Secretariat and key Alliance stakeholders; (3) interviews with Secretariat staff as well as with members of a gender advisory group, the Independent Review Committee (IRC), other Task Teams and stakeholders.

The key findings of the stocktaking exercise can be summarised as follows:

Gender and immunisation

- Gender equality, and its underlying power relations, is a powerful determinant of health outcomes and is well documented. There is significant evidence of the gender determinants of demand for, access to and utilisation of health services, with implications for immunisation coverage – particularly *vis-à-vis* the hardest to reach populations. These include asymmetrical power relations within families and society in relation to influence over resource allocation, decision making, use of time, formal and informal employment and other responsibilities, discrimination in service delivery, participation in clinical trials, etc, all of which ultimately influence immunisation coverage.
- Immunisation is widely perceived as gender-neutral but the existing evidence suggests that: (1) sex differentials in immunisation coverage exist in a range of contexts (against both boys and girls); (2) such differentials are often exacerbated in the hardest to reach populations; and (3) there are major sex differentials in the burden of disease across vaccine-amenable illnesses.
- The evidence on the gendered dimensions of immunisation coverage is limited by the failure of the international community to uphold its commitment to support the generation, consistent reporting and analysis of age- and sex-disaggregated data. Although the United Nations Children's Fund (UNICEF) Multiple Indicator Cluster Survey (MICS) and the Demographic and Health Surveys report immunisation coverage by sex, there are limitations to these data that hinder evidence-informed, gender-sensitive immunisation policy development.

Gender mainstreaming

- Approaches to gender and development have evolved considerably over the past 50 years. Although lofty international commitments have been made to quite radical agendas for societal transformation in the treatment of the sexes, the application of these commitments in development programming has become increasingly technocratic and ritualistic. Innovative strategies to transform entrenched cultural attitudes underpinning gender inequalities have received inadequate attention.
- Meta-analysis of gender mainstreaming within organisations and policies identifies the following variables as particularly important determinants of failure and should be taken into consideration in the development of initiatives to address the gendered dimensions of immunisation service access, quality and impacts: (1) according the issue low priority and insufficient resources; (2) insufficient senior leadership; (3) active and/or passive resistance; and/or (4) lack of linkages between mainstreaming

in external programming and the development of internal gender-sensitive organisational structure and culture.

Applying a gendered lens to the operations of the GAVI Secretariat

- There is nascent, strong, high-level and widespread interest across the Alliance Secretariat and among its partners to mainstream gender issues.
- Notwithstanding recent commitment, there has been minimal attention to gender within Secretariat documentation and processes as they relate to policy and planning (e.g. the GAVI Roadmap), guidance for and review of country funding proposals, country progress reporting indicators, human resources (HR) and communication.
- Concerns were expressed that the GAVI Alliance should not be perceived to impose additional obligations on countries to consider the gendered dimensions of their immunisation programmes in order to apply for support from GAVI. However, (1) almost all GAVI countries are signatories to a range of international agreements which commit them to the progressive realisation of gender equality and girls' and women's empowerment, including the collection of age- and sex-disaggregated data; (2) the GAVI applications from some countries already indicate concerns to address the gendered dimensions of immunisation; and (3) past positive examples in GAVI guidelines have been demonstrated to have a strong impact on the content of country proposals.

Applying a gendered lens to the operations of Alliance country partners

- A survey of Alliance country partners revealed strong support by country stakeholders for the Gender Equality Policy as a necessary component of achieving the Millennium Development Goals (MDGs) (53%), as contributing to improving programme effectiveness (50%) and as part of a rights-based approach to development (47%). There was, however, a limited degree of awareness regarding the implications of gender inequalities in the context of immunisation services.

Policy development entry points

The knowledge base suggests that the GAVI Alliance Gender Equality Policy ought to prioritise six thematic areas:

1. Evidence base

Understanding and knowledge of the gender dimensions of immunisation are currently weak and inadequate for evidence-informed policy development. The GAVI Alliance, through its evidence-informed approach to development, could play a pivotal role in redressing this lacuna by leveraging the partnership in the pursuit of gender equality, and specifically in supporting sex and age-disaggregated data collection, analysis and reporting on immunisation coverage and impacts across the life-cycle.

2. Public-private partnership business model

The Alliance has demonstrated partnership proof-of-concept on a range of such issues and is a high-performing public-private partnership. Its high profile in the health policy community could be used to demonstrate that gender mainstreaming as a core business practice can lead to development success, but this will require tapping more effectively the gender skills, expertise and resources of partner organisations and applying these to immunisation service policy and programme design and implementation. Communication channels can also be used to better inform all GAVI constituencies of the gender dimensions of immunisation and related programmes, including the development of gender storylines.

3. Policy, programming and funding support

Although based on a country-driven model, the Alliance exerts subtle influence on country immunisation programmes and priorities through the support it makes available, the technical norms and standards it endorses and the signals the Board and Secretariat convey through both statements of policy and guidelines for preparing proposals to access funding through the various windows. The latter offers considerable potential to encourage and support countries to introduce a gender lens into their immunisation programmes, as some are already doing. Encouraging countries to introduce a gender lens into their proposals and performance evaluation aspects is an important component of promoting a gender perspective across the project cycle.

4. Donor harmonisation

A number of existing international commitments, ranging from the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) to the Beijing Platform for Action (BPfA), the Millennium Development Goals (MDGs) to the Global Immunisation Vision & Strategy (GIVS) could serve to guide the GAVI Alliance in spearheading and supporting partners and country efforts to mainstream gender in immunisation and related health services. As countries have almost universally signed up to these agreements, including the obligation to integrate gender into all policies, programmes and projects; to collect age- and sex-disaggregated data; and to report regularly on progress towards gender equality outcomes, GAVI's emphasis should be on facilitating and supporting donor and country partners in this process.

5. Communications

External communication and advocacy is particularly important for the GAVI Alliance as a public-private partnership. Currently, there is little explicit discussion of gender in GAVI's publicly available materials. Within the communications, policy advocacy and private philanthropy teams of the Alliance, there is a hitherto untapped potential to convey the commitment of the partnership to gender equality and the underlying rationale linking gender to the unfinished business of the Alliance in realising its vision.

1. Introduction

1.1 Objectives and methods

This report provides a synthesis of a knowledge stocktaking exercise on the incorporation of gender equality considerations into immunisation service policies and programmes and related health services and systems. It is concerned with not only the gender dimensions of access to immunisation services but also experiences of service quality and impact. The report is also an independent assessment of the current state of attention to gender within the GAVI Alliance. The report was undertaken as part of the GAVI Alliance's (formerly the Global Alliance for Vaccines and Immunisation) Gender Equality Policy development process. The starting point of this work was the recognition that an innovative Gender Equality Policy has the potential to improve the effectiveness of GAVI Alliance policy and programming, and in turn to enhance the GAVI Alliance's contribution to the achievement of the Millennium Development Goals (MDGs) and the expansion of women's and children's rights and health status. It could also strengthen the GAVI Alliance's role and profile as a catalyst for change in the global health arena.

The report's scope is as follows:

- 1) A synthesis of existing evidence regarding links between gender and immunisation and health service strengthening, and identification of research gaps and future research directions to strengthen the business case. We will put emphasis both on what is said about gender relations and on the silences, which are often as or more revealing.
- 2) Assessment of the current gender perspectives and practices within GAVI through a document analysis of all GAVI Secretariat materials, ranging from the GAVI Alliance strategy, objectives and work plan, to country support guidelines (for immunisation services strengthening, health systems strengthening and civil society support), applications from countries and monitoring and evaluation procedures.
- 3) A desktop review of GAVI Alliance partners' approaches to gender and gender mainstreaming action plans (contextualised within the broader literature on gender mainstreaming), especially in the health field, so as to ensure that GAVI's policy is complementary and adds value. This review also includes a discussion on opportunities for donor harmonisation, including reference to key agreements to which countries have already committed to this.⁴

1.2 Caveats

As part of our broader evidence-based policy approach, we employed a variety of methodological tools to underpin the development of a Gender Equality Policy and Implementation Strategy for the GAVI Secretariat and Alliance. These tools and the content area to which they apply are presented in Table 1 below. It is important to note that, although we have carried out a significant number of stakeholder interviews with GAVI Secretariat staff and international Alliance partners to date⁵, we have not included an in-depth analysis of these in this document. These interviews have proven of greatest value in terms of the forward-looking insights they offer on the strengths and weaknesses, opportunities and

⁴An online questionnaire with GAVI Secretariat staff designed to assess gender mainstreaming in development, gender-based issues in the health sector, gender-based issues within GAVI and visions for a Gender Equality Policy for the GAVI Alliance was also undertaken but is not reported on in this abridged version.

⁵A full set of appendices is available upon request from the GAVI Secretariat, including a full list of interviewees.

threats for mainstreaming gender within the GAVI Alliance. Accordingly, the insights from the stakeholder interviews and gender-sensitive stakeholder analysis will inform an important part of our thinking in terms of the development of the Gender Equality Policy and Implementation Strategy. In the case of the discussion board, to date there has been little active engagement – owing perhaps to time constraints and to unfamiliarity with such forums within GAVI’s work culture.⁶

Table 1: Gender Equality Policy Development Assessment Tools

Content area	Assessment tools	Application
Knowledge/evidence: gender, immunisation and health	Document content analysis	Baseline assessment
Policies/programming Internal procedures	Gender analysis/audit	Baseline assessment
Organisational structure	Stakeholder interviews	Gender Equality Policy and Implementation Strategy recommendations
Organisational linkages (external)	Gender-sensitive stakeholder analysis	Gender Equality Policy and Implementation Strategy recommendations
Human resources	Staff competencies questionnaire	Baseline assessment
Organisational culture	Discussion board	Gender Equality Policy and Implementation Strategy recommendations

Key:

Methods applied to this baseline assessment

Methods to be applied to Gender Equality Policy and Implementation Strategy development

⁶ It is also important to point out that in this abridged version we do not discuss human resources issues, although this is an important consideration in any gender mainstreaming assessment. This material is reported on elsewhere where a distinction was made between HR issues that (1) are related to workplace culture, managerial practices and benefit packages, etc and (2) pertain to gender sensitivity and competencies in the application of gender analysis tools and perspectives to GAVI’s policy design and programme-related work, funding and investment strategy decisions, and the internal and external communication of these activities.

2. Gender Matters: Gathering the Evidence

2.1 Gender and health

There is substantial empirical evidence illustrating the centrality of gender equality to effective and equitable development and poverty reduction.⁷ Gender equality is an issue of programming effectiveness for the most vulnerable populations, human rights and well-being and, ultimately, development effectiveness.⁸ In the health sector, gender equality plays a critical role in reducing maternal and child mortality and in mitigating the spread of the most devastating epidemic diseases, as immunisation rates have been shown to significantly improve with the level of maternal education (World Bank, 2001). Similarly, gains in child survival and nutrition as a result of income growth are more significant when that income is concentrated in the hands of women, or when the balance of power between women and men in the home is more equitable.⁹ Healthy, educated, empowered women are better able to contribute to economic productivity, as well as to facilitate the socioeconomic development of the next generation (Glick, 2002).

The gender-based relations of power that are at the root of gender inequality form one of the most influential social determinants of health (Sen and Östlin, 2007), structuring vulnerability to disease and ill-health, the extent to which people's health needs are acknowledged,¹⁰ access to health services, quality of health care and the very research on which health policies and decision making are based.¹¹ Although socioeconomic inequality is commonly addressed in health analysis, health gradients can be significantly different for women and men as a result of the differential effects of poverty on men's and women's health. For example, in Malawi, the delay period for treatment for tuberculosis, AIDS or malaria was greater among women owing to the financial and opportunity costs of accessing care, as well as to the stigma associated with seeking treatment (i.e. assumed to be a sign of HIV infection). When women do seek treatment, they may be forced to sell their assets in order to afford it. This may exacerbate their poverty and their vulnerability, such as to other diseases associated with, for example, the inability to afford safe water sources (Nhlema et al, 2006). It is therefore critical to understand the ways in which gender-based social inequalities intersect with economic health determinants (as well as racial/ethnic hierarchies, caste domination, differences based on sexual orientation and other social stratifiers, such as levels of education) and influence demand for, access to and uptake of health care services.¹²

⁷ See e.g. Kabeer (2003), UNICEF (2006; 2007), Whitehead and Lockwood (1999) and Wong (2003).

⁸ See e.g. Durrant and Sathar (2000), Mosedale (2005) and O'Connor et al (1999).

⁹ Christiaensen and Alderman (2004), McKennon et al (2005) and Pal (1999).

¹⁰ This refers to the extent to which decision-making power (often concentrated in the hands of men owing to greater wealth and education levels and to socio-cultural norms of behavior) affects not only access to treatment, but also whether women's health needs are acknowledged. At times, research has shown that women (e.g. young women with TB in Vietnam) will not publicly acknowledge their health problems, as this would lead to lower chances of marriage. Families, on the other hand, may turn a blind eye to women's health needs owing to low value or priority attached to investing in women's lives.

¹¹ Historically, women have often been excluded from participation in medical research and clinical trials owing to the potentially compounding variable effects of the menstrual cycle and concern over inadvertent effects of research upon women's reproductive health and fertility. Yet, clinical trial results based upon solely male participants have been applied to females and males regardless. Criticism has led to major revisions in the process of including women in clinical research (e.g. the 1993 US National Institute of Health requirement to include women subjects in all clinical trials). However, much work remains to ensure that methodologies themselves are gender-sensitive, addressing potential barriers to women's participation in research.

¹² An annotated bibliography on key gender mainstreaming resources is available by request from the GAVI Secretariat as a component of a complete set of appendices.

2.2 Immunisation coverage: an example of gender equality?

Immunisation – one of the ‘best buys’ in health and successfully provided across some of the most difficult contexts for health service provision – is often assumed to be ‘gender-neutral,’ reaching girls and boys, women and men at equal rates of coverage, or perhaps even biased positively towards women as they are often the sole recipients of tetanus toxoid vaccinations. However, an analysis of recent health literature and data reveals a nuanced and complex range of gender-inequalities, reflecting both immunisation coverage obstacles to be addressed and a substantial knowledge gap.¹³

Analysis of the most recently available¹⁴ Demographic and Health Surveys (DHS) and UNICEF (United Nations Children’s Fund) Multiple Indicator Cluster Surveys (MICS) data¹⁵ demonstrates that girls and boys in different contexts experience differential access to immunisation. Although socioeconomic inequality continues to be the most significant determinant of immunisation coverage,¹⁶ the data reveal gender inequality as a complicating factor, one that must be analysed along with socioeconomic inequalities, in order to fully understand how inequality functions in relation to immunisation and health systems.

Significant biases in immunisation coverage exist against girls in South and Southeast Asia. In Pakistan, for example, there is a 7.8% differential between boys and girls in terms of complete immunisation; in Cambodia, the difference is 4.9 percentage points; and in Nepal, 4.3 percentage points. India has the largest gap, with a 13.4 percentage point higher full immunisation rate among boys (Gwatkin and Deveshwar-Bahl, 2001). Moreover, although the worst performing Indian states regarding immunisation are located in the ‘Northern belt’ (Bihar, Nagaland, Meghalaya, Assam, Rajasthan, Arunachal Pradesh, Uttar Pradesh and Madhya Pradesh), compounding poor coverage rates among girls, studies have found that gender inequality cuts across socioeconomic and rural-urban divides (Pande and Yazbeck, 2003). The continued norm of son preference and its negative consequences for the survival, health and education of girl children is well documented in India: what is critical to note here are the implications for immunisation services. The picture is also further nuanced: a recent study indicates that, more than ‘son-preference,’ family balance considerations drive the likelihood that a girl child will be vaccinated. In a sample of 25,549 children aged 12-60 months in India, girls with two or more older brothers and no older sisters were equally likely to be immunised as boys, whereas girls with two or more older sisters were 1.72 times less likely to be immunised than boys (Pande and Malhotra, 2006).

¹³ Boorah (2004), Brugha et al (1996), Gwatkin and Deveshwar-Bahl (2001), Kwaak and Dasgupta (2006), Pande and Yazbeck (2003), Perry et al (2007) and Wirth et al (2006).

¹⁴ It is important to recognise that these data, although the most recently available, are often up to a decade old, owing to the multiple difficulties in making collected data ready for use and widely available.

¹⁵ DHS: Benin 2001, Botswana 1988, Burkina Faso 2003, Burundi 2000, Cameroon 2004, Central African Republic (CAR) 2000, Chad 2004, Comoros 1996, Congo 2005, Côte d’Ivoire 2000, Democratic Republic of Congo (DRC) 2001, Eritrea 2002, Ethiopia 2005, Gabon 2000, Gambia 2000, Ghana 2003, Guinea 1999, Kenya 2003, Lesotho 2004, Liberia 1986, Madagascar 2003/04, Malawi 2004, Mali 2001, Mauritania 2000/01, Mozambique 2003, Namibia 2000, Niger 2006, Nigeria 2003, Rwanda 2005, Sierra Leone 2000, Somalia 1999, Senegal 2005, South Africa 1998, Sudan 1990, Tanzania 2004, Togo 1998, Uganda 2006, Zambia 2001, Zimbabwe 2005/06. UNICEF MICS 2 end-decade assessment national datasets, 2001.

¹⁶ On average, the rate of coverage is 25 to 30 percentage points higher among the richest quintile of the population than the poorest quintile (Gwatkin and Deveshwar-Bahl, 2001).

Biases against girls in immunisation coverage are not confined to Asia, but are perpetuated in West and East Africa too, for example in: Gabon (7.2% difference), Gambia (6.7% difference), Côte d'Ivoire (4.5% difference), Ethiopia (4.3% difference) and Sierra Leone (3.6% difference). Qualitative research on East Africa suggests that this is closely linked with maternal education levels: higher immunisation coverage is associated with higher levels of maternal schooling and vice versa (Wirth et al, 2006).

Gender differences in immunisation not only impact girls. Biases exist against boys as well in Africa. 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. 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.¹⁷

Gender differences are present in both the DHS and UNICEF MICS survey results. As these survey instruments are known to entail potentially large sample errors owing to the stratified cluster sampling methodology used,¹⁸ the gender differences noted here were cross-analysed¹⁹ between both DHS and MICS surveys and found to be present in both survey instruments. A more in-depth analysis of these data is clearly warranted, including trend analysis that integrates multiple survey instruments. However, the presence of sizeable gender gaps in the data for a number of countries in diverse country contexts, combined with qualitative literature on gender gaps in immunisation, strongly suggests that immunisation – like health status more broadly – is not gender-neutral and is an area deserving further research attention.

In addition to these differences, the aggregation of data at 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,²⁰ as well as age- and sex-disaggregated data analysis by wealth quintile. For instance, DPT3 rates differed by sex in Kenya in the non-dominant ethnic groups; in urban areas, 98% of urban boys were vaccinated, compared with 90% of urban girls. Rates of maternal education are also a significant determinant of immunisation rates. In Ethiopia, for example, measles immunisation coverage rates among daughters of women with no education are 20%, compared with 25% among boys (P-value of 0.06). If the mother completes primary education, the rates equalise between girls and boys and rise to 39%. When maternal education is at a secondary level, the tables turn, and immunisation of girl

¹⁷ 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 and Adewuyi, 2005; Science in Africa, 2005).

¹⁸ Personal communication with Professor David Gordon, 14 May 2008.

¹⁹ Gender gaps crosschecked from UNICEF MICS and DHS surveys based on available data for countries with noted gender gaps:

Cambodia	MICS 2000	DHS 2000	DHS 2005	
	5.4	5.4	4.9	
Côte d'Ivoire	DHS 1994	DHS 1998/99	MICS 2000	MICS 2006
	2.5	0.1	4.5	2.6
Malawi	MICS 1995	DHS 2004		
	-3	-0.8		
Madagascar	MICS 2000	DHS 2003/4		
	-3.2	-12		

²⁰ Sex was not a significant factor at the bivariate level; however, at the multivariate level, sex became a significant stratifier.

children rises to 76% compared with 48% among boy children (P-value of 0.03) (Wirth et al, 2006).

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.

2.3 Gender as a factor in reaching the most marginalised populations

In recent years, immunisation programmes, often with GAVI support, have in many cases recorded rapid and substantial increases in coverage. However, as the rates of coverage increase, populations with low coverage are those that are increasingly difficult to reach owing to geographical remoteness, poverty and socio-cultural barriers, including gender inequalities. This results in a plateau of coverage rates, typically around 70-80%, and the corresponding difficulty of reaching 'the last 20%,' where issues of access are most difficult to overcome (GAVI Alliance, 2006).

In reaching this last 20-30%, it is particularly critical to understand the additive and multiplicative inequalities in access to care, including how socioeconomic inequalities interact with and often exacerbate gender inequalities. Overall, immunisation coverage rates are worst among the lowest wealth quintiles of a population. Recent studies have shown that, as immunisation geographical coverage increases, wealth inequalities often widen, as service coverage tends to improve among the wealthiest quintiles before the poorest quintiles (Gaudin and Yazbeck, 2006). If programmes are to effectively scale up coverage among lower wealth quintiles, a comprehensive understanding of the obstacles existing to service access must be developed.

In line with the widely observed linkage between poverty and unequal gender relations, our preliminary analysis of age- and sex-disaggregated immunisation coverage rates by wealth quintile suggests²¹ complicated and nuanced effects of gender inequalities (see Table 2 below). Often, gender gaps are greater among the lowest wealth quintiles; however, as noted above, important exceptions occur, where gender differentials cut across wealth quintiles, or where a bias against boys/girls reverses across wealth quintiles. This analysis highlights the pervasiveness and complexity of gender inequalities in immunisation coverage, and the contextually based variation that occurs between and within countries and regions. This underlines the need for countries to report on and analyse immunisation coverage and health systems barriers with a gender-sensitive perspective at a sub-national level.

Often, there is a larger gender gap in the lower quintiles of a population, most often biased against girls. For full basic immunisation coverage, this is the case in Bangladesh, Ethiopia, Nigeria and Tanzania, and less so in Cambodia and Yemen. This trend indicates that girls are less often reached with follow-up services than boys, indicating possible preferential allocation of resources for care to boys. More significant gender gap differences by wealth quintile occur within the rates of those receiving no basic immunisations. Here, girls are significantly worse off in lower quintiles in Bangladesh, Haiti, Malawi, Mali, Tanzania, Uganda and Zimbabwe.

²¹ It is recognised that this data analysis remains subject to general problematic aspects of establishing wealth quintiles for data collection.

Interestingly, however, in the wealthiest quintiles for these same countries, the bias often reverses, and boys experience greater rates of no immunisation coverage than girls. For example, in Bangladesh, the ratio of girls to boys not immunised leaps from 0.5 (bias against girls) in the poorest quintile to 1.6 (bias against boys) in the wealthiest quintile. In Ethiopia, a similar leap occurs for full immunisation coverage, from a 0.4 ratio against girls in the poorest quintile to a 1.2 ratio, biased against boys, in the wealthiest quintile. Although such reversals have been observed in qualitative studies, which show that girls are more likely to be vaccinated with increasing levels of maternal education, these have not been linked to wealth quintiles before. These data warrant further epidemiological analysis, particularly because of the range of confidence intervals of these ratios (i.e. some ratios reflect very small percent coverage rates, likely to have a large confidence interval).

Table 2: Full and No Immunisation Coverage, Female to Male Coverage Rate Ratio

Country	Ratio female to male coverage rates			
	Lowest quintile Full basic coverage	Highest quintile Full basic coverage	Lowest quintile No basic coverage	Highest quintile No basic coverage
Bangladesh (2004)	0.9	1.0	0.5	1.6
Cambodia (2000)	0.7	0.8	1.1	0.5
India (1998/99)	1.0	0.9	0.9	1.1
Pakistan (1990/91)	1.0	0.7	1.1	0.4
Yemen (1997)	0.8	0.9	0.8	0.8
Haiti (2000)	1.2	0.8	0.9	2.6
Nicaragua (2001)	1.0	0.9	0.8	n/a
CAR (1994/95)	2.1	0.9	108.5	n/a
Côte d'Ivoire (1994)	0.9	0.7	0.8	n/a
Ethiopia (2000)	0.4	1.2	1.6	0.6
Ghana (2003)	1.1	1.2	0.7	0.6
Kenya (2003)	1.0	1.4	1.3	4.7
Madagascar (1997)	1.0	1.0	1.0	2.0
Malawi (2000)	1.0	1.1	0.6	1.4
Mali (2001)	1.3	1.1	0.9	1.2
Nigeria (2003)	0.2	1.8	1.2	3.4
Tanzania (2004)	0.9	1.0	0.6	1.5
Uganda (2000/01)	1.0	1.0	0.7	0.7
Zambia (2001/02)	1.0	1.0	1.0	6.3
Zimbabwe (1999)	0.9	0.8	0.8	1.5

Source: Gwatkin et al (2007).

Significant concentrated biases against boys in some contexts were also found. In the CAR, although average rates of immunisation coverage show no gender gaps in basic coverage, in the poorest quintiles, shockingly large biases exist against boys. There is a 2.1 ratio of girls to boys covered by full basic immunisation and, although only 0.4% of girls in the poorest quintile receive no basic immunisation coverage, for boys this is 39.7% (108.5 ratio boys to girls). In Nigeria, the patterning by quintile is distinct from the national average. Overall, boys exhibit lower immunisation coverage but, in the poorest quintile, girls exhibit lower rates of full basic immunisation coverage (0.2 ratio girls to boys). This trend is reversed in the wealthiest quintile (1.8 ratio girls to boys). For those receiving no basic immunisation coverage, there is a consistent bias against boys. However, this gender gap increases from the poorest quintile (1.2 ratio girls to boys), to the wealthiest quintile (3.4 ratio girls to boys). The recent immunisation controversy in Nigeria, spreading fears of potential contamination of

vaccines with a male sterilising chemical, has significantly affected immunisation coverage rates. As we have seen, these gender gaps are exaggerated among the wealthiest quintiles; such trends may reflect greater access to information and choice regarding health care among wealthier populations (potentially similar to fear among middle- and upper-class Western populations regarding the potential link between MMR and autism).

In India, significant gender inequalities exist, often compounded by other social inequalities. For example, data show that considerably fewer girls have been fully immunised than boys, and even larger gaps occur between girls and boys who have received no immunisation at all, in both rural and urban areas and at almost every level of household wealth. This indicates that many households are not even starting girls on an immunisation schedule, much less completing the full course. Gender differentials were, however, more pronounced by geographical location than by wealth, with the largest gender gaps in the poorest performing states of the Northern region (Punjab, Haryana, Jammu, Himachal, Bihar and Orissa).

Although immunisation levels, wealth and urban-rural inequalities appear connected in India, in that poor performers in one tend to fare poorly in the others, this is not the case with gender differentials. Gender inequality in immunisation appears to be spread across the country, even in states that perform relatively well in other counts (Pande and Yazbeck, 2003). Gender inequality functions additively on other inequalities, such that children who are female, in the poorest households, in rural areas and residing in Northern states have notably the lowest rates of immunisation coverage (ibid).

It is critical to understand the interlocking effects of these various social inequalities and how addressing the gender-based inequalities within these marginalised populations could be a powerful influence in scaling up immunisation coverage rates. This type of research is not a core element of the GAVI Alliance mandate, but these are core issues influencing the work of the Alliance, and require attention if immunisation coverage rates are to improve among marginalised groups. Developing a full understanding of these interactions and manifestations of gender inequality, however, hinges on developing the evidence base on which analysis is conducted.²²

2.5 Age- and sex-disaggregated data: gaps in the knowledge base

The above-mentioned findings indicate that significant gender-based dimensions are manifest in immunisation, but the full extent of these challenges remains to be known, owing to significant gaps in the knowledge base. **Health policy can not be gender-sensitive unless informed by age- and sex-disaggregated data and gender-sensitive analysis.** Despite this acknowledged importance (ARROW, 2000; WHA, 2007), there is a continued lack of systematic collection and, to a greater extent, a lack of analysis and reporting on age- and sex-disaggregated data in immunisation and the health sector more broadly: 'Surprisingly, in many situations data are not presented in an age- and sex-disaggregated way, even if they are collected' (Sen and Östlin, 2007). Although the DHS and UNICEF MICS

²² Please note that there are also some questions as to whether there are gender differentials in terms of the impact of immunisations, which are currently under-researched. See the following for more information:

Aaby P, Ibrahim S, Libman M, Jensen H. (2006) The sequence of vaccinations and increased female mortality after high-titre measles vaccine: Trials from rural Sudan and Kinshasa. *Vaccine* 24:2764-71.

Benn, C.S., A.B. Fisker, M.J. Jørgensen and P. Aaby (2007) 'Why Worry: Vitamin A with DTP Vaccine?', in *Vaccine* 25(5): 777-9.

Benn, C.S., A. Rodrigues, M. Yazdanbakhsh, A.B. Fisker, H. Ravn, H. Whittle and P. Aaby (submitted) 'The Effect of High-dose Vitamin A Supplementation Administered with BCG Vaccine at Birth may be Modified by Subsequent DTP Vaccination', *International Journal of Epidemiology*.

datasets are disaggregated by sex, they are not available for all countries and are collected sporadically in many, with the most recently available data often 10 years old. DHS surveys have been criticised for their small sample size (or their spread over large geographical areas), resulting in a push from the World Health Organization (WHO) for higher sample size surveys on immunisation data.²³

Additionally, owing to the methodology of stratified cluster sampling utilised in the DHS and MICS, these surveys are often prone to relatively large sampling errors. It is thus important to crosscheck data analysis of one survey instrument against that of another survey instrument in the same country. However, as a result of the low degree of systematic data collection, data are often not available from multiple surveys in the same country in a similar timeframe. This provides further impetus to improve the systematic collection of data for immunisation as well as all health indicators.

Furthermore, although the raw data from these datasets are age- and sex-disaggregated, these data are hardly reported on or submitted to a full gender analysis. As discussed above, gender inequalities may be masked within national averages, or more pronounced within socio-economically and geographically marginalised populations. Understanding the intersections of gender equality with other social stratifiers is critical. As called for by the WHO Commission on the Social Determinants of Health, this type of analysis hinges on the analysis of age- and sex-disaggregated data by indicators of social position (e.g. wealth quintile, education, occupation, ownership of land, etc) (Sen and Östlin, 2007). Furthermore, age- and sex-disaggregated immunisation data are critical across the lifecycle (often reported on only for early childhood vaccinations), particularly as new adolescent and adult vaccines come onto the horizon (e.g. HPV, malaria). Without such gender analyses and reporting, evidence-informed analysis (and policy) is not possible.

Initiatives such as the WHO Health Equity Gauge (HEG) (GEGA, 2003) are seeking to redress such gaps in the knowledge base, placing emphasis on monitoring avoidable and unjust health inequalities. Interestingly, lower immunisation coverage rates among girls are included as an example in the accompanying manual. The aim of the HEG is to utilise the focus garnered from such monitoring as a trigger for actions to reduce inequities. However, despite advances made by the UN system on the availability of data, these remain reported on at the national level and hindered by the often insufficiently supported national systems on which they draw. The World Bank has recently drawn attention to the inadequacy of the official indicators for monitoring progress towards the gender equality-focused MDG 3²⁴ (for which there are currently no health indicators). There is an even greater dearth of attention given to gender in the reporting and analysis of immunisation services. In many reports, including the UNICEF Annual Immunisation Summary and the annual UNICEF State of the World's Children report, and the jointly produced WHO/UNICEF annual Immunisation Summary Report (2007), immunisation progress is not reported on, nor analysed, by sex. Although a recent World Bank analysis of inequalities in health, nutrition and population indicators in 56 countries reported on indicators by sex and acknowledged the importance of gender inequalities, the summary report focused on wealth inequalities, with little attention paid to gender in the synthesis analysis (Gwatkin et al, 2007).

International progress towards age- and sex-disaggregated data collection and gender-sensitive analysis is therefore mixed. Data are now being collected by sex, but support and encouragement needs to continue for more systematic age- and sex-disaggregated data collection from infancy through old age. There is a critical gap to be filled in the gender analysis and reporting of data disaggregated by sex, not just nationally but also regionally and within wealth quintiles, and by other social stratifiers, in order to provide analytical

²³ Interview with PATH immunisation expert, 12 March 2008.

²⁴ Interviews with World Bank Gender Unit, 29 February 2008.

weight. This lack of gender analysis in the immunisation field is symptomatic of the widespread neglect of gender analysis in monitoring health equity (Sen and Östlin, 2002). Greater support and funding is needed for systematic collection, analysis and reporting on age- and sex-disaggregated data, in order to invest in the evidence base on which health policy is decided (Sen and Östlin, 2007): 'Without gender-sensitive and human-rights-sensitive country level indicators to guide policies, programs and service delivery, interventions to change behaviours or increase participation rates, will operate in a vacuum' (ibid). Building this evidence base is thus critical in order to understand and effectively address gender-based obstacles to creating effective immunisation programmes.

2.6 Gender as a factor in accessing immunisation and other health services

In aiming to reach the most marginalised populations with health services, it is often gender-based difficulties that present significant obstacles to accessing care. The literature emphasises that these factors are multiple and often overlapping, and has similarly linked them with access to immunisation services, as well as health care services more broadly. These patterns underline the importance of comprehensively addressing gender issues as a part of health systems strengthening.

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, yet 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, 2002) and UNICEF, 2006; 2007). The effect of a lack of decision-making power has been well documented in the case of HIV/AIDS prevention interventions, where a significant obstacle has been the inability of women to negotiate condom usage, leading to the proliferation of women's empowerment prevention programmes (Campbell, 2003). Studies have also shown that women are disproportionately affected by the effects of poverty on health care access, as they have less access to household resources and require more preventative reproductive health services. In general, families have been found to 'ration' scarce resources preferentially for men and boys relative to girls and women, particularly for 'non-emergency' health services (Sen and Östlin, 2007) (a category into which immunisation may fit).

Addressing men and fathers in health initiatives is therefore critical to improving the support for women's and children's health needs as well as to addressing the power-based gender inequalities in decision making. Health interventions that solely address women neglect the critical influence that men have over women's decision-making power. For example, a study in Ghana found that the inclusion of fathers in an immunisation campaign subsequently led to fathers taking greater responsibility for children's health, and led to greater rates of immunisation (Östlin et al, 2007). It is crucial to involve men in health initiatives in a positive light, emphasising the transformative power of men's involvement through innovative programming addressing the power inequalities resulting from gender bias (Sen and Östlin, 2007).

The problem of women's time poverty

Just as importantly, time costs owing to poor infrastructure are often greatest among women; as primary caregivers, women spend many more hours per day gathering water or fuel, or taking children to distant health care service centres.²⁵ **Therefore, physical, time and economic barriers to accessing health services, such as user fees, distance to services, inconvenient hours, long queues, etc may be a significant hindrance to the access of women (and children under their care) to health services** (Sen and Östlin, 2007).

²⁵ Leslie (1989), Kabeer (2003) and World Bank (2002).

Gender-based power inequalities limit women's voice and empowerment in their own health decision making

Socio-economically and culturally defined gender roles also limit the participatory voice and power of women in community programming, including many community health initiatives (Campbell and Jovchelovitch, 2000). As a result, growing numbers of health programmes are linking success to having addressed gender-based inequalities and incorporating women's participation in programme development, implementation and evaluation. For example, the Sonagachi project (India) has shown a successful reduction in HIV infection and increased condom usage, based on the involvement of women in the planning of the project, allowing the opportunity for women to voice and address the specific gender-based obstacles they face in HIV prevention (ibid; Sen and Östlin, 2007).

Health clinics as sites of unequal gender and socioeconomic relations

In addition to gender-based obstacles in accessing health services, health service provision is neither gender-neutral (owing to the high proportion of male health professionals), nor sensitive to differentials by wealth, caste and class, compounded by gender-based power differentials. In Bangladesh, women were found to avoid immunisation services as a result of a fear of humiliation from being 'scolded' by the vaccinator for losing their child's immunisation card. At the immunisation sites, poor women have to interact with higher-status vaccinators (often men in this context) and also higher-status mothers. Women are often humiliated by other mothers who are able to pay an extra fee to jump the queue. These factors were cited by women as significant barriers to completing their child's vaccination schedule; similar findings were reported in a study in Zimbabwe (Perry et al, 2007). These encounters are underpinned by power differentials, both socioeconomic and gendered. It is critical to understand gendered experiences of health care quality as potential deterrents to accessing health services and to improving the responsiveness of services to all, regardless of sex or socioeconomic status (WHO, 1998).

Gendered dimensions of clinical trial participation and health research

Although the GAVI Alliance is not directly involved in the research process of vaccine development, it is important to recognise the gendered elements of the health research process and the effects of these on the evidence base on which the GAVI Alliance relies. As we have seen, in the past, women have often been excluded from being subjects of clinical trials, citing women's menstrual cycles as a compounding variable, as well as potential harmful effects of trial vaccines and drugs on women's reproductive health. Yet, clinical trial results based on male subjects have often been applied to both women and men. Efforts have been made in the past decade to correct this bias, and continue to be a critical component of improving medical research (Sen and Östlin, 2007). Recently, efforts have been made to extend a gender-based perspective in vaccine development to qualitative studies of women's experiences in vaccine trials. The International Centre for Research on Women has found that **women's decisions to enrol in (HIV) vaccine trials are influenced by a wide variety of gender-based factors stemming from their socially determined gender roles.** This is particularly the case with regards to diseases such as HIV/AIDS whose transmission and disease process are closely entwined with sexual and gender relations, raising particular issues for women associated with the disease through vaccine trials.²⁶ An additional bias in health research has been the dominance of individualistic, biomedically focused research and policy paradigms. These often distil women's health needs to reproducers, and fail to adequately address the broader political and social determinants of women's health and experience of health care that influence health-seeking behaviour and access to health services (Kwaak and Dasgupta, 2006).

²⁶ Interview with International Centre for Research on Women, 29 February 2008.

2.7 Burden of disease: gender implications of immunisation investment

Women and men, girls and boys have differential exposure and vulnerability to disease experienced as a product of biological and social aspects of sex and gender and the interactions between these factors. Although women overall have a greater biological 'robustness', resulting in overall longer life expectancies, the 'gender paradox' is that, during their lifetimes, women experience greater rates of illness. Recent analysis of the Global Burden of Disease 2002 estimates²⁷ indicate that 68 out of the 126 health conditions and health risk factors have at least a 20% difference between women and men. In terms of HIV, reproductive infections and cancers, and morbidity and mortality related to maternity, women experience 2.19 times more disability-adjusted life years (DALYs) than men; in reproductive cancers alone, women lose seven times more DALYs than men. Women also lose more DALYs than men in illnesses related to eyesight (including trachoma), migraine, mental health, muscle and bone strength (e.g. rheumatoid arthritis, multiple sclerosis, osteoarthritis), ageing, burns and nutrition (e.g. iron deficiency anaemia, Vitamin A deficiency). Men, on the other hand, tend to lose more DALYs in areas related to excess consumption (e.g. gout, alcohol disorders, lung cancer), infectious diseases and deaths or injuries related to drowning, falls and road accidents.

It is important to understand these differences as a product of both biological sex differences and gendered social determinants. 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).

Gender-based determinants of individuals' life spaces for work can also have significant impacts on the disease to which they are at risk. For example, a Nigerian study has found that the high prevalence of schistosomiasis in girls of five to 15 years old is linked to the fact that 71% of all water-related activities are carried out by women (Oxaal and Cook, 1998). Although women and men have different biological exposures to health risks, their vulnerability to health risks and conditions is determined socially. With malaria, pregnant women comprise the main adult risk group in malaria endemic areas owing to their compromised immunity. However, vulnerabilities from a range of socially determined factors (i.e. lack of access to malaria treatment during antenatal care, of bed net prevention, of the removal of stagnating water and of good nutrition) mean that pregnant women even in areas of low malaria transmission are two to three times more at risk of developing severe malarial disease than other non-pregnant adults (Sen and Östlin, 2007).

Decisions regarding vaccine investment must account for the complex social and biological interactions structuring the burden of diseases; it is critical that the multifaceted aspects of gender (beyond biologically determined risk) be incorporated into decision-making processes. A gender-based analysis of disease would take account of:

- Diseases from which women or men suffer because of their sex;
- Diseases from which both women and men suffer, but which are more prevalent in one particular sex or affect one sex more severely;
- Diseases from which both women and men suffer, but which adversely affect women during pregnancy;

²⁷ See Appendix 3 of Sen and Östlin (2007).

- Diseases from which both girls and boys and both women and men suffer, but which men or women specifically are less able to protect themselves from (or access care for) owing to gender-based social determinants.²⁸

In short, the importance of gender equality is multidimensional and interlocking (UNICEF, 2006; 2007). The available evidence clearly shows significant **gender gaps (for both girls and boys) in immunisation coverage**, often more pronounced at a sub-national level, illustrating the **importance of comprehensive age- and sex-disaggregated data collection and reporting** and gender-sensitive analysis. Underlining these quantitatively noted gaps, substantial research has illustrated the means by which gender-based social structures act as a powerful health status determinant, including risk of disease and ill-health, access to immunisation and other health services and quality of the health care experience. Gender is a critical factor in addressing immunisation services – both in terms of coverage and access to services, and as a component of strengthening health systems.

²⁸ Adapted from Commonwealth Secretariat (2002).

3. Assessing the GAVI Alliance Secretariat from a Gender Perspective

3.1 Assessment of the GAVI Alliance windows of support

A document review was conducted of the GAVI Alliance's portfolio of work in order to understand to what extent gender is embedded within GAVI's thinking, how issues of gender inequality are conceptualised and the extent to which they are currently being addressed. Representative documents were analysed from across the GAVI Alliance's portfolio of work as follows:

- **GAVI Alliance strategy, objectives and work plan:** GAVI Alliance Strategy 2007-10, GAVI Work Plan 2007, Executive Secretary/CEO Report November 2007, Lessons Learned from GAVI Phase 1 and Design of Phase 2: Findings of the Country Consultation Process – Final Report July 2005, 2007-10 GAVI Roadmap, GAVI Alliance Progress Report 2006, fact sheets;
- **Country support** (Immunisation Services Support – ISS, Health Systems Strengthening – HSS, Injection Safety Support – INS, New and Underused Vaccine Support – NVS, Civil Society Support – CSS): country proposal application forms, proposal guidelines, Independent Review Committee (IRC) review documents;
- **Monitoring and evaluation:** performance reviews, annual progress reports.

Additionally, country proposals were reviewed for the following eight countries: Nigeria, Madagascar, Ghana, Ethiopia, Cambodia, Vietnam, India and Pakistan. These countries were selected because of their geographical spread (East, West and Southern Africa, and South and Southeast Asia) as well as the fact that they had notable sex-based differences in immunisation coverage rates, indicating a potentially greater impetus for countries to include a gender perspective in their applications.

This document review was complemented by interviews with staff across the Secretariat (in both Geneva and Washington, DC), providing qualitative insights into the practices that manifest from GAVI Alliance's documented policies.

Overall, the document review and interviews conducted indicated that there is currently minimal attention to gender within country support, funding and country progress reporting indicators, HR capacity building and external communications, as we will elaborate below.

GAVI Alliance Strategy

The attention to gender in GAVI Alliance strategic planning and documentation reflects a significant but recent addition to what has otherwise been a minimal to nonexistent record of consideration of gender issues. The development of the Gender Equality Policy, coming out of a series of communications and Board discussions regarding this issue, has now been affirmed in several strategic documents of the GAVI Alliance.

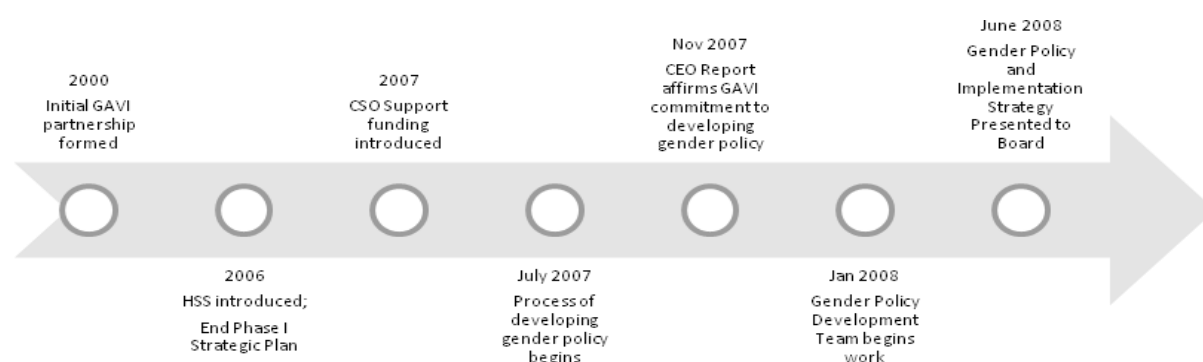
The long overdue recognition of the critical interrelation between the health of women and children, and development increases the urgency for us to place the potential influence and catalytic effect of GAVI firmly behind the goal of erasing gender inequities in health. We need to be part of the global effort to rectify the scandalous reality of poor women's health in many GAVI-supported countries. (GAVI Alliance Executive Secretary/CEO Report: November 2007, GAVI Alliance & Fund Board Meeting 28-29 November 2007 Doc #AF-1).

This quote from the 2007 Executive Secretary/CEO Report summarises **the current gender perspective within the GAVI Alliance: forward-looking attention to rectifying past inattention to gender issues through developing an innovative gender approach whereby GAVI can catalyse wider action towards eliminating gender inequality in**

health. More specifically, GAVI has located its commitment to addressing gender issues within the context of achieving the MDGs, and identifying how GAVI can address gender inequalities in access to health. The development of a gender policy has been conceptualised as a milestone necessary to achieve the broader organisational objective of demonstrating innovation in GAVI operations as a part of the GAVI Alliance strategic goal to increase the added value of GAVI as a public-private partnership in the 2007-10 GAVI Alliance Roadmap.

Additionally, the new vaccine investment strategy country consultation process currently underway asks countries whether the degree to which a particular vaccine impacts gender issues (e.g. rubella in pregnant women, HPV) should be included as a criterion for vaccine investment decisions. This represents a significant step, as the initial list of 18 vaccine selection criteria prepared by the WHO omits any mention of gender. It is also likely that this preliminary inclusion of a gender perspective will be expanded as the ODI Gender Equality Policy Team continues discussions with the investment strategy team.

Figure 1: Timeline: Gender Equality Policy Development in the Context of GAVI Alliance Strategic History



Except for these forward-looking strategies, however, our document review confirmed that the GAVI Alliance's lack of a gender policy would be reflected in a low level of attention to gender inequalities within the GAVI Alliance portfolio of work. Indeed, our document review highlighted a pervasive lack of explicit acknowledgement of gender issues relating to the GAVI Alliance's external work, internal policies and strategic goals. This lack of attention to gender-related issues was also identified in a desktop review by Social Development Direct commissioned by DFID (Watkins, 2007) on the extent to which gender is incorporated into the policies and programming of leading multilateral organisations.²⁹ In this evaluation, the GAVI Alliance scored poorly across all areas of the review and, as such, received the lowest overall evaluation of the eight multilateral organisations assessed (see Table 3 below).

Although overall our document review of the GAVI Alliance highlights a currently minimal to nonexistent gender perspective, it is critical to note that criticism of this has led to a clear emphasis on gender equality as a priority strategic focus for the GAVI Alliance, reflected in leadership by the SMT, and buoyed by significant levels of support among GAVI Secretariat staff (as discussed further in the staff survey analysis to follow). Therefore, this document review should be viewed as a springboard for future action.

²⁹ Multilaterals in the review included: the European Community and the European Development Fund, the World Bank, the African Development Bank, the Asian Development Bank, the Caribbean Development Bank, the Inter-American Development Bank, the Education for All-Fast Track Initiative, the GAVI Alliance and the Global Fund to Fight AIDS, TB and Malaria.

Table 3: Assessing Capacity of Multilaterals to Address Gender Issues, GAVI Results

Gender criteria area	Summary assessment	Comments
Delivery of results	Urgent development area	Despite past studies indicating some gender-based differences in immunisation rates, no disaggregation of results by gender
Managing resources	Urgent development area	Nothing publicly available shows institutional commitment to gender
Managing external relationships	Urgent development area	Few women and non-Northerners represented in Secretariat
Building for the future	Development area	Plan for baseline research on socioeconomic and gender equality in immunisation. Initial GAVI document analysis (Alliance Strategy 2006-10, Work Plan 2007, GAVI Alliance Principles, Roadmap 2007-10) suggests negligible reference to gender (two mentions)

Source: Watkins (2007).

Public-private partnership business model

Launched in 2000 as one of the first major Global Health Partnerships (GHPs), the GAVI Alliance has been at the forefront of the revolution of the international health architecture. The Alliance's strength derives from synergistically combining the contributions of each of its partners and those of the constituencies they represent: implementing country governments; multilateral and bilateral aid agencies; foundations and civil society; public health institutes; and the vaccine industry and the financial community. Representatives work collaboratively at a number of organisational levels (e.g. Boards, Working Groups, Task Teams) and across a diverse range of functional areas to develop solutions to, and consensus around, collective actions problems concerning immunisation and the health services required to deliver them. The Alliance focuses on those areas in which no one partner can work effectively alone and on adding value to what some partners are already doing.

The Gender Advisory Group, providing oversight to the development of a Gender Equality Policy for the Alliance, serves as an example of the power of the partnership, as representatives from many of the Alliance partners bring the strengths, perspectives and realities of their organisations to bear on how best to leverage the resources of the Alliance to address gender inequality. Thus, the potency of the Alliance is more than the sum of interlocking complementary resources to achieve common goals and to spread the risks of doing so more thinly; it emerges from leveraging the unique assets of each partner to work together in new ways to meet collective goals while fulfilling individual mandates.

The Alliance has demonstrated partnership 'proof-of-concept' in a number of important respects. These range from the way it:

- Successfully raises funds through innovative financing instruments (e.g. the International Finance Facility for Immunisation – IFFIm);
- Allocates funds to countries (country-led and increasingly in accordance with the principles of the Paris Declaration on Aid Effectiveness) and to industry (in stimulating late-stage vaccine development, for example the Advance Market Commitment and the pneumococcal vaccine pilot);
- Disburses funds (performance-driven);
- Has mainstreamed certain practices in the immunisation sector (e.g. widespread use of autodestruct syringes in immunisation programmes).

An analysis of independent evaluations of GHPs identified seven contributions of effective GHPs to global health and, unusually for any GHP, the GAVI Alliance ticks all the boxes: (1) getting specific health issues onto national and international agendas; (2) mobilising additional funds for these issues; (3) stimulating research and development; (4) improving access to cost-effective health care interventions among populations with limited ability to pay; (5) strengthening national health policy processes and content; (6) augmenting health service delivery capacity; and (7) establishing or rolling out international norms and standards (Buse and Harmer, 2007). Moreover, these evaluations identify seven habits of highly effective partnerships; the Alliance leads the way on many of these practices as well.

Consequently, the Alliance is well placed to capitalise on the mechanisms that it has established to solve collective action problems, so as to mainstream gender more thoroughly in the activities of its partners as well as in immunisation programmes and health programmes more widely.

Country support

Policies and documentation relating to country support within the GAVI Secretariat devote minimal attention to gender issues. The guidelines for country applications offer no suggestions for addressing gender inequality issues. The 2007 revised HSS guidelines contain a single reference to gender, consisting of a passing suggestion to disaggregate country-selected indicators by sex if data are available. There is no indication of support for countries to improve data availability itself or to strengthen the gender analysis capacities often necessary to utilise such data. Disaggregating data by sex is an optional choice given to countries, with no active encouragement from the GAVI Alliance.

Despite concerns voiced at the Secretariat level regarding asking countries to report on and address gender-based issues in immunisation services and health systems strengthening proposals, interestingly, a number of countries within our case study sample are already proactively addressing these issues within their proposals. Of the eight countries selected as case studies, Ethiopia, Pakistan and (to a lesser extent) Cambodia have addressed gender issues within their recent funding proposals.

Significant attention to gender:

The **Ethiopia** 2007 HSS Application calls for collecting age- and sex-disaggregated data and generally to address gender imbalances in the health sector. In the NVS 2005 Proposal, Ethiopia proposes addressing gender imbalances in the health sector, referring especially to women and children who are difficult to reach because of the population group to which they belong (e.g. nomadic populations).

Pakistan addresses gender equity issues in its 2007 HSS Proposal. Promotion of gender equity in health is discussed as a critical component of achieving WHO prioritised 'health for all.' Pakistan discusses the gender-based socio-cultural barriers that are exacerbated by the current lack of women working as health care professionals. In other words, men often provide vaccinations to women, compromising women's access to immunisation and other primary health care services. Pakistan also addresses gender in its 2007 CSS Proposal, proposing to use civil society organisations (CSOs) to increase health system delivery capacity, and thereby expand coverage among women and children.

Medium attention to gender:

Cambodia, in its 2006 HSS Proposal, considers gender as a part of the activities under the National Strategic Development Plan, with immunisation acting as an entry point for addressing gender-based health service needs across the lifecycle. Cambodia cites alignment with the Health Sector Strategic Plan, focusing on improving the health of women and children as a means of contributing to broader development goals through improved economic growth.

Minimal attention to gender:

Minimal references are made to gender in other countries' proposals. These are confined to:

- Vaccination of pregnant women (primarily the TT vaccine); and/or
- Distribution of Vitamin A supplements to childbearing women; and/or
- Percentage of HIV positive pregnant women receiving anti-retroviral treatment.

Attention in country proposals to gender inequality issues in the health sector indicates that these are issues with which some countries are currently grappling and which are incorporated into other country commitments in the health sector (e.g. National Health Sector Plans). It will be critical in the process of strategy development and country consultation to develop an understanding of (1) the origin of the impetus to address gender issues (e.g. is it instigated by other donors? Is it country-led by government officials? Or does it owe to pressure from CSOs?); (2) the motivations on which this impetus is based (e.g. programme effectiveness arguments, social justice concerns, etc); and (3) the reality of these commitments in practice. These questions will be addressed by the ODI team through a country-level survey and consultation process that are currently underway.

Overall, though, these instances of proactive country-level attention to gender issues offer opportunities for GAVI to build on and to catalyse broader and more systematic attention by country proposals to their own context-specific gender-based health issues. Currently, attention to gender equality is not actively encouraged by the GAVI Alliance guidelines or the IRC. Although the GAVI Secretariat has been concerned about imposing further reporting requirements on countries, this analysis illustrates that it is countries that are leading the way in addressing gender issues (as a result either of donor pressure or of their own agenda setting). **It will therefore be critical for a gender analysis of all country applications to be undertaken in order to understand gender-related concerns and priorities at the country level and eventually to develop a gender meta-analysis of country proposals and reports.**

Outcome-based funding and reporting indicators

Since its inception, the GAVI Alliance has significantly expanded the funding available for vaccines and immunisation services. It has done so through collaboration with partners and recipient country governments in order to ensure sustainability of financing and to encourage increased domestic financing of immunisation programmes. Through its outcome-based funding system and independent review process, the GAVI Alliance evaluates multiple performance indicators, based on which decisions are made regarding continued funding to countries. However, currently, there is no requirement (or even active encouragement) through any of these assessments and review processes for countries to report on indicators by sex, nor to monitor their immunisation coverage rates for gender equality. Interviews with IRC members and UNICEF representatives and workshop discussions with the Working Group and the IRC have illustrated that, prior to the discussions surrounding this report, there has been a widespread but erroneous assumption that immunisation coverage rates are essentially equal between girls and boys, women and men. Therefore, this has not been pushed as an important issue in assessing country progress, as made evident by its absence from performance review policies and processes.

Communications and advocacy

Among all of GAVI's externally distributed publications, only two short references are made to gender (in the 2006 Annual Progress Report). Here, immunisation is referred to as a critical contributor to helping women and children access health services, and as a key factor in enabling both girls and boys to stay in school. Private philanthropy communications discuss the GAVI Alliance's efforts to 'immunise every child,' which interviewees mentioned as an implicit reference to gender equality. However, with no gender policy in place, these

external communications do not make explicit commitments to supporting efforts to achieve gender equality in the health sector. In the eyes of the public, therefore, the GAVI Alliance appears not to have joined international efforts to mainstream commitment and action towards achieving gender equality.

Implementing a GAVI Gender Equality Policy

Despite the high degree of support for addressing gender equality issues, the biggest perceived obstacle among staff related to: (1) the fact that gender equality is not perceived as a high priority issue, (2) a lack of internal gender expertise and (3) the risk of a Gender Equality Policy becoming lost in change fatigue. However, it should be noted that the two most significant **opportunities** for implementing a Gender Equality Policy in the GAVI Secretariat – leadership commitment and adequate resourcing – can be utilised to encourage the awareness of gender equality as a high priority issue and to support necessary staff training and capacity building.

4. Assessing the GAVI Alliance's Country Partners' Work from a Gender Perspective

This section focuses on the GAVI Alliance's country partners' portfolios of work from a gender perspective, and assesses the extent to which gender has been mainstreamed into their immunisation and health-related work portfolios in a systematic way.³⁰

4.1 An overview of gender frameworks and mainstreaming approaches

In order to situate our discussion within the broader debates on gender mainstreaming, we begin with a very brief overview of the evolution of gender and development conceptual frameworks and the strengths and weaknesses of gender mainstreaming approaches to date. We will revisit this literature as we develop the GAVI Gender Equality Policy and Implementation Strategy, particularly with regards to recent meta-evaluations of the factors that have been identified as consistently shaping the success or failure of gender mainstreaming approaches.³¹

Gender mainstreaming is most commonly defined according to the definition developed by the UN Economic and Social Council (1997):

Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality (Moser, 2005).

Approaches (summarised in Table 4 below) to addressing gender inequality within international development have evolved over the past 50 years, resulting in the endorsement of a gender mainstreaming approach as key to the promotion of gender equality and the empowerment of women by the UN Beijing Conference Platform for Action (BPfA) (1995).

However, although significant progress has been made since Beijing, including high-level global endorsement of gender mainstreaming goals, a growing number of analysts and practitioners are criticising gender mainstreaming for becoming too narrow and technocratic in its approach to promoting gender equality. Gains have been made in 'recognising' gender issues, but there has been slow progress regarding the institutional and socio-cultural transformation required to address attitudes and behaviours underpinning gender inequalities and the 'redistribution' efforts necessary to achieve more meaningful empowerment of women.³² Going forward, what is needed is change that tackles four separate but interlocking dimensions of change, in:

- 1) Individual consciousness (knowledge, skills, political consciousness);
- 2) Girls' and boys', women's and men's objective condition (rights and resources, access to services);
- 3) Informal norms (ideologies, cultural and religious practices);
- 4) Formal institutions (laws and policies).

³⁰ Note that an assessment of GAVI's multi-lateral, bilateral, civil society organisations and industry partners was also undertaken through a combination of key informant interviews and desk review work but that these have been removed at the request of the GAVI Alliance in this abridged form of the report.

³¹ Key themes in this literature that we will address when developing the Gender Equality Policy and Implementation Strategy will include the politics involved in change processes, power relations, frameworks of implementation and lessons learned regarding the process of implementation.

³² Berger (2007), Rao and Kelleher (2005) and Subrahmanian (2004).

It is now widely recognised that this process of transformative change requires active stakeholder participation, by both women and men, to engage in a process of change that addresses gender-based power relationships (Howard, 2002).

Table 4: Evolution of Approaches to Gender and Development

Period	Approach	Characteristics
1950s-70s	Welfare approach	Linked to the social welfare model. Focused on women's practical needs: maternal and child health, nutrition, hygiene, education, food distribution programmes
1970s	Poverty approach	Perceived issue as underdevelopment, rather than gender subordination. Aimed to improve material conditions of women's lives, enabling them to catch up with men through income generation, skills training and access to marketing and credit
1975-85	Equity approach	Concentrated on women's strategic needs, advocating changes (UN Decade) in the economic, legal, social and ideological realities of women's situation. Equity projects encompassed consciousness-raising initiatives, as well as practical action in areas such as legal rights and access to credit
1990s	Efficiency approach	Harnessed women's labour to make development more efficient. Assumed that women's increased economic participation would lead to increased equity
1990s	Empowerment approach	Focus on strategic needs as identified by women. Concentrated on changing practices and enabling people to define their own agenda, rather than on changing laws, rules or frameworks
1990s	Integration approach	Recognises that society assigns different gender roles to women and men. Stresses the need for both women and men to have access to and control over resources and decision-making processes. Integrates gender awareness and competence into 'mainstream' development

Since the mid-1990s, most development organisations, multilaterals and bilaterals have put in place gender mainstreaming policies. However, a significant gap has persisted among the majority of organisations between their policy statement and implementation (Moser and Moser, 2005).

A recent meta-analysis of multilateral and bilateral organisations' evaluations of gender mainstreaming processes has identified a number of common challenges for effective policy implementation. These include: a lack of political will; inadequate gender analytical technical capacity; insufficient incentives and accountability structures to ensure systematic integration of gender equality outcomes into programme deliverables; a lack of age- and sex-disaggregated data to monitor progress over time; insufficient funding/resources; and both active and passive resistance from those whom the policy affects. Accordingly, although many mainstreaming processes have focused predominantly on external programming, it has become clear that the effective integration of a gender approach must be supported by a gender-sensitive organisational structure and culture. In other words, one's 'own house must be in order' before effective change can be achieved externally. In addition to overcoming these obstacles, evaluations have suggested that clearer mandates; more specific objectives; making management more accountable to delivering on the goals of gender mainstreaming; and integrating gender analysis into planning will substantially help to ward off gender 'policy evaporation'.³³

³³ Policy evaporation refers to the dilution of a gender focus between policy and practice. See Moser (2005), Mukhopdhyay et al (2006) and World Bank (2005).

These are key lessons for the GAVI Alliance to take forward in the development and implementation of its own Gender Equality Policy. They also provide a useful framework within which to assess the approaches, gender-related work and implementation record of GAVI Alliance's partners, and thereby identify how best to complement ongoing gender mainstreaming initiatives in the health sector.

4.2 Country partners

Owing to time and resource constraints, rather than carry out an analysis of country partners' gender policies, we carried out an online survey aimed to gather feedback from country-level implementing partners on: gender issues considered important for immunisation services and health service strengthening; the strategic direction of a GAVI Alliance Gender Equality Policy; and potential obstacles to effective implementation. Survey invitations were sent to GAVI Alliance contacts in the health sector and stakeholders in gender ministries within eight case study countries (Cambodia, Vietnam, Pakistan, India, Ghana, Ethiopia, Nigeria and Madagascar), with 30 responses received.³⁴

Overwhelming support was indicated for addressing gender equality in international development (77% of respondents) and within their respective organisations (70% of respondents), indicating strong potential for the Gender Equality Policy to build on substantial country-level efforts already in place to address gender equality issues. The majority of stakeholders indicated that their organisations are currently addressing gender issues related to health service access; gender analysis of health sector policies; introduction of female health workers at the grassroots level; support for gender mainstreaming efforts led by the WHO; and (particularly within CSOs) a push to empower women within decision-making processes in the health sector. In addition, all of the major gender issues in the health sector identified by country survey respondents have relevance for immunisation services and health systems strengthening programming: that the quality of services are not meeting gender specific needs; that women disproportionately shoulder the burden of care; that there is unequal access to both financial and decision-making resources for health services; that there is an unequal risk of and burden of illness; and that there is a lack of age- and sex-disaggregated data. The identification of these issues as priorities for country-level responses indicates strong potential for the Gender Equality Policy to provide added value.

Regarding the design and implementation of a GAVI Alliance Gender Equality Policy, strongest support was given for a policy that addresses gender issues as an important component of achieving the MDGs (53% of respondents), as contributing to programme effectiveness (50%) and as part of a rights-based approach to development (47%). Overwhelming support was given for the GAVI Alliance Gender Equality Policy to provide support to countries to address gender issues through health systems strengthening (43%) and support for CSOs (20%). These are two of the most innovative GAVI Alliance windows of support, so this provides a positive opportunity to work with countries to develop a gender perspective.

The largest potential obstacles to successful implementation (similar to those identified through both the GAVI Secretariat survey and meta-evaluations of gender mainstreaming) were a lack of training and expertise in gender-related skills (67%), a lack of resources (50%) and a lack of perception of gender as a high-priority issue (53%). There was mixed awareness regarding gender gaps in immunisation (discussed in the above sections of this

³⁴ Significant efforts were made to contact and include stakeholder representation from national gender ministries or the related department. However, owing to difficulties in obtaining current contact information, and a lack of response from contacts made, we received no feedback. However, feedback was gathered from UNFPA representatives, as well as several gender issues-focused CSOs.

report), except in Nigeria, India and Pakistan, where gaps were perceived as related to cultural norms. It is important to note that the risk of a gender policy being contrary to cultural norms was identified as a potentially significant obstacle (50%). This reinforces the need for GAVI's Gender Equality Policy to be country-led in its implementation in country-level programming and for GAVI to continue dialogue with country partners regarding the obstacles encountered in addressing gender equality issues.

The information gained through this survey provides an insight into the key issues and priorities many country-level stakeholders think are critical for a GAVI Gender Equality Policy. The results are mixed, owing in part to a low level of awareness regarding the broad linkages between gender equality issues and their potential impacts on immunisation access. These results will inform the development of the Gender Equality Policy, including discussion in an upcoming consultation workshop that will include country partner representatives.

4.3 Opportunities for donor harmonisation and leveraging off existing commitments

A number of international commitments relating to gender equality, children's rights and the rights to health for all together provide an internationally agreed-upon framework within which GAVI can establish a Gender Equality Policy and strive towards donor alignment and harmonisation, as detailed below. Although there is a considerable gap between aspirations and practice, these agreements represent a clear and shared roadmap for the progressive realisation of gender equality and women's and girls' empowerment. Moreover, because the vast majority of GAVI country partners are signatory to these commitments, concerns that asking countries to collect and report age- and sex-disaggregated data in order to measure progress towards gender equality goals constitutes 'an additional burden' would appear to be unfounded. We acknowledge that such reporting will entail extra effort, but this is a burden that has already been accepted by GAVI country partners.

Specific opportunities for harmonisation include the following. National governments are already legally bound owing to their commitments to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) to report periodically on progress in addressing the rights of all children and women. All national governments that signed up to the UN Beijing Platform for Women (1995 and subsequent Beijing+5 and Beijing+10 agreements) also committed to the collection and reporting of age- and sex-disaggregated statistics in order to inform gender-sensitive policy formulation and implementation. In addition to these conventions, national governments are also required to report according to progress against the MDGs and, in the case of low-income countries, progress according to nationally agreed-upon Poverty Reduction Strategy (PRS) goals and measurable indicators.

In short, by spotlighting the importance of quality age- and sex-disaggregated data collection and analysis, and supporting the necessary capacities and infrastructure required, GAVI could potentially play a key role in promoting the realisation of existing international commitments.

Table 5: International Agreements on Gender Equity, Children's Rights and the Right to Health

<i>International agreements on gender equity</i>
<p>The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). CEDAW (1979) sets out the normative framework for women's rights and gender equality and obliges (Article 3) all 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 as men. 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 subsequent dialogue and recommendations offered by the CEDAW Committee provide valuable guidance for governments and their development partners to improve their performance for women's empowerment and gender equality.</p>
<p>The Beijing Platform for Action (BPfA) 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).</p>
<p>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: <i>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 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.</i></p>
<p>The addition of a new target in MDG 5, 'Achieve by 2015 universal access to reproductive health,' by the International Conference on Population and Development (ICPD) agenda is another important entry point for thinking about countries' obligations vis-à-vis vaccines that promote reproductive health goals (for example, hepatitis E, rubella, HPV).</p>
<p>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.</p>
<p>Through the recently established Joint Institutional Approach (JIA 2006), 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.</p>
<i>International agreements on children's rights</i>

The UN Convention on the Rights of the Child (CRC) obligates all countries to ensure progress towards the realisation of all children's rights, regardless of their sex and other social stratifiers, to survival, i.e. health and nutrition, as well as development, protection and participation. A core principle of the CRC is that of 'progressive realisation', which obliges countries to demonstrate progressive progress towards the realisation of children's rights and well-being in accordance with the state's resource capacities. 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 health for all women and men, girls and boys, as well as commitments to gender equality as a component of achieving the right to health, are stipulated by multiple global commitments, including the following:

- The WHO Constitution aspires to the 'enjoyment of the highest standard of health' for all (WHO, 2006). In 2007, the World Health Assembly noted the importance of integrating gender analysis and actions into the work of the WHO.
- Article 12 of ICESCR defines the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'
- 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, to renewed urgency in accelerating progress towards the health-related MDGs through partnership and country-led improvement in sustainable health systems (IHP, 2007).
- The UN Rights Council Special Rapporteur on the Right to Health (Hunt, 2008) endorses the importance of applying a gender perspective in 'the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (UN Rights Council, 2002).
- 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 immunization 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.

5. Strategy Development Entry Points

Based on the findings in this background analysis, we have identified a number of key entry points that have important implications for the Gender Equality Policy and Implementation Strategy. We summarise here the findings based on six key thematic clusters: (1) the evidence base on gender and immunisation; (2) GAVI's public-private partnership model; (3) country support; (4) donor harmonisation; and (5) communications.

5.1 Evidence base

Developing an understanding of the gender-based implications of the evidence base on which immunisation policy decisions are currently made is critical to developing a Gender Equality Policy. Currently, this is hindered by a lack of age- and sex-disaggregated data and gender analysis at multiple levels:

- Available data provide evidence of uneven immunisation coverage for both girls and boys in different contexts. However, although DHS and UNICEF MICS data is sex-disaggregated, a lack of comprehensive and systematic age- and sex-disaggregated data collection and reporting precludes a full understanding of the gaps in immunisation coverage for children. Ideally, immunisation data need to be age- and sex-disaggregated, not only at national levels, but also by sub-national regions and wealth quintiles.
- Greater attention needs to be given to gender analysis of immunisation and broader health service access, including issues of gender and socioeconomic power differentials. This is necessary to understand the multifaceted influences of gender-based social structures, roles and responsibilities influencing individual demand for and access to health care services.
- Immunisation has been identified as a vehicle for increasing access to broader health services (e.g. as a point of contact for providing primary care health services to women bringing their children for immunisation, or health education programmes for adolescents at the time of immunisation). A gender analysis is critical to understand how best to address gender-based health needs, to overcome obstacles to care and to create the most effective linkages between health services for improving gender equality in health and health outcomes for all.
- In addition to access issues at the point of service delivery, a gender perspective is critical for the vaccine investment decision-making process. Women and men, girls and boys are differentially at risk of contracting diseases and suffering from ill-health owing to complex interactions between biological and socially determined risks and vulnerabilities. As the GAVI Alliance moves forward with its vaccine investment strategy, a gender perspective on this process will help to identify the key questions to be addressed in order to make gender-sensitive vaccine investment decisions.

In short, as a catalytic leader in scaling up existing vaccine coverage, in the introduction of new and underused vaccines, as well as in vaccine research and development, there is considerable scope and potential for the GAVI Alliance to incorporate a gender perspective into these initiatives in tackling disease.

5.2 Public-private partnership business model

Launched in 2000 as one of the first major Global Health Partnerships, the GAVI Alliance has been at the forefront of the revolution of the international health architecture. The Alliance's strength derives from synergistically combining the contributions of each of its partners and those of the constituencies they represent: implementing country governments; multilateral and bilateral aid agencies; foundations and civil society; public health institutes; and the vaccine industry and the financial community. Representatives work collaboratively at a

number of organisational levels (e.g. Boards, Working Groups, Task Teams) and across a diverse range of functional areas to develop solutions to, and consensus around, collective actions problems concerning immunisation and the health services required to deliver them. **The Alliance focuses on those areas in which no one partner can work effectively alone and on adding value to what some partners are already doing.**

The knowledge stocktaking exercise suggests a number of potential entry points through which the specific strengths of the Alliance's public-private partnership can be creatively harnessed to address gender inequality:

Awareness raising

- 1) Capitalise on the high profile of the Alliance to draw the attention of the international community to gender issues and commitments and to challenge the community to redouble its efforts in so far as gender mainstreaming is concerned for both intrinsic (human rights) and instrumental ends purposes (e.g. MDGs). Thus, use the innovative approach of the Alliance to develop a novel and more tractable approach to gender mainstreaming which illustrates that incorporating gender into the core business model leads to development success (i.e. immunising every child).
- 2) Use the Alliance network and communication channels to better inform all GAVI constituencies of the gender dimensions of immunisation and related health programmes.
- 3) Develop and use gender inequality storylines to raise funds from sympathetic funding sources.

Capacity strengthening

- 4) Assist partners to implement their existing gender policies more effectively so as to realise the potential benefits in so far as immunisation and strengthened health services are concerned.
- 5) Assist other partners to better understand the importance of gender to immunisation and development outcomes and to assist those that express a willingness to adopt a Gender Equality Policy and/or support gender mainstreaming in their immunisation and related health spheres of operation.
- 6) Tap more effectively the gender skills, expertise and resources of partner organisations in so far as gender is concerned – currently not well accessed by the Alliance – by bringing them into Alliance processes (such as Task Teams).
- 7) Rely on the partnership model to tap the skills, expertise, experience and resources of organisations with a gender-related mandate to support the Alliance in its gender mainstreaming activities.

Incentivising

- 8) Capitalise on the performance-based funding windows of the Alliance to leverage attention to the gender dimensions of the demand, access and utilisation of immunisation and related health services in GAVI eligible countries.
- 9) Capitalise on the influence of the Alliance in relation to late-stage development and introduction of vaccines to increase demands for gender dimensions of the risks and burden of vaccine preventable diseases to play a role in vaccine candidate selection.
- 10) Foster more creative use of the windows of country support to foster small-scale pilots that may provide a potential narrative of success in relation to gender mainstreaming and improve voice and accountability in relation to gender and development (e.g. the CSS window).
- 11) Build on the Alliance with performance-based funding to leverage gender equality improvements through programme grants.
- 12) Capitalise on the impact that the Alliance could exercise on the gender sensitivity of the vaccine supply community through its purchasing power by including a gender indicator in the terms (conditions) of procurement. This could be accomplished, for

example, by adding an indicator such as ‘bidder has gender policy which meets international standards’ (as defined by lessons from meta-analysis of gender mainstreaming and commitments arising from BPfA+5) into UNICEF guidelines on corporate social responsibility screening (which include indicators on use of child labour, deriving income from sale of tobacco, etc).

- 13) Use the monitoring and evaluation function of the Alliance to hold partners to account to deliver on gender-related goals.

5.3 Policy, programming and funding support

GAVI provides country support through several distinct funding windows. In the background report, we focus on ISS, HSS, NVS and CSS (as the most directly relevant windows for a Gender Equality Policy). Support through these windows is based on the provision of funding in response to specific proposal guidelines and is continued on the basis of progress noted in related annual reports. One of GAVI’s strengths to date has been its strong emphasis on country ownership and flexibility in tailoring support to context-appropriate strategies and proposals for funding. This is reflected in the GAVI Working Group and IRC’s efforts to avoid imposing undue conditions on countries in relation to eligibility criteria and reporting requirements. Nonetheless, the guidelines (and their illustrative examples of possible areas of support) have been demonstrated to send strong signals to governments in relation to what they do and do not seek funding for from the Alliance. Moreover, the funding application and reporting guidelines have been gradually evolving over time in response to emerging issues, for example the inclusion of waste disposal considerations. Currently, there is minimal to no attention to gender in the guidelines for country proposal development, or in the country annual reports, or in the performance-based funding process, owing to assumptions of gender equality in immunisation coverage.

Interestingly, **our analysis showed that a number of country partners are already proactively addressing gender issues in their proposals and reports, having identified gender as an important concern for programme effectiveness, service delivery and the achievement of broader development goals.** Moreover, of the two CSS proposals approved to date, the Pakistan proposal has a significant gender component.

This suggests that encouraging countries more broadly to introduce a gender lens into their proposals and into performance evaluation aspects of country support has the potential to promote a gender perspective across the project cycle and to add value to GAVI and its partners’ work.

5.4 Donor harmonisation

Because GAVI works through partners to assist countries to achieve their immunisation goals, it is important that any changes that GAVI introduces in order to address gender inequalities are harmonised with the efforts of other donors, in order to promote synergies and avoid duplication and overburdening national governmental agencies. Initiatives to promote gender mainstreaming in the health sector are not new; **what is needed is to highlight existing international commitments (especially CEDAW, BPfA, MDGs, GIVS) and to support country and donor partners’ ability to fulfil these obligations through capacity strengthening, improved resources and active encouragement.** The latter could include the use of gender-sensitive examples in funding application and reporting guidelines, the development of performance-based funding mechanisms and/or gender-sensitive IHP indicators. Importantly, such an approach would also be in the spirit of global partnership embedded in MDG 8.

5.5 Communication

Given GAVI's role as a catalytic actor and its working modality through partners, external communication and advocacy is particularly important in conveying the Secretariat and Alliance's commitment to gender equality. As highlighted by the document analysis, there is currently little explicit discussion of gender issues in GAVI's publicly available materials; references made are vignette pieces on female community health workers and the necessity of increasing vaccine coverage among women and children. **External communications offer a key entry point to make clear the GAVI Alliance's commitment to addressing gender inequalities and the role this has in achieving programme effectiveness and rights fulfilments.** This storyline is as of yet untapped by the communications, policy advocacy and private philanthropy teams – partly because GAVI has not proactively sought to develop these storylines – at both the Secretariat and the partner level. There is, therefore, considerable scope in the Gender Equality Policy and Implementation Strategy to address these issues and to thereby promote GAVI's role as an innovator and champion in an area that has recently been gaining renewed prominence on the international stage.

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