Gender Equality Strategy

2019-2023

POLIO GLOBAL ERADICATION INITIATIVE

Contents

Acronyms

AFP	Acute flaccid paralysis
CDC	US Centers for Disease Control and Prevention
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CSW	Commission on the Status of Women
cVDPV	Circulating vaccine-derived poliovirus
C4D	Communications for development
FCV	Female Community Volunteer
FLW	Front-line worker
GPEI	Global Polio Eradication Initiative
GRAS	Gender-responsive assessment scale
HQ	Headquarters
LQAS	Lot quality assurance sampling
M&E	Monitoring and Evaluation
NEAP	National Emergency Action Plan
NGO	Non-governmental Organization
OPV	Oral polio vaccine
POB	Polio Oversight Board
PSEA	Prevention of sexual exploitation and abuse
SDG	Sustainable Development Goals
SEA	Sexual exploitation and abuse
SHRUC	Super high-risk Union Council (Pakistan)
SOP	Standard operating procedures
TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPV	Wild poliovirus

Acknowledgements

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Foreword

On behalf of the Polio Oversight Board, I am pleased to introduce the Global Polio Eradication Initiative's (GPEI) Gender Equality Strategy 2019-2023. The Strategy provides direction and scope for advancing gender equality and strengthening gender mainstreaming in our programmatic activities as well as organizational policies and practices as we continue our determined efforts to eradicate polio.

Gender equality is a fundamental human right and a powerful driver for better health outcomes globally. If gender roles, norms and relations are not adequately understood, analysed and addressed, polio interventions will not be as effective in reaching every last child with life-saving vaccines. Gender equality is central to achieving more effective and sustainable results in polio eradication.

Successful gender mainstreaming means changes to the way we work both internally and externally. This is why this Strategy highlights interventions related to GPEI's programmatic work as well as internal work environments and culture. We are fully committed to increasing women's meaningful and equal participation and leadership at all levels of the GPEI. The GPEI is committed to providing its staff and all those it serves, an enabling, safe and inclusive work environment.

Effective implementation of this Strategy requires support from all partners and staff at different levels. Strengthening delivery for all requires dedicated gender expertise, scaled-up resources and a greater understanding of gender by all staff. Together with the Polio Oversight Board and the GPEI Strategy Committee, we will regularly review results, identify challenges and make adjustments accordingly to further strengthen the implementation of this strategy.

We look forward to working with all our partners and colleagues to take concrete action and decisive steps to promote gender equality, strengthen gender-responsive programming and enhance women's meaningful participation at all levels in our joint efforts to deliver a polio-free world.

Dr Tedros Adhanom Ghebreyesus

Chair of the Polio Oversight Board

Executive Summary

Gender roles, norms and inequalities, along with other factors such as age, race, socio-economic background, disability, religion and caste, operate as powerful determinants of health outcomes. To reach every last child and achieve a polio-free world, the GPEI is committed to identifying and addressing gender-related barriers to immunization, communication and disease surveillance and advancing gender equality. The GPEI also recognizes that gender-equitable organizations are more effective in delivering results and producing better outcomes.

This strategy reiterates the GPEI's commitment to putting gender equality at the core of its programming and ensuring equitable participation and benefit of women and men, girls and boys for enhancing programme quality and sustainable outcomes. This document outlines the GPEI's global strategy for gender-responsive programming with a five-year time frame (2019-2023). It is designed as a guide for HQ, country, and regional programme and management staff and partners to integrate gender into their work. The Gender Equality Strategy defines how the GPEI approaches gender issues externally and internally – in its programming, working culture, organizational and management structures and systems. The goal of the strategy is to generate change in the way the GPEI integrates gender issues into different aspects of its work and to deepen and improve knowledge and best practices across the GPEI.

The specific objectives of the strategy are to a) promote the integration of a gender perspective into different aspects of the GPEI's programming and interventions as well as organizational and management structures; b) support countries in addressing gender-related barriers to polio vaccination to increase vaccination coverage; c) increase women's meaningful[1] participation at the different levels of the polio programme to work towards greater gender parity across the partnership; and d) create gender-equitable institutional environments.

The present Strategy is designed to support the work carried out by GPEI staff and contractors at headquarters, regional offices and country level as well as the GPEI oversight, advisory and management bodies. It is also useful in informing GPEI partners at country, regional and headquarters level, including national governments, donors, UN agencies, NGOs/civil society organizations and other cooperating partners, about the GPEI's approach and focus areas on gender.

This Strategy is based on an inclusive and consultative process across the partnership. It builds on the results and feedback obtained through a comprehensive baseline assessment of the GPEI's current state of gender responsiveness, conducted in 2018, including an online survey completed by 634 GPEI staff working in the five GPEI organizations in the polio-endemic countries, regional offices and HQs, as well as national governments.

The Strategy will be operationalized by an action plan, complete with a communications plan, that is jointly developed by GPEI organizations and offices. The specific action plans, complete with a monitoring

[1] Meaningful participation means that women are not just included or represented but that they are empowered and able to make decisions and influence the agenda and functioning of the GPEI, at all levels of the partnership.

and evaluation plan and assigned responsibilities, will be tailored to meet the specific needs and challenges encountered within different country contexts.

GPEI Mission Statement on Gender Equality

The Global Polio Eradication Initiative is committed to advancing gender equality and the empowerment of women in its efforts to eradicate polio. The GPEI supports national partners to accelerate their progress towards a polio-free status, while supporting progress on the achievement of Sustainable Development Goals (SDGs), by identifying and responding to gender dimensions of polio eradication. The GPEI collectively works towards identifying and addressing gender-related barriers to immunization, and recognizes and addresses the diversity of people's specific needs, challenges, and priorities so that our work equally benefits girls, boys, women and men and people with diverse gender identities.

The GPEI seeks to foster a professional work environment where gender equality and the empowerment of women are actively promoted by staff in all aspects of institutional processes and programmatic work. The Initiative is committed to progressing towards gender parity, increasing women's meaningful and equal participation at all levels of the programme, and providing a safe, inclusive and respectful work environment for all staff, contractors and partners working towards a polio-free world.

Introduction

Gender roles, norms and inequalities, along with other factors such as age, race, disability and socio-economic background, operate as powerful determinants of human rights and health outcomes. To reach every last child and achieve a polio-free world, the GPEI is committed to identifying and addressing gender-related barriers to immunization, communication and disease surveillance and advancing gender equality.

This Gender Equality Strategy is a guiding document reiterating the GPEI's commitment to putting gender equality at the core of its programming and ensuring equitable participation and benefit of women and men, girls and boys for enhancing programme quality. It is grounded in the growing body of evidence that health and immunization programmes designed and executed with a gender focus produce better and more sustainable outcomes[23]. It is also underpinned by evidence highlighting that gender-equitable and diverse organizations produce more effective results[45].

This document outlines the GPEI's global strategy for gender-responsive programming with a five-year time frame (2019-2023). The strategy will be updated after a mid-term reflection and based on learning that emerges from programme implementation. It is designed as a guide for HQ, country, and regional programme and management staff and partners for integrating gender into their work. An action plan, complete with a communications plan, will be developed to operationalize the present strategy, tailored to meet the specific needs and challenges within different country contexts.

The Gender Equality Strategy defines how the GPEI approaches gender issues in its programming, working culture, organizational and management structures and systems. The goal of the Strategy is to generate change in the way the GPEI integrates gender issues into different aspects of work and to deepen and improve knowledge and best practices across organizations forming the Initiative. The Strategy is aligned with, and further elaborates on, the strategic gender approaches outlined in the GPEI Polio Endgame Strategy 2019-2023.

The Gender Strategy is based on the GPEI's understanding that gender-related barriers to immunization operate at multiple levels, from the individual and the household to the community, hindering access to immunization services. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risks, and in differential access to and utilization of vaccination information and services.

An integral part of reaching every last child with vaccines is also the increased participation of women in immunization activities.

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[2] Global Health 50/50 Initiative (2018) *2018 Report: Towards accountability for gender equality in global health*
[3] Global Health 50/50 Initiative (2019) *2019 Report: Equality Works*
[4] McKinsey&Company (2016) *Women Matter: Reinventing the workplace to unlock the potential of gender diversity*
[5] McKinsey&Company (2018) *Delivering through Diversity*

Understanding and awareness of how gender norms, roles and inequalities affect development, health and emergency outcomes is critical to the GPEI's work. If gender dynamics, roles and norms are not considered, polio interventions will not be as effective in reaching every last child with life-saving vaccines, and they may exacerbate existing gender inequalities.

This Strategy outlines the case for gender integration as a critical issue for the GPEI, and is based on an inclusive and consultative process across the partnership. It builds on the results and feedback obtained through a comprehensive baseline assessment of the GPEI's current state of gender responsiveness, conducted in 2018, including an online survey completed by 634 GPEI staff working in the five GPEI organizations in the polio-endemic countries, regional offices and HQs, as well as national governments. The Strategy was developed with feedback and input from GPEI donors, members of the GPEI Strategy Committee, the Polio Oversight Board (POB), country, regional and HQ office staff, civil society organizations, regional polio advisers, gender experts at WHO and UNICEF, and it has been critically reviewed and endorsed by the Polio Oversight Board.

Objectives of the strategy

This Gender Equality Strategy is designed to guide the work of the GPEI in integrating gender into different aspects of its work[6]. It intends to support and complement the overall GPEI goal "to complete the eradication and containment of all wild, vaccine-related and Sabin polioviruses, such that no child ever again suffers paralytic poliomyelitis."[7]

The Strategy supports the goals of the 2019-2023 Polio Endgame Strategy to interrupt transmission of all remaining wild poliovirus (WPV); to stop all circulating vaccine-derived poliovirus (cVDPV) outbreaks within 120 days of detection and mitigate the emergence of any further VDPVs; to strengthen immunization and health systems to help achieve and sustain polio eradication; to sustain sensitive poliovirus surveillance through integration with comprehensive vaccine-preventable disease (VPD) and communicable disease surveillance systems; and to respond to outbreaks and emergencies to benefit eradication and effective humanitarian response.

Goal:

The goal of this strategy is to enable the GPEI to effectively integrate gender considerations into its interventions in order to support the achievement of a polio-free world.

Specific objectives:

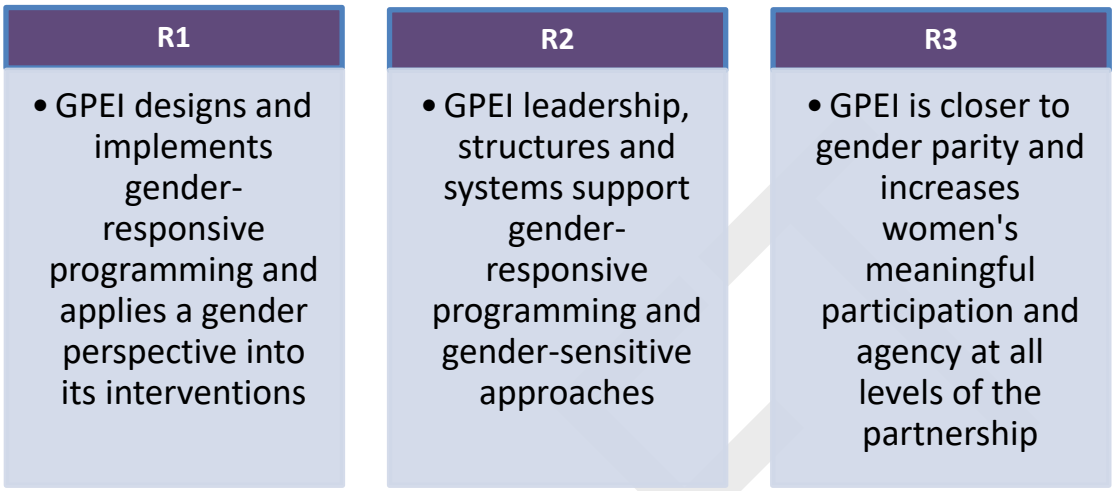
Specifically, this strategy seeks to:

- Promote the integration of a gender perspective into different aspects of the GPEI's programming and interventions as well as organizational and management structures.
- Support countries in addressing gender-related barriers and opportunities to polio vaccination to increase vaccination coverage.
- Increase women's meaningful participation and agency at the different levels of the polio programme to work towards greater gender parity across the partnership, including at management level.
- Create more gender-equitable institutional culture and environments.

[6] This Gender Equality Strategy is also referenced in the Polio Endgame Strategy 2019-2023 for Eradication, Integration, Certification, and Containment.

[7] http://polioeradication.org/who-we-are/our-mission/

Expected results:



Target audience

The target audiences for this Strategy include:

- GPEI staff and contractors at headquarters, regional offices and country level
- GPEI partners at country, regional and headquarters level, including national governments, donors, UN agencies, NGOs/civil society organizations and other cooperating partners
- GPEI's oversight, advisory and management boards and bodies

The Gender Equality Strategy is intended primarily as a guideline for GPEI staff working in polio eradication in the Bill & Melinda Gates Foundation, Centers for Disease Control and Prevention, Rotary International, UNICEF and WHO, including staff working in country and regional offices as well as headquarters. For other GPEI stakeholders, the strategy will provide a clear understanding of the GPEI's strategic priorities and planned work on gender.

Background

The rationale for gender mainstreaming

Gender[8] mainstreaming is a strategy for assessing the implications for both men and women of any planned actions, policies or programmes in all areas at all levels[9]. It is about making women's and men's concerns and experiences a key dimension of the design, implementation, monitoring and evaluation of policies and programmes so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality[10].

The empowerment of women often forms an important part of gender mainstreaming, since in most contexts women continue to be largely disadvantaged in relation to men. However, gender mainstreaming in polio eradication is not solely about women or "women's issues" but about gender inequalities, norms, roles and relations, underpinned by power relations which also impact men, communities and organizations as a whole. It is therefore also important to engage men and boys when designing and implementing gender-responsive programmes to advance gender equality.

Gender mainstreaming has been an explicit strategy in international development, health and humanitarian programming since the Fourth World Conference on Women in 1995 in Beijing, when the UN General Assembly adopted a resolution establishing gender mainstreaming as a UN system-wide policy. In addition to the 1995 Beijing Declaration, building on the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) and the World Conference on Human Rights (Vienna, 1993), strong foundations for gender mainstreaming requirements include the Sustainable Development Goals (SDGs), particularly SDG5 on Gender Equality and Women's Empowerment in addition to SDG3 on Good Health and Wellbeing and SDG10 on Reduced Inequalities. Additionally, the Commission on the Status of Women (CSW), the principal global intergovernmental body dedicated to the promotion of gender equality and the empowerment of women, has a leading role in monitoring and reviewing progress in the implementation of the Beijing Declaration and Platform for Action, and in mainstreaming a gender perspective in UN activities[11].

[8] *Gender* refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. https://www.who.int/gender-equity-rights/understanding/gender-definition/en/

[9] See also *Gender and Polio – Frequently Asked Questions* http://polioeradication.org/wp-content/uploads/2018/07/polio-vaccination-gender-FAQ-Frequently-Asked-Questions-GPEI_Gender-and-Polio_20180710.pdf

[10] Definition for gender mainstreaming: United Nations Economic and Social Council's agreed conclusions 1997/2.

[11] See e.g. UN Economic and Social Council Commission on the Status of Women Sixty-third session 11–22 March 2019 (E/CN.6/2019/3) *Social protection systems, access to public services and sustainable infrastructure for gender equality and the empowerment of women and girls. Report of the Secretary-General.*

Moreover, World Health Assembly resolution WHA60.25[12] urges all Member States to integrate gender analysis into strategic and operational planning and formulate national strategies to address gender issues in health policies, programmes and research, ensuring that a gender-equality perspective is incorporated in all levels of health-care delivery and services. The resolution also specifically calls for the collection and analysis of sex-disaggregated data to inform health policy and programmes.

Gender analysis, a requirement for effective gender mainstreaming and a vetted social science tool, is used to identify and understand the different roles, opportunities and power dynamics that exist between women and men in a specific context. It identifies gender disparities, examines why such disparities exist and looks at how these disparities could be addressed. Gender analysis in health can highlight differences in e.g. risk factors and vulnerability, access to health services and decision-making processes related to health, and access to and control over resources. A thorough gender analysis of polio eradication is included in the GPEI Gender Technical Brief (2018)[13] – the following section summarizes key points covered in the Technical Brief.

Gender and polio

Gender roles and norms, and their underpinning power relations, are powerful determinants of health outcomes[14]. Gender-related barriers to immunization operate at multiple levels, from the individual and the household to the community, hindering access to immunization services. An integral part of reaching every last child with vaccines in the last remaining strongholds of polio is also the increased participation of women in immunization activities.

Health interventions cannot effectively meet the needs of all unless informed by gender-sensitive analysis and data disaggregated by sex, and other crucial variables such as age, ethnicity, disability and socio-economic status. Intersectional analysis [15] highlights how different forms of marginalization and discrimination are often intertwined and overlapping, underlining the need for analysing data by gender and also by other social stratifiers influencing health outcomes.

Gender is relational, operating between people and across social factors. Gender determinants of health do not act alone, but together with individual, household, communal factors and institutional barriers. A multiplicity of gender-related factors affect children's immunization status. From son and male preference

[12] WHA60.25 Strategy for integrating gender analysis and actions into the work of WHO. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/reso-60-en.pdf?ua=1

[13] Global Polio Eradication Initiative technical brief: gender. Geneva: World Health Organization (2018) Available at: http://polioeradication.org/wp-content/uploads/2018/07/GPEI-Gender-Technical-Brief-2018.pdf

[14] A thorough gender analysis of polio eradication is included in the GPEI Gender Technical Brief (2018)

[15] Greta R. Bauer, Ayden I. Scheim (2019) "Methods for analytic intercategorical intersectionality in quantitative research: Discrimination as a mediator of health inequalities" *Social Science & Medicine*. Vol. 226, 2019, pp. 236-245

to maternal education, the relevant gender dimensions of childhood immunization vary between and within countries.

Girls' and boys' vulnerability to polio

Worldwide, a child's sex does not have a significant influence on immunization status. A SAGE report on 67 countries found no significant difference between immunization coverage of girls and boys.[16] Subsequent studies have confirmed the lack of gender disparity in immunization coverage. A study specifically investigating unvaccinated children (having received no doses) across 96 countries also confirmed no significant gender differences[17].

Nevertheless, within countries and regions, there are notable variations, where immunization coverage is higher for girls in some countries and higher for boys in others. For instance, girls receive lower immunization coverage in south-central Asia[18]. Additionally, gender interacts with other factors such as socio-economic status, ethnicity and disability, to affect immunization and overall health status.

An important exception is India, where one study found that gender was significantly associated with poliovirus seropositivity[19]. Girls were also associated with missed polio vaccination in another Indian study[20]. Although gender disparities in immunization are not widespread, the preferential treatment of boys is perpetuated in certain contexts. Countries with higher levels of gender inequality have been associated with lower, less equitable levels of immunization. Anecdotally, there have been cases where, due to harmful rumours about the effects of the polio vaccine, caregivers have not vaccinated their sons but have opted to give the vaccine to their daughters. More social research is needed to examine the ways in which gender impacts boys' and girls' vaccination status in different contexts, accounting also for subnational differences within countries.

Decision-making power to access immunization

Since polio mostly affects children aged under 2 years, parents or caregivers are the critical decision-makers for allowing a child's access to immunization. The type of decisions they make, their power to make decisions and their available resources to act on those decisions are all influenced by gender.

The compounding of social and physical barriers for women in patriarchal societies constrains their capacity to provide health care to their children. Mothers are at the intersection of two conflicting sets of

[16] Martin Hilber, A; Bosch-Capblanch, X; Schindler, C; Beck, L; Sécula, F; McKenzie, O; Gari, S; Stuckli, C; Merten, S (2010) Gender and immunisation: summary report for SAGE

[17] Bosch‐Capblanch, X; Banerjee, K; Burton, A (2012) Unvaccinated children in years of increasing coverage: how many and who are they? Evidence from 96 low‐and middle‐income countries

[18] WHO (2007) Addressing sex and gender in epidemic-prone infectious diseases

[19] Kaliappan, SP; Venugopal, S; Giri, S; Praharaj, I; Karthikeyan, AS; Babji, S; John, J; Muliyil, J; Grassly, N; Kang, G (2015) Factors determining anti-poliovirus type 3 antibodies among orally immunised Indian infants

[20] Jain, S; Basavaraj, P; Singh, S; Singla, A; Kundu, H; Singh, K (2014) Polio Eradication–Lessons from the Past and Future Perspective

demands; on the one hand they are seen as responsible for care work including children's health but, on the other, they may lack the resources and autonomy to seek out health care.

A woman's autonomy affects her ability to access health services for herself and her children. Women's agency and decision-making have been significantly associated with children's immunization status[21]. The higher the mother's agency, the more likely she will immunize her children. Where women lack autonomy, they may require spousal permission to immunize their children. Mothers who perceive that spousal permission is required for their child's immunization are less likely to fully immunize their child.[22]

Education and literacy

Although paternal education is also associated with a child's immunization status, lower educational levels of maternal caregivers are more commonly related to under-vaccination in lower and middle-income countries[23]. A comprehensive review of immunization equity found that the greatest disparity exists for children with uneducated mothers[24]. A mother's individual educational level as well as the literacy rate of her community are important factors for a child's complete immunization.

Access to resources

Access to and control over resources are other limiting factors for accessing vaccination services. When mothers have to travel to receive vaccinations for their children, they incur costs, even if the vaccination itself is free. Travel imposes direct costs associated with transportation and indirect costs associated with wage loss and unpaid care work in the home including childcare. Where gender norms preclude mothers from travelling alone, mothers face the additional burden of arranging a guardian or suitable companion to travel with them.

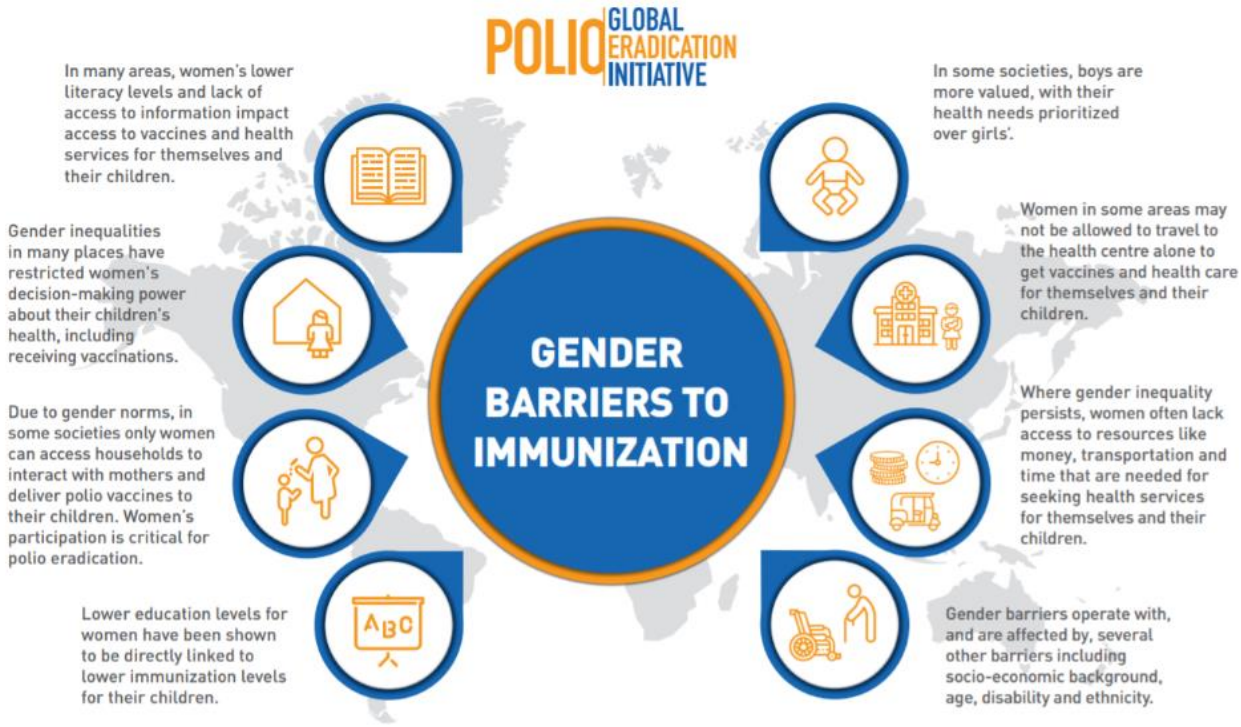
Gender-related barriers to immunization:

[21] Singh, K; Haney, E; Olorunsaiye, C (2013) *Maternal autonomy and attitudes towards gender norms: associations with childhood immunization in Nigeria* and Antai, D (2012) *Gender inequities, relationship power, and childhood immunization uptake in Nigeria: a population-based cross-sectional study.*

[22] Monguno, AK (2013) *Socio cultural and geographical determinants of child immunisation in Borno State, Nigeria*

[23] Rainey, JJ; Watkins, M; Ryman, TK; Sandhu, P; Bo, A; Banerjee, K (2011) *Reasons related to non-vaccination and under-vaccination of children in low and* middle income countries: Findings from a systematic review of the published literature, 1999–2009

[24] Hinman, AR; McKinlay, MA (2015) *Immunization equity*



Gender and immunization delivery

Gender norms around acceptable interactions between women and men shape and determine the delivery of immunization. For example, Islamic law often regulates the type of behaviour allowed between women and men who are not blood relatives. Unrelated men are generally not permitted to enter Muslim households if women are alone with their children.[25] In certain cultural contexts, such as in the Nigerian Hausa tradition, unrelated men may not speak to women without permission from their husbands[26]. Because of these religious and social customs, women may be prevented from receiving health-care services from men, especially at the household level.

In contexts where having an open conversation with a male health worker is not possible, it is imperative that female front-line workers are available to speak to women and deliver health services. In the GPEI's immunization activities, female FLWs have also increased the effectiveness of health service delivery, and in many settings only women can access households and vaccinate infant children inside the household. Female social mobilizers have improved attitudes towards polio vaccination and the perceptions of risks

[25] Obregón, R; Waisbord, S (2010) *The complexity of social mobilization in health communication: top-down and bottom-up experiences in polio eradication.*

[26] An evaluation of polio supplemental immunization activities in Kano, Katsina, and Zamfara States, Nigeria: lessons in progress (2014) Gammino, VM, et al. *The Journal of Infectious Diseases*, 2014, Vol. 210, pp. S91-S97

associated with the disease[27]. All-male vaccinator teams, on the other hand, were found to be ineffective, posing a critical gender-related barrier to polio eradication efforts[28]. In Nigeria, for example, all-male vaccination teams were unable to engage with young mothers during polio supplementary immunization activities[29]. A review of polio immunization in Afghanistan from 1997 to 2013 suggested that mothers' refusals were related to interactions with all-male vaccination teams. Women also demonstrate gender preferences for front-line workers, as there is generally greater demand from mothers for female vaccinators and social mobilizers.[30]

The Female Community Volunteers (FCV) initiative, re-initiated in areas of "super high-risk Union Councils" (SHRUCs) in Pakistan in 2014, has also shown how an increase in female frontline workers' participation brings about better results for polio eradication. The FCV strategy, with strong community participation, has greatly contributed in breaking down long-existing barriers to polio vaccination for the hardest-to-reach and most vulnerable people in Sindh and Baluchistan. Local Female Community Volunteers go from house to house to administer OPV vaccine to children, in addition to regular health camps. In Baluchistan, at the start of the programme, only 60% of the Lot Quality Assurance Sampling (LQAS) lots were passing, with 80% of them failing with more than eight children missed. A year after the CBV programme started, the proportion of lots passing had increased to 92%.

Assessment of the GPEI's gender-responsiveness

To guide the development of a targeted and relevant Gender Equality Strategy for the GPEI and to assess the current state of gender-responsiveness of the GPEI, a thorough baseline assessment was carried out. A GPEI-wide staff survey, completed by 634 polio personnel in the polio-endemic countries[31] as well as at headquarters and regional offices in June 2018, examined the knowledge levels and attitudes, and current practices, of staff and GPEI partners, while highlighting critical gaps and challenges related to gender mainstreaming within the GPEI.

In addition to a staff survey, the current state of gender parity in staffing in the different organizations forming the GPEI, as well as key polio oversight and advisory bodies, was examined. Additionally, a content analysis of key GPEI publications was carried out to measure the extent to which they have to date incorporated gender considerations.

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[27] Obregón, R; Chitnis, K; Morry, C; Feek, W; Bates, J; Galway, M; Ogden, E (2009) *Achieving polio eradication: a review of health communication evidence and lessons learned in India and Pakistan.* WHO Bulletin.

[28] Obregón, R; Waisbord, S (2010) *The complexity of social mobilization in health communication: top-down and bottom-up experiences in polio eradication.* Journal of Health Communication. Vol. 15: S 1.

[29] Gammino, VM; Nuhu, A; Gerber, S.; Gasasira, A; Sugerman, DE; Manneh, F; Chenoweth, P; Kurnit, MR; Abanida, EA (2014) *An evaluation of polio supplemental immunization activities in Kano, Katsina, and Zamfara States, Nigeria: Lessons in progress. The Journal of Infectious Diseases. Vol. 210:1.*

[30] Simpson DM, Sadr-Azodi N, Mashal T, Sabawoon, W; Pardis, A; Quddus, A; Garrigos, C; Guirguis, S; Zahoor Zaidi, SS; Shaukat, S; Sharif, S (2014) *Polio eradication initiative in Afghanistan, 1997–2013. The Journal of Infectious Diseases. Vol. 210:1.*

[31] Currently Afghanistan, Nigeria and Pakistan

The baseline analysis highlighted that, although gender is a significant determinant of health outcomes and a key focus area for many critical GPEI donors, the GPEI has remained largely gender-blind. However, the GPEI survey results also indicated that the majority of GPEI partners and staff at different levels recognize the importance of considering gender issues in polio programming and show willingness to do so. The analysis of the GPEI survey results, the current state of gender parity, as well as the absence of gender in key GPEI documents and publications indicate that there is a strong need for the GPEI to take decisive steps to adequately mainstream gender into its work.

Summary of GPEI gender assessment results

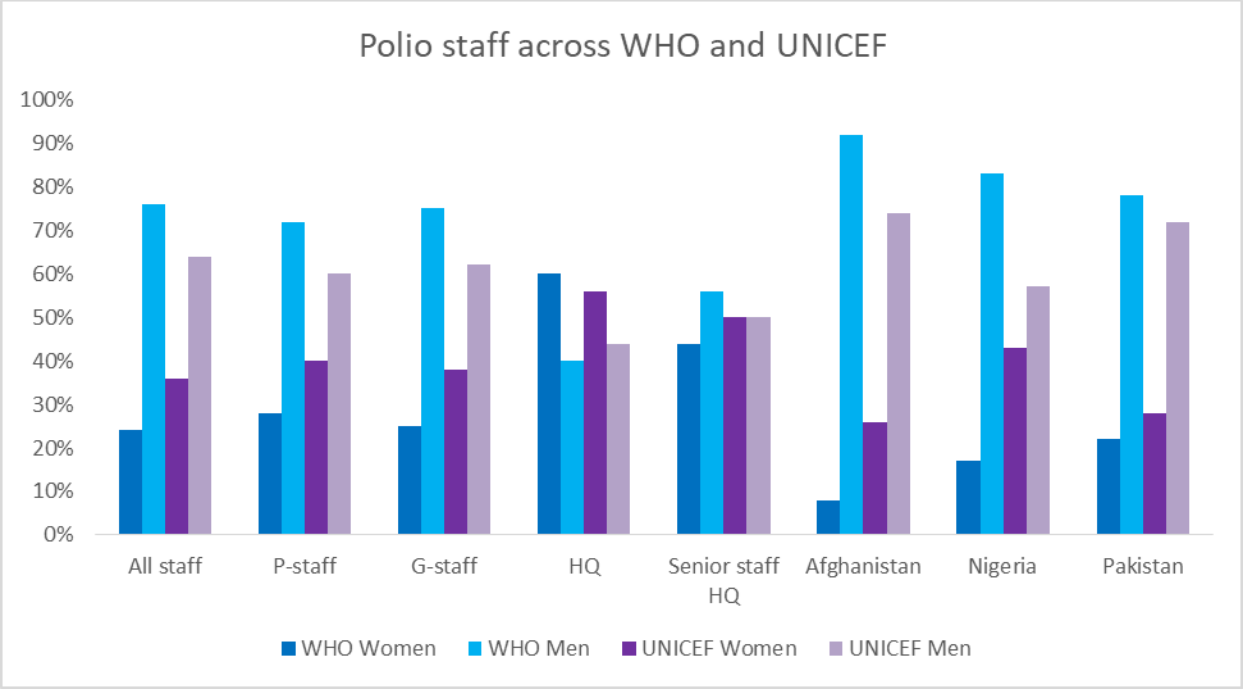
GPEI staff survey:

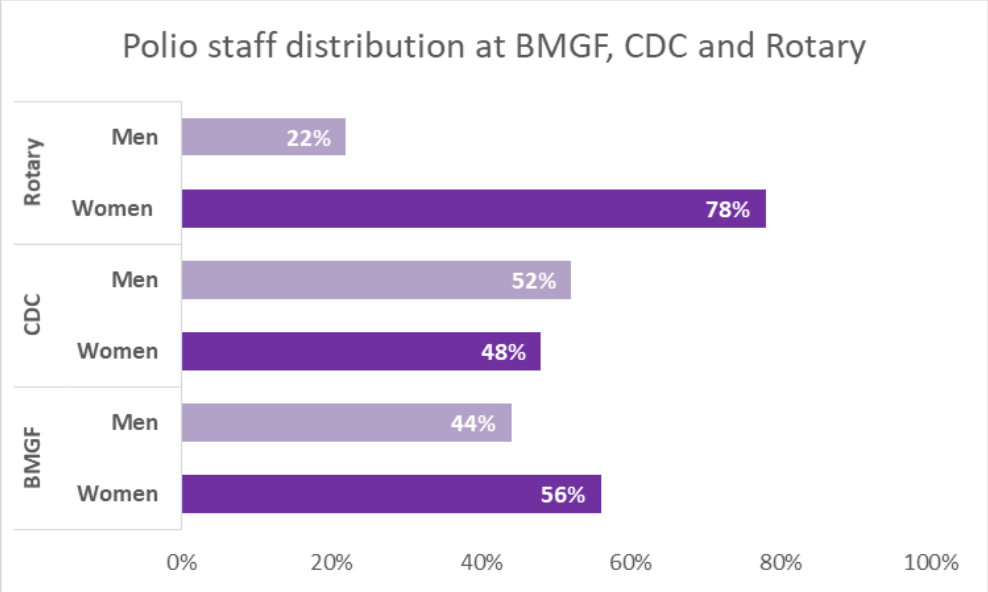
- Of 634 GPEI partners and staff who took part in the survey, 79% work at WHO and 11% at UNICEF; 21% are women and 78% men.
- 91% of respondents indicated that the GPEI needs a Gender Strategy.
- Of all UNICEF respondents, 35% reported recalling gender being discussed “regularly”, compared to only 17% of WHO respondents.
- 36% reported needing technical support to be able to integrate gender in their work and 33% stated needing training on gender and polio issues.
- 66% stated never having received any training related to gender.
- 94% of WHO and UNICEF respondents working in HQ felt it is important to collect and analyse sex-disaggregated data, compared to 76% in the country offices.
- The majority (78%) of GPEI staff and partners who took part in the survey were not aware of the programme’s gender-sensitive indicators developed in 2017 and reported on in the GPEI Semi-Annual Status Reports since April 2018.
- 75% strongly agreed with the statement that *women and men should be treated equally*.
- Only 36% of female respondents “strongly agreed” that women and men are treated equally in their organization.
- Only 5% of women working in polio in WHO HQ “strongly agreed” that women and men are treated equally, with the majority of women (60%) either somewhat or strongly disagreeing with the statement.
- Of all respondents, 37% stated that based on their knowledge and experiences, sexual harassment is a very serious issue in the polio programme.
- When asked about gender-based discrimination, 36% of polio staff responded that it is a “very serious issue”. Of all female respondents, 78% felt it is either “somewhat an issue” or a “very serious issue”, compared with 69% of male respondents
- Of all respondents, 78% were aware of a mechanism in their workplace to make an official complaint to report sexual harassment, abuse, and/or gender-based discrimination.

Gender parity (status in June 2018):

- Women comprise 24% of all WHO polio staff at HQ and the five WHO Regions; women constitute 28% of all P-grade[32] staff and 25% of all G staff.
- In WHO HQ, women comprise 60% of polio staff; however, there is a clear division between women and men in terms of the types of grades and levels they occupy. All 21 G-staff currently working at WHO HQ are women, and women hold 43% of all P-level posts. Of all senior-level polio staff (P4 and above) at HQ, 56% are men. All D1 and D2 level posts are held by men.
- In WHO Country Office in Afghanistan, women comprise 8% of all polio staff – 17% in Nigeria and 22% in Pakistan.
- Of all UNICEF polio staff, 36% are women and 64% are men. Women comprise 40% of all P-graded polio staff at UNICEF and 38% of all G-level staff.
- In UNICEF HQ, women constitute 56% of all polio staff. Women currently hold 55% of all P-level posts and 57% of G-posts at HQ. Of the senior-level staff positions (P4 and above) at UNICEF HQ, 50% are women.
- In the UNICEF Afghanistan Country Office, women comprise 26% of all polio staff, whereas the figure is 43% in Nigeria and 28% in Pakistan.
- At Rotary International 78% of polio staff are women, at BMGF 56% and at CDC 48%.
- GPEI oversight bodies and advisory groups are largely led by men. The Polio Oversight Board (POB), which oversees the management and implementation of the GPEI through its core partner agencies, is currently formed of four men and one woman.
- The Strategy Committee, formed by the heads of agencies of the core GPEI partner organizations, is currently formed of three men and two women.
- Technical Advisory Groups (TAG), which review progress towards polio eradication and provide technical advice on strategies, priorities and programme operations, are also largely male-led. For instance, all TAG Members of the November 2017 TAG both in Afghanistan and Pakistan were men. Women are also largely absent from the "technical advisor" category of TAGs, with only two out of 10 advisors being women in the November 2017 TAG in Afghanistan, and one out of 17 in Pakistan.

[32] P refers to staff in the Professional category in the UN system, while G refers to staff in the General Service category





Gender in GPEI documents:

A content analysis was carried out to measure the extent to which recent GPEI publications (from 2016 onward) promote or use gender analysis or sex-disaggregated data. A total of 16 GPEI publications were selected from the GPEI website, covering categories of a) country-specific National Emergency Action Plans (NEAPs) in Afghanistan, Pakistan and Nigeria, b) annual and semi-annual GPEI reports and c) tools/normative guidelines and standard operating procedures.

The content analysis matrix and methodology were modified and adapted from a WHO publication *Gender Mainstreaming at WHO: Where are we now?*[33]

The content analysis of GPEI documents focused on the following questions:

- Does the document include one or more "explicit" statements/references to gender equality or gender equity? (a one-off reference to having women in vaccination teams is not counted)
- Does the document refer to consultation/ partnerships with women's groups?
- Does the document recommend use of sex-disaggregated data?
- Does the document use/present sex-disaggregated data, where relevant?
- Does the document analyse/interpret the differences between women and men's outcomes, needs, roles, norms (i.e. gender analysis)?
- Does the document specify at least one action/recommendation to address gender issues?

Overall 740 pages of a total of 16 GPEI documents published on the GPEI website in 2016-2018 were examined for the content analysis. In addition to the above questions, specific keywords commonly included in gender-responsive documents were searched in each document, including: *gender, sex, equity, equality, women, and girls*. Notably, only three out of 16 documents included the word "gender" while only one included "equality". The key guiding document of the GPEI, the *Polio Eradication & Endgame Strategic Plan 2013-2018*, mentioned gender once, but only in the context of the polio programme's achievements in addressing gender barriers, without including any analysis or background of the content or dynamics of these barriers. However, the updated Polio strategy document for 2019-2023 addresses gender issues systematically.

The majority of the reviewed GPEI documents did not contain any gender analysis or sex-disaggregated data. Notable exceptions are the two latest GPEI Semi-Annual Reports, published in 2018, which explicitly mentioned gender issues, used and promoted the use of sex-disaggregated data, included gender analysis and specified actions to address gender inequalities.

[33] *Gender mainstreaming in WHO: Where are we now? Report of the baseline assessment of the WHO Gender Strategy* (2011) World Health Organization.

Strategic Framework

Strategy overview/logic model

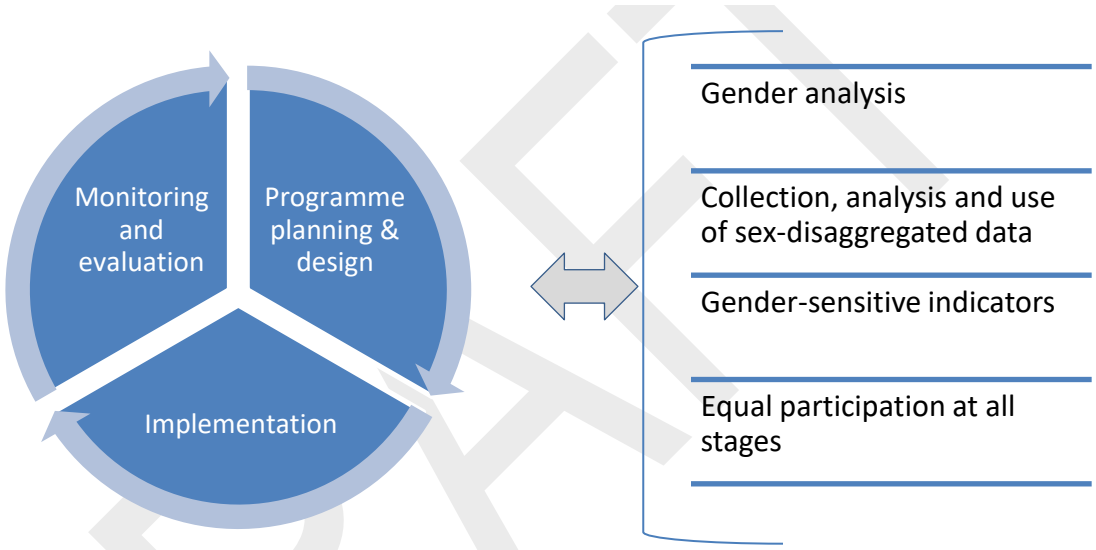
Inputs and Assumptions	Activities and Outputs	Outcomes	Overall Goal
Sufficient human resource allocations dedicated to gender expertise	Systematic collection, analysis and use of sex-disaggregated data and gender analysis where relevant	GPEI interventions, guidelines, strategies and policies systematically integrate gender considerations and address gender equality, equity and women's equal participation at all levels	Increased number of girls and boys reached with polio vaccines to support the achievement of a polio-free world
Dedicated and sustained technical expertise on gender	Regular reporting on gender aspects and gender-sensitive indicators of the programme	Sex-disaggregated data is collected, analysed and used in key documents and publications	
Adequate financial resources for programmatic and institutional gender mainstreaming	Capacity building of GPEI staff on gender mainstreaming and other key gender topics (including PSEA)	Explicit commitment to gender equality and equity exists in organizational strategies and policies	
Senior management ownership and leadership on gender mainstreaming	Appointing and training gender focal points	GPEI staff have adequate capacity for gender integration	
Strong global, regional and local partnerships	Utilization of gender-sensitive communication approaches in all communications/C4D interventions	Gender focal points are operational and supported	
Staff and partners have the capacity and willingness to address gender and equity	Revision of human resource policies and protocols on recruitment and promotion	Improved gender balance across the GPEI	
	Implementation of specific quotas	Gender-related barriers to immunization systematically addressed	
	Concrete action from senior leadership to support gender equality and gender responsiveness (official communication with staff, publications, statements, speeches)	GPEI provides a gender-equitable, safe and inclusive work environment with zero tolerance to gender-based harassment	

Note: this framework is an indicative snapshot of required action; a detailed action plan with activities, outputs and indicators will be developed based on the strategic framework

Gender-responsive programming

Programmes, policies and interventions are gender-responsive when gender roles, norms and inequalities have been analysed and appropriate measures have been taken to actively address them. In order for the GPEI to strengthen its gender-responsiveness, a gender perspective needs to be systematically mainstreamed into the different stages of programme planning, implementation and monitoring and evaluation at various levels.

Gender-responsive programming

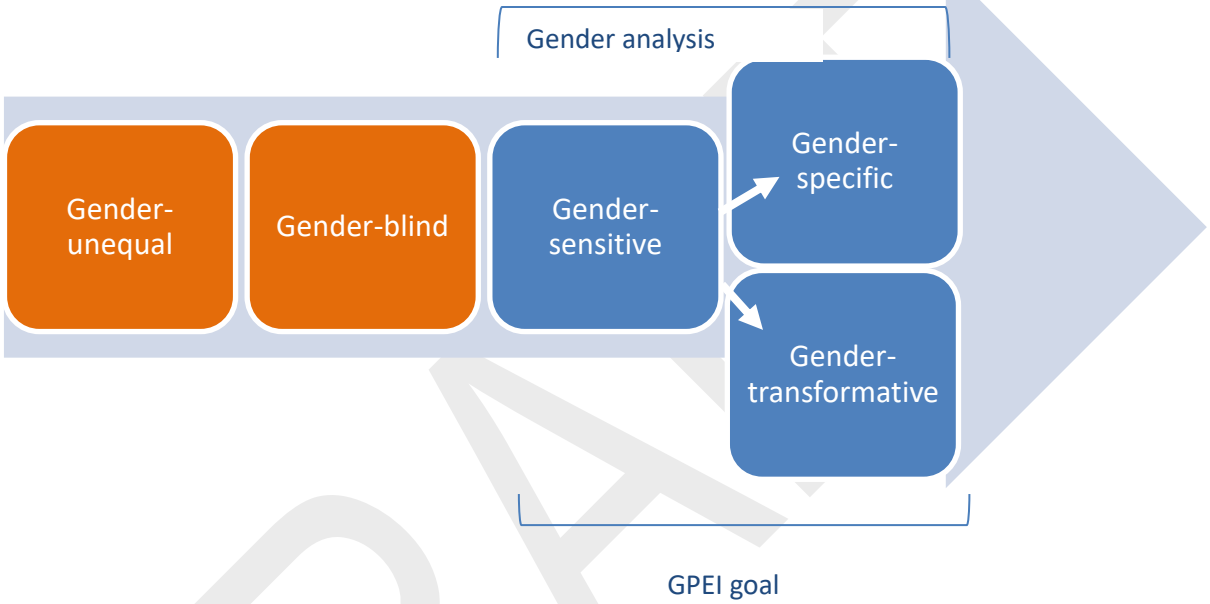


The Gender Responsive Assessment Scale (GRAS) developed by WHO defines five different levels of gender-responsiveness, categorizing programmes either as gender-unequal, gender-blind, gender-sensitive, gender-specific or gender-transformative. Gender-unequal programmes (level 1) perpetuate gender inequalities by reinforcing unbalanced norms, roles and relations and privileging men over women (or vice versa). Gender-blind programming (level 2) ignores gender roles, norms and relations and the differences in opportunities and resource allocation for women and men, girls and boys.

Gender-sensitive programming (level 3) considers gender roles, norms and relations while not necessarily addressing inequality generated by gender norms and roles. Gender-specific (level 4) programming acknowledges different norms and roles for women and men and how they influence access to and control over resources, and takes account of the specific needs of girls, women, boys and men. Gender-transformative programming (level 5) goes beyond this by also including ways to transform harmful gender roles, norms and relations, with the objective to promote gender equality.

The actions presented in this Gender Equality Strategy aim to ensure the GPEI approaches are, at a minimum, gender sensitive in all aspects, combined with gender-specific and gender-transformative approaches. The selected approaches, to be elaborated in specific action plans, will depend on current baselines and existing restraints and challenges in a given country context/programmatic setting.

WHO Gender-responsive Assessment Scale



Gender analysis and project management

Gender analysis is used to identify and understand the different roles, opportunities and power dynamics that exist between women and men in a specific context. Gender analysis in health and immunization can highlight differences in e.g. risk factors and vulnerability, access to health services, resources such as money, information and transportation, as well as decision-making processes related to vaccination.

Conducting gender analysis is a key component of gender-responsive programming and gender mainstreaming, and therefore a crucial area for the GPEI to focus on in different aspects of its work.

The GPEI will:

- Implement gender-responsive interventions and systematically integrate a gender perspective into programme design, implementation, budgeting, monitoring and evaluation.
- Include a gender analysis component in all relevant publications, including polio eradication strategies, contributions to National Emergency Action Plans (NEAPs), communications/C4D

strategies and plans, technical reports, project proposals and standard operating procedures (SOPs).

- Systematically incorporate gender analysis (including the GPEI gender-sensitive indicators) into key presentations and briefings on polio to internal and external audiences.
- Ensure women, men, boys and girls of diverse backgrounds are equally consulted and participate in the design, implementation, monitoring and evaluation of programmatic interventions affecting them, making sure their perspectives and voices are heard and integrated.
- Introduce, monitor and enforce the use of gender guidelines to support staff in integrating gender into technical reports, funding proposals and other relevant publications.
- Ensure budgets include specific allocations for gender equality related considerations.
- Gather and analyse further data and evidence around gender and polio with a focus on understanding and addressing gender-related barriers to immunization.
- Ensure that in all GPEI publications, gender is defined in a manner consistent with global norms (e.g. the WHO definition[34]), moving away from conflating "gender" with "women" and only the participation of female front-line workers.
- Widely publish and disseminate the 2018 *GPEI Gender Technical Brief* and other GPEI publications, tools and success stories around gender and polio among staff, partners and external audiences at all levels.

Collecting, analysing and using sex-disaggregated data

The collection, analysis and use of sex-disaggregated data is a crucial component of gender-responsive programming. Collecting and analyzing data disaggregated by sex allows the programme to track that girls and boys are equally reached with vaccines and through polio surveillance, and where any gender discrepancies are found, these can be effectively tackled and addressed. In addition to collecting data disaggregated by sex, it is also crucial to address intersectionality and collect data disaggregated by other variables influencing health outcomes, such as ethnicity, age, religion, disability, geographic area (urban/rural and/or geographic unit of relevance), and socio-economic background.

Collecting sex-disaggregated data about polio front-line workers and staff is also important in order for the programme to monitor gender parity and work towards reaching set targets for the equal participation of women and men. All GPEI publications and reports should present disaggregated by sex and other social stratifiers where relevant and available.

The GPEI will:

- Ensure that all relevant programmatic data is disaggregated by sex and other critical variables, and that this data is analysed to find and address existing gaps.

[34] *Gender* refers to "the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men"

- Provide training for all relevant staff about the importance of and requirement for collecting and analysing disaggregated data.
- Ensure that a standardized system for data collection and reporting is in place with clear lines of accountability.
- Systematically use, publicise and present this data in relevant GPEI publications, presentations and reports, including the GPEI semi-annual status reports and annual reports, key polio eradication strategy documents, standard operating procedures (SOPs) as well as country-specific annual reports, progress reports, Technical Advisory Group (TAG) reports and National Emergency Action Plans for polio eradication.

Gender-sensitive indicators

To ensure equal access to vaccinations and the engagement of women, in 2017 the GPEI developed four gender-sensitive indicators for monitoring progress, which have been reported on every six months in the GPEI Semi-Annual Status Reports since 2018. The indicators measure that girls are boys are equally reached with polio vaccines, the timeliness of surveillance for girls and boys, as well as measuring women's participation as frontline workers.

These indicators will be regularly monitored and reported on for the polio-endemic countries[35], as well as for outbreak and high-risk countries[36]. Furthermore, the programme will develop further gender-sensitive indicators in addition to the current ones, for example measuring gender balance at the different levels of the polio programme, including middle and senior management roles (including at the country level), tracking specific gender training received by staff, and the extent to which gender analysis informs specific interventions. These indicators will be further elaborated on in the individual action plans developed to operationalize this Strategy, and they will also be monitored by third-party evaluators.

The GPEI's current gender-sensitive indicators:	
(1) Girls and boys reached in vaccination campaigns	Percentage of girls and boys aged under 5 years recorded as vaccinated from post-campaign monitoring data.
(2) Total doses received by girls and boys	Median number of doses of girls and boys aged 6–59 months. Percentage of girls and boys aged 6–59 months with 0 doses. Percentage of girls and boys aged 6–59 months with 3+ doses.

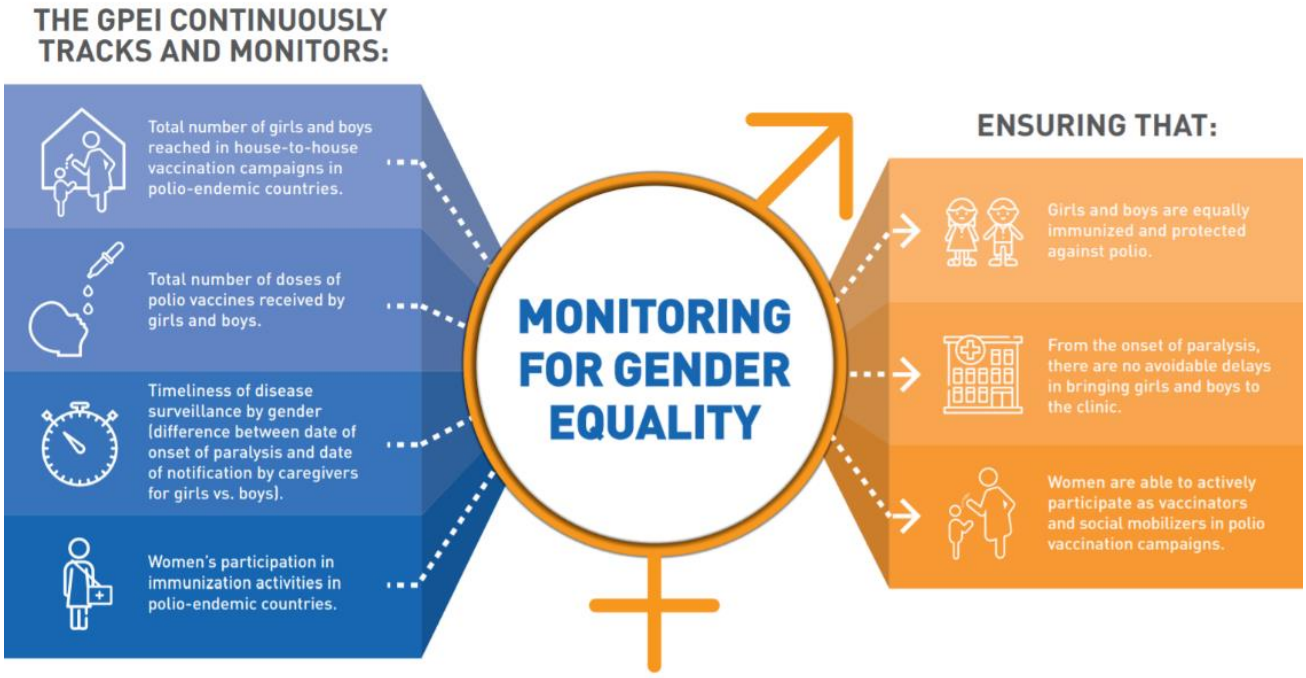
[35] As of April 2019: Afghanistan, Nigeria and Pakistan

[36] As of April 2019, the outbreak and high-risk countries include Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Guinea, Iraq, Kenya, Lao People's Democratic Republic, Liberia, Madagascar, Mali, Mozambique, Myanmar, Niger, Papua New Guinea, Sierra Leone, Somalia, Syria, and Ukraine

(3) Timeliness of disease surveillance for girls and boys	Median number of days for disease notification for males and females. Percentage of males and females with disease notification within three days.
(4) Women's participation in immunization activities	Percentage of female and male front-line workers (vaccinators and social mobilizers).

The GPEI will:

- Collect data on all four indicators for polio-endemic countries, and for acute flaccid paralysis (AFP) surveillance indicators (2 and 3) for all outbreak and at-risk countries.
- Regularly monitor the gender-sensitive indicators and publicly report on them semi-annually.
- Take action whenever any gender discrepancies are found to find reasons for these gaps and support countries in addressing them through appropriate interventions (e.g. targeted communications/C4D strategies).
- Develop further gender-sensitive and gender-specific indicators to monitor performance and measure results through specific action plans.
- Include data on the indicators to relevant polio briefings, updates, reports and publications and disseminate this data widely.



Gender-responsive communications

Communication plays a crucial role in the effort to reach all children under 5 years of age with polio vaccines, and to convince caretakers about the importance of having repeated doses of the vaccine. It is therefore important that gender is mainstreamed into different communications interventions and activities and to ensure that the GPEI adopts gender-sensitive and gender-responsive approaches in all communications.

An example of a photo not reinforcing typical gender stereotypes – a man from Kandahar, southern Afghanistan, holds his baby as he waits for him to be vaccinated. Photo: WHO/J.Jalali

In the design stage of communications/C4D interventions, a gender analysis should be consistently conducted, assessing the roles of, and relations between, women and men, girls and boys, identifying how gender, and other crucial variables such as age, disability and ethnicity, impact experiences, needs, capacities, specific vulnerabilities, access to and control over resources, barriers and priorities. The GPEI will avoid gender-blind communications plans and strategies that assume that gender plays no role for instance in the selection of appropriate messages, and the delivery mechanisms and channels for these messages.

All GPEI communications and tools, from external communications to behavior change and community engagement, must portray women, girls, men and boys equitably and fairly. By doing this, the GPEI contributes towards transforming attitudes and behaviors related to gender inequality and women's exclusion and marginalization. The GPEI will also ensure that women, girls, boys and men are equally consulted during initial situational analysis as well as the design, testing, implementation and M&E stages of communications interventions.

The GPEI will refrain from reproducing harmful gender stereotypes portraying traditional female/male roles, but will aim to present women's voices in areas traditionally occupied by male voices, and vice versa. For example, in official communication materials, the GPEI will refrain from portraying women as passive and inherently vulnerable but will highlight women's agency and power to make decisions, and the positive change achieved by women's contributions and actions within polio eradication.

The principles for gender-inclusive written and oral communications also apply to audiovisual materials such as videos, photographs, and infographics. The GPEI will avoid stereotypical portrayals of men and women in terms of norms and expected behaviors, division of labour and access and control over resources. In addition to choosing and using photos that show women in non-traditional and non-stereotypical roles and professions and ensuring equal numbers of women and men in image selection in general, the GPEI will ensure that the overall portrayal of women conveys messages of equal status. The GPEI will also avoid conflating the issue of "gender" with "women" and "women's issues" in its official publications.

The GPEI will consistently apply gender-transformative C4D approaches according to UNICEF's existing guidelines[37] by for instance engaging fathers to take on a more active role in child rearing and by promoting decision-making over health issues among women. It is crucial that the design of polio materials, messages and interventions considers and challenges negative gender norms, and that they take into account the way in which gender impacts differences in access to information and services.

It is essential to also ensure that all communications are sensitive to diversity in gender identity and sexual orientation and avoid reproducing a typical gender dichotomy of women/men. For instance, when issuing research surveys and polls, it is good practice not to limit the options to female/male, woman/man, but to allow space for other possible gender identities. All communication materials with portrayal of individuals must always take into account the local context and guarantee the safety of the individuals involved.

The GPEI will:

- Include gender analysis, gender equality and women's empowerment as integral elements in all communications plans, guidelines, strategies and action plans.
- Include gender analysis and the collection, analysis and use of data disaggregated by sex and other crucial variables as a critical component of the design, implementation, monitoring and evaluation of all polio-related communications/C4D interventions and activities.
- Integrate gender considerations into all communications/C4D-related surveys, research and polls, and ensure that results of such research are also disaggregated by sex and other variables such as age, ethnicity and disability, and presented with gender analysis.
- Ensure women, men, girls and boys are equally consulted and their specific needs, barriers, views and preferences are taken into account when designing, testing and delivering communication interventions.
- Consistently apply gender-transformative C4D approaches during the design, implementation, monitoring and evaluation of communication interventions according to UNICEF's existing guidelines[38]
- Establish a gender review process, led by the Polio and Country Office Gender Focal Points, for the development and implementation of all polio C4D interventions in the country offices of the endemic countries.
- Ensure that communications materials, publications and tools do not contain harmful gender stereotypes.
- Ensure that women and men are seen, heard and treated equally in media products and messages, and that quotes from both men and women are included in press releases, web stories, videos, photo essays and other communication pieces.
- Develop and disseminate specific tools to support communications and programme staff in utilizing a gender-responsive approach, including key message documents and FAQ documents.

[37] UNICEF South Asia (2018) *Gender-Responsive Communication for Development: Guidance, Tools and Resources*

[38] UNICEF South Asia (2018) *Gender-Responsive Communication for Development: Guidance, Tools and Resources*

- Use inclusive language in all official communication and refrain from using exclusionary forms of language (for example the use of “he”/“his” when actually referring to both women and men)[39].
- Portray and refer to women as equal and active participants in all aspects of polio eradication, not merely as mothers and caretakers.
- Ensure gender balance and diversity of speakers and thematic experts in polio-related events, workshops and panels.
- Apply the principles of gender-sensitive communications also to audiovisual materials, e.g. photographs, videos and infographics.

Organizational Culture and Systems

To achieve the projected objectives of this Gender Equality Strategy, change within the GPEI is required at the technical level (addressing capacities, systems and instruments for gender mainstreaming), as well as at the policy level (including commitment, prioritizing and decision-making) and the organizational cultural level where routine attitudes and behaviours form and sustain the environment and daily activities within the GPEI organizations. In addressing the challenges of commitment, leadership, accountability and capacity, adjustments are required not only in the work that the GPEI carries out but also in *how* the work is done.

The successful implementation of this Gender Equality Strategy relies on systems of accountability for gender results, and re-shaping the culture of the GPEI organizations by tackling attitudes, beliefs and behaviours. Commitment to gender must be sustained and sincere, with full engagement of men and women, spanning from senior management down to all levels, and effectively integrated into systems, ways of working and the overall organizational culture within the GPEI. The implementation of this Strategy and its action plan will be regularly monitored and reviewed by the Polio Oversight Board, GPEI’s principal internal oversight mechanism.

The GPEI is committed to increasing the prominence of gender considerations in its organizational values, working culture, and management systems and structures. To foster a more gender-responsive value system, the GPEI leadership will affirm commitment to gender integration across the partnership and promote adoption of the Strategy at the country programme, regional and HQ levels.

Gender parity

Gender balance in GPEI staffing mirrors the GPEI’s commitment to gender equality. Currently the GPEI is not on track to reaching adequate levels of gender balance as decision-making power remains in the hands

[39] See e.g. UN Women’s “Gender-inclusive language guidelines
Promoting gender equality throughthe use of language” http://www.unwomen.org/-/media/headquarters/attachments/sections/library/gender-inclusive%20language/guidelines-on-gender-inclusive-language-en.pdf?la=en&vs=2129

of men, and the GPEI is largely led by men. Key governance, advisory groups and oversight bodies, such as the Technical Advisory Groups (TAG), the Strategy Committee and the Polio Oversight Board, are mainly composed of men. Staff in GPEI organizations are mostly men, especially in higher grade levels and in senior posts.[40] For example, of all Polio personnel working at WHO Afghanistan, 8% are currently women, and at UNICEF Afghanistan, 26% of all Polio-hired staff are women[41].

While fundamentally a right, parity is necessary to the GPEI's efficiency, impact and credibility. Many GPEI partners already have specific gender equality policies related to recruitment and human resources. Where currently missing, GPEI organizations need to adopt specific affirmative measures to achieve gender equality among staff and governing/advisory bodies, and to identify gender-related barriers related to recruitment, hiring, retention and advancement. The human resource strategies of each GPEI partner must include specific strategies, targets and actions to increase the pace towards gender parity in staffing. The focus will also be on furthering geographic diversity, particularly from underrepresented groups. Without specific and targeted measures to recruit and retain more women, gender parity will remain elusive.

To increase the number of female front-line workers and other polio staff in countries where women's participation remains low (especially in Afghanistan), the GPEI will ensure that measures are put in place to enable more women to be recruited, retained and trained as polio workers and supervisors while supporting the development of a safe, respectful and inclusive work environment. While the recruitment of female front-line workers poses challenges, for example in the more conservative and rural areas of Afghanistan, efforts must be made to reduce barriers for women's full participation in areas where women are able to work outside the household. For example, the GPEI must ensure gender parity in polio frontline worker and supervisor selection committees to ensure it reaches its set target of at least 50% of front-line workers being women in urban areas.

The GPEI will:

- Introduce quotas and commit to reaching gender parity (50%-50%) in technical advisory groups and panels, governance and oversight bodies by the end of 2020.
- Where currently missing, include specific strategies, targets and actions in each GPEI organization's human resource strategies to increase the pace towards gender parity in staffing.
- At a senior leadership level, commit to recruiting and promoting more women to address the current gender imbalance, especially in senior-level posts across the organizations.
- Ensure that policies and training for the prevention of harassment and abuse of authority, conflict resolution and protection against retaliation are in place and implemented in each GPEI organization.
- Provide training to senior management and human resources units on unconscious bias and review language in job descriptions to ensure it is gender-neutral.

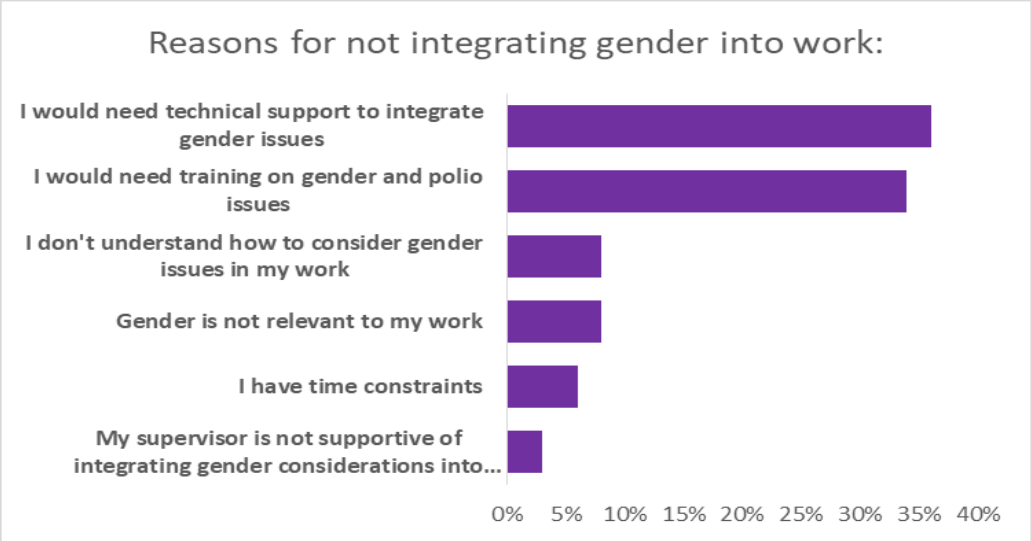
[40] See also "Assessment of the GPEI's Gender Responsiveness" in this document for more detailed breakdowns.
[41] These figures do not include front-line workers such as vaccinators and social mobilizers, but professional and general service UN staff.

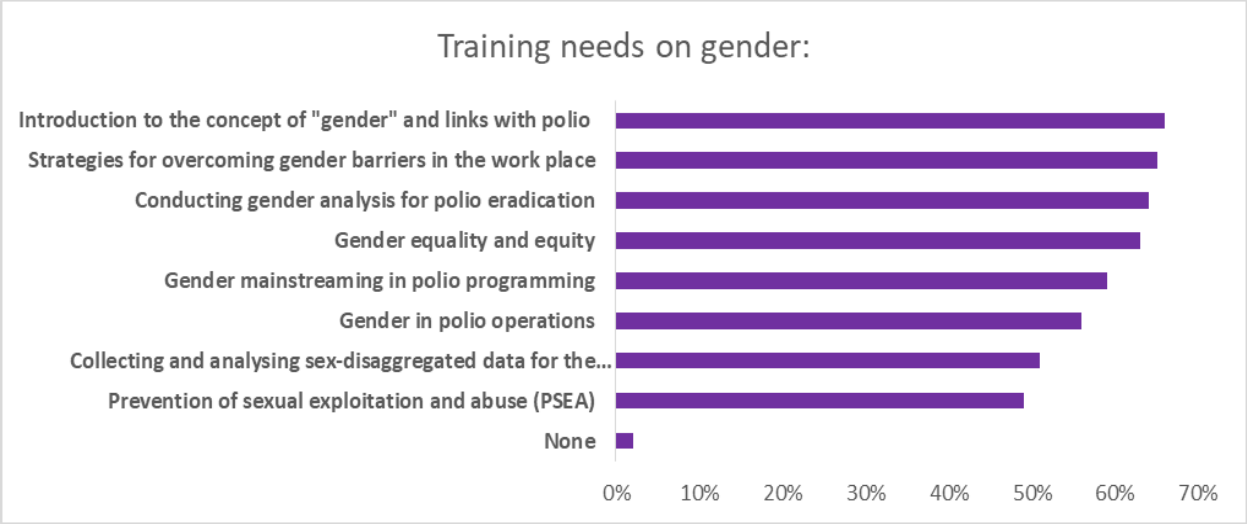
- Foster gender-responsive workplaces, supporting all staff to take advantage of family-friendly policies such as maternity and paternity leave and flexible work arrangements; each entity should have a breastfeeding policy in place, including designated nursing zones with appropriate facilities.
- Put in place concrete measures to increase women's participation as front-line workers in areas where stark gender imbalance currently exists, while ensuring their security and safety
    - Ensure that at least one-third of polio worker selection committee members are women
    - Where major gender imbalance exists, adopt and enforce a quota of 30% women in all of newly-recruited frontline workers, including vaccinators and social mobilizers, where possible.
    - Invest in equal training opportunities for women and men, addressing the specific challenges and barriers faced by women.

Capacity for gender mainstreaming

To achieve adequate and systematic levels of gender responsiveness of GPEI programming, it is important to strengthen capacity and institutional support for GPEI staff to apply gender analysis skills and gender-responsive actions in their planning, programme and technical work. Based on the 2018 GPEI Gender Survey completed by 634 staff members, 66% stated never having received any training related to gender. Of the 34% who had received training, they had completed trainings mainly as online courses.

Importantly, when GPEI staff were asked reasons for why they did not integrate gender issues into their work, main reasons flagged included the need for training on gender, as well as technical support on the subject matter.





Necessary resources will be acquired and allocated to ensure gender integration across the partnership. A dedicated full-time staff member (at least at the P4 level), will act as the main technical focal point for gender mainstreaming within the GPEI. Additionally, dedicated gender focal points, with specific terms of reference, will be appointed within each GPEI organization, at different levels, including HQ, regional offices and field/country offices. However, promoting gender equality and the empowerment of women is everyone's responsibility in the GPEI and should not be viewed as solely the responsibility of the gender focal points; their role is to provide coordination and technical support.

The appointed gender focal points will form a GPEI Gender Network, requiring a clear rationale for selection of focal points, including seniority, dedicated time, resources and clear, measureable expected deliverables and responsibilities included within their work plans and performance appraisals. Gender balance on gender focal point teams should be ensured.

In addition to ensuring that specific staff are appointed to deliver on gender results within the different GPEI organizations, emphasis will be put on building the capacity of polio staff on gender mainstreaming and gender analysis.

The GPEI will:

- Ensure that all staff working for the GPEI have completed mandatory trainings in Prevention of Sexual Exploitation and Abuse (PSEA) and sexual harassment, and that a mechanism is in place for monitoring compliance with training completion.
- Provide training to staff members and national partners on gender analysis and gender-responsive programming, especially the appointed Gender Focal Points.
- Ensure that senior management support staff in participating in learning activities related to gender, health and polio, when relevant.

- Systematically share with all staff new guidelines, tools and resources developed on gender and polio.
- Disseminate, via senior management, a list of available online trainings on gender mainstreaming and gender analysis, encouraging all staff at different levels to complete at least one technical training.
- Develop and make available checklists to support staff in gender integration in the development of proposals, reports, guidelines and strategies.
- Make specific efforts to ensure gender balance in training activities, especially at the field-level, to ensure women's equal participation as well as the engagement of men.
- Appoint gender focal points in each GPEI organization to provide coordination and technical support for gender analysis and integration through the GPEI Gender Network.
- Facilitate collaboration with respective organisational gender focal points and units, ensuring that each organization has a specific gender focal point with clear terms of reference.
- Ensure that senior management include gender issues into their official speeches, as well as briefings and presentations with staff, and regularly circulate materials related to gender and polio with all staff, at all levels.

Prevention of sexual exploitation, abuse and harassment

Tackling sexual exploitation and abuse[42] against the people the GPEI serves, together with sexual harassment[43] in the workplace, is a top priority for all GPEI partners[44]. All staff shall work and behave in a way that respects and fosters the rights of the people they serve, and contributes to a work environment free from disrespect, discrimination, abuse of authority, and harassment.

The GPEI is committed to providing a trusted, respectful and inclusive environment where the people served through polio eradication efforts, as well as those who work for the GPEI organizations, feel safe, equipped and empowered to speak up for themselves and others, and to take appropriate action to end sexual exploitation and abuse, as well as sexual harassment.

[42] Sexual exploitation - any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, threatening or profiting monetarily, socially or politically from the sexual exploitation of another. Sexual abuse - the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. Sexual exploitation and abuse also includes sexual relations with a child (a human being under the age of 18 years), in any context. *WHO Sexual exploitation and abuse prevention and response policy and procedures 2017*, available at: http://www.who.int/about/ethics/sexual-exploitation_abuse-prevention_response_policy.pdf

[43] Sexual harassment - any unwelcome, unsolicited and unreciprocated, sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature (including pornography, sexually-coloured remarks) that has or that might reasonably be expected or be perceived to offend, humiliate or intimidate another person. *WHO Code of Ethics and Professional Conduct 2017*. Available at: http://www.who.int/about/ethics/code_of_ethics_full_version.pdf

[44] Polio Oversight Board (POB) Statement on Sexual Misconduct (2018) Available at: http://polioeradication.org/wp-content/uploads/2018/04/polio-oversight-board-statement-on-sexual-misconduct-20180426.pdf

The GPEI will ensure that each organization has clear guidelines and recourses for staff and collaborators on available reporting and protection mechanisms, and addresses any acts of sexual harassment or abuse. The GPEI commits to enforcing a strict zero tolerance policy towards all forms of sexual exploitation and abuse, as well as harassment, sexual harassment and gender-based discrimination.

Importantly, it is critical for the GPEI to ensure that all beneficiaries as well as staff and contractors, including front-line workers in countries where polio vaccination campaigns are conducted, are protected from all forms of SEA and harassment and are guaranteed a safe working environment.

The GPEI will:

- Publicize and disseminate the relevant policies on the prevention of sexual exploitation and abuse and sexual harassment to all staff, at all levels, in all GPEI organizations, including in HQ, regional and field offices.
- Ensure that all GPEI staff are made aware of the existing confidential and safe reporting mechanism, along with a confidential and survivor-centred investigation process, for SEA and harassment within their organization through in-person trainings and briefings.
- Assess staff knowledge of and trust levels in existing mechanisms for reporting different forms of harassment, and adjust the mechanism/enhance direct communication about the mechanism accordingly.
- Make trainings related to PSEA and sexual harassment available and accessible, and ensure that all staff have completed at least the mandatory trainings.
- Brief all new GPEI staff and managers on PSEA and sexual harassment prevention and response during induction/orientation sessions, reiterating the zero-tolerance approach.
- Make no offers of appointment before the background check of an applicant has been completed, and ensure that any contractual engagement is terminated when an employee is proven to be involved in SEA.
- Put in place specific field-level mechanisms to guarantee the safety of beneficiaries and a safe work environment for all staff and contractors, including front-line workers, and enforce the GPEI's zero tolerance policy towards SEA and harassment.
- Ensure that senior management consistently and strongly enforce the principle of zero tolerance for all forms of sexual harassment and abuse in public statements and official communications with staff and contractors.
- Ensure anyone in a supervisory position is aware of existing policies, expectations and obligations regarding procedures for handling reported SEA and harassment cases.

Senior leadership commitment and cultural change

The support and commitment of senior leadership to gender integration is key to achieving and sustaining organizational cultures supporting gender mainstreaming and gender equality at all levels of the organization. The GPEI will promote a gender-responsive organizational culture by continuously raising

awareness and strengthening the environment for learning. The GPEI leadership will affirm commitment to gender integration across the agencies as well as promoting adoption at the country programme, regional and HQ levels.

The GPEI will:

- Include formal oversight responsibility and accountability for the implementation of this Gender Equality Strategy to the Chair of the GPEI Strategy Committee and the Polio Oversight Board
- Ensure senior management support their staff, specifically their gender focal points, in gender mainstreaming, including through making available training opportunities for staff.
- Ensure senior management include references to gender and women's empowerment in public speeches and encourage all staff to do the same in their technical work.
- Add gender mainstreaming and gender equality criteria into performance evaluation systems of all senior managers.
- Incorporate gender into any new polio strategies, guidelines and action plans under development.
- Provide necessary financial resources for gender mainstreaming to ensure adequate budgets for gender expertise and capacity building, as well as for the sustained and consistent implementation of gender equality programming (including research and analysis).
- Systematically document and share internally and publicly knowledge on, and tools and good practices for, gender equality and women's empowerment.
- Ensure senior management enforce a strict zero tolerance policy to sexual exploitation, abuse and harassment, regularly following up on staff completion of mandatory trainings, and disseminating information to staff about existing policies and confidential reporting mechanisms.