



Gender and Polio Profile

Prepared for the Enhanced Polio Surveillance at the Community Level in Africa Project

GenderTech

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The initial report was drafted by Sini Ramo and further developed and finalized by Chris Hunter with Franz Wong. Quantitative and qualitative analysis of the training need assessment was undertaken by Sini Ramo and Loida Erhard. The report draws on key informant interviews undertaken by Faty Kane and Fabrice-Mickaël Ramadan-Mamata. The report’s layout and graphic design were provided by Rebecca Richards-Diop and Jessica Stone-Weaver (RRD Design). Copy editing was completed by Kathy Schienle. Cover photo by Sam Phelps.

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Executive Summary of Gender Enablers and Barriers in Polio Eradication

The aim of the Gender and Polio Profile is to highlight the connections between gender and polio eradication processes and outcomes, and to identify gender gaps in, and barriers to, polio surveillance, immunization, and other polio eradication activities. This profile has been specifically developed to enhance the understanding of staff of the Enhanced Polio Surveillance at the Community Level in Africa Project. This executive summary focuses an overview of gender enablers and barriers in polio eradication at individual, household, community and health system levels.

At the **individual level**, there are four main gender barriers of education and literacy, time as a resource, experience with the health system and financial constraints. *Low education levels and illiteracy* of parents have been linked to inadequate vaccination of children by a wide range of studies. Most research, however, focuses on the mother as the primary caregiver, and research in diverse settings has found a strong link between maternal education, child health and positive immunization outcomes. Education and/or literacy may relate to childhood immunization and other health issues in several ways including low education status often closely correlating with low socio-economic status and a lack of resources acting as a barrier to accessing health services, including immunization.

While women who are more literate, regardless of their educational level, are more likely to vaccinate their children in both urban and rural settings, other research concluded that ‘health literacy’ of mothers is more relevant for childhood immunization than education status, suggesting a useful entry point for improving polio vaccination rates.

Time is a resource in short supply for many women, and the need to juggle competing obligations can create barriers to immunization. The demands on women’s time for family caring are driven by gender roles and responsibilities, and affected by factors such as household composition, economic status, livelihoods, and environmental conditions among others. Weak social and physical infrastructure is likely to have the greatest effect on women in remote or conflict-affected areas, whereas demands of employment outside the household is a more common constraint on the women’s time in urban areas.

Several studies have linked women’s *use of maternal health services* to increased likelihood of child immunization; gender barriers they face in accessing health care for themselves will also affect access to childhood immunization services. A different aspect of health care experiences is that women who experience discriminatory treatment or are stigmatized as bad mothers because of sick or malnourished children may be reluctant to seek out health services in future.

Financial barriers are a frequently cited barrier to health services including vaccination. Both men and women may lack financial resources but women tend to have less money than men in the same household

and generally paid less/not at all than men and are significantly over-represented in unpaid productive work. Although immunization services are usually free of charge, transportation, for example, adds a 'hidden' cost in many settings. This can be a gender barrier when women who are not close to health services, and who do not have their own transportation, need to raise resources or otherwise mobilize a means of transport to take children for vaccinations. When there are conflicting demands for limited resources, subsistence will take precedence over most health services, and particularly over preventative services such as vaccines.

Decision making at the **household level** is critical gender dimension given its central focus for interventions to increase childhood immunization as well as the creation and maintenance of gender inequalities. The different roles and status assigned to women and men in the household affect women's control over resources and the decisions they can make, including those related to health care and for other household members as well as themselves. For example, women may need permission from their husband or others to meet any costs associated with health services or travel to services outside their household or immediate community. The link between specific decisions and immunization may also relate to the practical steps required to access vaccinations in a specific area. There is evidence that women's decision-making power may influence child health outcomes beyond their own household.

Community context impacts women's and men's opportunities and constraints in a variety of ways that are relevant to polio eradication strategies. Social hierarchies based on ethnicity, socio-economic status, gender and other social markers affect the status of households and individuals influencing their access to services and participation in collective processes. Cultural and religious beliefs affect how disease is understood and how preventative measures are valued and the impacts of these beliefs are often gendered. Remote or isolated communities are more likely to have beliefs that differ from the majority. Women from socially excluded groups may lack social connections that make going to a health facility easier, such as knowing the health workers or being able to travel with other women or access support for childcare or other household needs. Communities shape and uphold gender norms, the unwritten rules about what it means to be a woman or a man. These community norms influence household decisions and actions where women are judged on how they live up to community standards about what it means to be a good wife or mother where the health of a child may be taken as an indication of her capacity as a mother to maintain and nurture her child.

Women's opportunity to voice their concerns, and power to influence decisions and community programming around health are often limited by gender roles and structural gender inequality. Family wealth, caste/ethnicity, and religion also affect how women can occupy public space, and the community roles they are able to play.

Community gender norms can affect the actions of volunteers recruited to support CBS. So while involving key community members can also be an opportunity to contribute to gender equality, CBS programs need to set clear gender equality standards and provide opportunities for training and dialogue on the importance of gender equality to improving health for everyone.

Community norms about the appropriate roles and behaviors for men and women, and attitudes toward violence, are an important factor in the type and extent of gender-based violence (GBV) perpetrated against women and girls. This has far-reaching implications for the project, given the high prevalence in the polio project countries. Apart from being a serious human rights violation rooted in gender inequality, GBV has multiple negative effects on women's and girls' physical, psychological, sexual and reproductive health. There is, however, limited research into the pathways through which women's experience of violence affects child health outcomes and vaccination rates. One mechanism may be that GBV affects women's access to health services for themselves, such as reproductive and maternal health services, or

their children. Women who experience violence from their spouse generally also report controlling behaviors by their husband. Also, women may also avoid health services to avoid health care workers finding out about the violence and therefore damaging the reputation of their husband and family. The threat of violence in community spaces is a common rationale for households or communities to limit women's mobility which can affect women's access to health services and be a barrier to women becoming community health workers.

Child marriage, a form of GBV, also has a direct impact on girls' and women's access to and utilization of health services, including immunization. Adolescent girls forced into early marriage are less likely to have knowledge about health, and are more likely to experience violence from their spouse (and sometimes in-laws), unwanted pregnancies and maternal morbidity and mortality, while gender norms restrict their mobility. Their age, lack of education, and limited livelihood options weaken their bargaining power, including on health decisions.

The **health system**, which is a gendered system, child health and immunization are based on gender norms. In particular, there is an assumption that women are responsible for the care and wellbeing of children. Services that recognize the gendered division of labor that puts responsibility for childcare on mothers, and explicitly address the barriers that they may face because of their gender, may be effective in reaching women and children. Some of those gender barriers, such as women's lack of control over resources and exclusion from some household decision-making, highlight the importance of reaching fathers and other gatekeepers with health education messages. Still, there is also evidence that gender barriers are not consistently considered in the design and management of health services. Examples include immunization hours that do not take account of other demands on women's time and the challenge of transportation, especially for remote communities.

In terms of human resources with the health system, women's position in the health system reflects social hierarchies: they are under-represented at the top of the system, in national systems and health ministries as well as in health care facilities, and most represented at the bottom, for example, nurses, midwives and community health workers (CHWs) as frontline health workers generally have lower status, lower pay and often face harassment and disrespectful treatment at work.

Increasing women's meaningful participation in polio eradication is not only important in terms of promoting equality, but in many settings women's increased participation affects the reach and effectiveness of polio eradication efforts. In areas where women's seclusion and restricted mobility are prevalent, women may not seek care for themselves or even for their children unless they have access to a woman health worker. In settings where social and religious norms restrict contact between women and men, male workers had no access to mothers and men in the family were less able to provide reliable information on children's health. Unequal decision-making in communities and health facilities can also create gender barriers in recruitment.

Women frontline workers, including vaccinators, social mobilizers, surveillance officers and focal points live and work within the same gender norms and power relations that influence the households, communities and societies they serve. Research from many countries has found that family support is essential to the productivity and effectiveness of women health workers, especially those working at the community level, and a lack of family support was a common barrier to recruitment. In some cases, the volunteer status or low pay of community health workers reduced family support. Real and perceived insecurity is another reason that families may object to women becoming community-based health workers. It is also a barrier to women choosing to take positions and continuing in those roles.

Health system response, particularly the quality, acceptability and accessibility of health services, may deter women from attending immunization services for themselves and their children. These obstacles include for instance lack of adolescent-friendly services, long distances, long waiting times or lack of appropriate opening hours, weak confidentiality measures, the lack of separate waiting areas, sanitation facilities, the absence of women healthcare providers and negative provider attitudes, skills and behavior. There is evidence that health care providers sometimes accept and reinforce social expectations of what it means to be a good mother, judging women on how well they meet these standards, and failing to recognize the gender barriers that affect them. Also, the interaction between health workers and mothers can be influenced by their different positions in social hierarchies. Health care workers will often be more educated and may be from a higher socio-economic class or a dominant ethnicity.

Health information and education is an essential component of immunization programs, primarily designed to reach women because of their socially assigned responsibility for childcare. Still, problems related to communication or information exist including lack of community outreach by health services, language barriers, inadequate or poorly targeted media messages, and inaccurate or insensitive delivery of information from health workers. Some of the challenges may be that material needs to be re-designed to better reach women with low literacy, who represent a significant part of the female population in project countries. Customizing health education materials for women from ethnic and linguistic minorities may, however, mean going beyond translation and addressing gender norms and/or health-related beliefs that might be specific to those communities. This also raises the need for more health information designed to reach men and other household decision-makers. Communications related to child health often place all the responsibility on women and can reinforce harmful gender stereotypes, including implying that mothers are to blame for any poor health outcomes. Recognizing that fathers (and sometimes elder women in the household) often act as gatekeepers for health care, health education could aim to build their understanding of the importance of vaccination and encourage them to share responsibility with mothers in making sure that their children are protected.

The evidence review provides several areas for further consideration by project partners in order to further integrate gender issues in polio eradication. Broadly, these include¹:

Programming, data, and analysis

Efforts to systematically collect, analyze, and use polio and AFP data (qualitative and quantitative) disaggregated by sex and other factors (e.g., age, ethnicity, socio-economic background, and disabilities) whenever possible can provide a basis for identifying context-specific gender enablers and barriers. Using participatory methods in data collection, while ensuring equitable participation of women and men from diverse backgrounds, can contribute to community and women's empowerment.

Outreach and communication

Undertaking gender analysis of community engagement and social mobilization will support development of gender-intentional outreach communication interventions that address gender barriers, such as literacy, and work within community dynamics. This can include ensuring the effective participation of women and men in the design, testing, and delivery of outreach tools and materials.

Capacity-building of CBO staff

GenderTech started the process of staff capacity-building, which lays the basis to extend efforts to other staff, as well as to deepen capacities targeted to particular project roles and needed gender competencies.

¹ An elaboration of these are included in the main report as "Implications for programming".

Other mechanisms for support to gender integration may need to be considered, such as gender focal points, to augment capacity-building efforts.

Community-level staff

Working with women and men community surveillance workers/CHWs and front-line workers to undertake analysis of key challenges and barriers affecting their work will support addressing gender barriers, such as facilitating safe and convenient transport, capacity-strengthening and professional development (particularly in gender-sensitive communications), and safe work environments free from violence, harassment, and discrimination.

Acronyms

AFENET	African Field Epidemiology Network
AFP	Acute flaccid paralysis
CBO	Community-based organization
CBS	Community-based surveillance
CHW	Community health worker
DRC	Democratic Republic of the Congo
GBV	Gender-based violence
GPEI	Global Polio Eradication Initiative
OPV	Oral polio vaccine
WHO	World Health Organization

Definitions²

Sex

The biological categorization of a person as male, female, or intersex. Sex is assigned at birth based on biological indicators, including hormones, sex chromosomes, internal reproductive organs, and external genitalia.

Gender

The socially and culturally constructed ideas of what it is to be male or female in a specific context. Gender is evident in the roles, responsibilities, attitudes, and behaviors that a society expects and considers appropriate for males and females, independent of an individual's own identity or expression.

Gender analysis

A critical and systematic examination of differences in the constraints and opportunities available to an individual or group of individuals based on their sex and gender identity.

Gender norms

The collectively held expectations and beliefs about how people should behave and interact in specific social settings and during different stages of their lives based on their sex or gender identity.

Gender relations

Socially constructed power relations between people based on their gender identity and/or expression.

Intersectionality

A perspective that acknowledges the concrete experiences of inequality that result from the interaction of gender with other social markers of difference.

Gender-based violence

Violence directed at an individual based on their biological sex, gender identity, gender expression, or failure to adhere to socially defined norms of masculinity and femininity.

Gender equity

Fairness in treatment of all people regardless of sex or gender identity and/or expression.

Gender equality

The state of being equal in status, rights, and opportunities, and of being valued equally, regardless of sex or gender identity and/or expression.

² The Bill & Melinda Gates Foundation (2018) Gender Equality Lexicon.

1. Introduction

The Global Center *for* Gender Equality (GCfGE) at Stanford University, through its GenderTech Team, provides technical assistance to the Enhanced Polio Surveillance at the Community Level in Africa Project (herein referred to as the project), which aims to enhance polio acute flaccid paralysis (AFP) surveillance in Africa, thereby contributing to global polio eradication.³ The project involves the African Field Epidemiology Network (AFENET) that supports community-based organizations (CBOs) in Cameroon, Chad, Democratic Republic of the Congo (DRC), and Niger in a variety of technical areas, including data management, planning, training, monitoring, and evaluation.

The sub-grantee partner organizations and project locations are:

Cameroon

International Medical Corps (Far North)

DRC

International Medical Corps (Tanganyika)

SANRU (Haut Lomami)

Caritas (Haut Lomami, Haut Katanga, and Mongala)

Chad

Alliance Sahélienne de Recherches Appliquées pour le Développement Durable ASRADD (Hadjer, Batha, and some new silent areas)

Niger

Bien Être de la Femme et de L'Enfant au Niger - BEFEN (Tillabéri and other silent areas)

The aim of the Gender and Polio Profile is to highlight the connections between gender and polio eradication processes and outcomes, and to identify gender gaps in, and barriers to, polio surveillance, immunization, and other polio eradication activities. This profile is specifically developed to enhance the understanding by project staff of the links between gender and polio eradication, and to support them to integrate gender in the design and implementation of project activities.

The Gender and Polio Profile aims to:

- Provide an overview of key gender equality issues, including gender barriers, in polio eradication, specifically community AFP surveillance.
- Provide a snapshot of the current capacity and challenges of AFENET and implementing partners to design and implement gender-intentional polio eradication programs.

³ See Annex A for sex-disaggregated AFP data for project countries.

- Identify needs and challenges to gender integration and AFENET’s polio eradication programs to enable these to be effectively addressed.

This document is comprised of four main sections. The first describes the approach to the profile. Section two provides an overview of polio and gender enablers and barriers, drawing on available literature and research. The third profiles project partners based on organizational documents, the training needs assessment survey, and key informant interviews with select CBO staff. Section four provides a conclusion and implications.

2. Methodology

Conceptual Framing

Gender refers to the socially and culturally constructed ideas of what it is to be male or female in a specific context.⁴ This includes norms, behaviors, and roles associated with being a woman, man, girl, or boy, as well as relations with and among each other. As a social construct, gender varies from society to society and can change over time. Gender-based discrimination intersects with other social markers of difference, such as ethnicity, socioeconomic status, disability, age, geographic location, gender identity, and sexual orientation, among others.⁵ Gender also interacts with, but is different from, sex, which refers to the different biological and physiological characteristics of females, males, and intersex persons, such as chromosomes, hormones, and reproductive organs.⁶

Gender norms and inequalities impact access to healthcare and health-related information, environmental and occupational risks, risk-taking behaviors, health-seeking behavior, healthcare utilization, access and control over key resources needed for advancing health, and treatment in the healthcare system, thus influencing health outcomes.⁷

Gender equality is a fundamental human right and a powerful driver for better health outcomes globally. Gender norms, roles, and relations, and gender equality, are also integral factors influencing global polio eradication efforts. Conversely, gender inequality can potentially affect polio eradication through impacts on three groups of people: children as the people vulnerable to the disease unless vaccinated, the caregivers responsible for children, and health workers. In its Polio Endgame Strategy, the GPEI is increasingly focused on gender as a determinant of health-seeking behaviors and a critical variable in vaccination outcomes.

Gender is particularly relevant for two important interventions in the efforts to achieve a polio-free world: immunization and community-based surveillance.

Immunization

The single biggest risk factor for contracting polio is not having been vaccinated against the virus. Barriers to vaccination are therefore the biggest obstacles to eradicating polio. A substantial body of literature explores how gender affects immunization, including research on differences in immunization of girls compared to boys and analysis of how broader issues of gender inequality may affect immunization of all children.

Global studies have not found major sex-based discrepancies in immunization coverage: girls and boys have the same likelihood of being vaccinated in most low- and middle-income countries. A few exceptions exist at sub-national levels within socio-economically and geographically marginalized groups—in some instances, boys have been found to be more immunized, and girls in others.⁸ The lack of overall sex

⁴ Ibid.

⁵ This is referred to as “intersectionality.”

⁶ WHO (2020) Health topics—Gender. Available at: <https://www.who.int/health-topics/gender>

⁷ Heidari, S., et al. (2016). Sex and Gender Equity in Research: rationale for the SAGER guidelines and recommended use. *Research Integrity and Peer Review* 1:2.

⁸ Feletto, M., Sharkey, A., Rowley, E., Gurley, N., Sinha, A. (2019). Gender Lens to Advance Equity in Immunization. Equity Reference Group.

differences in vaccination rates in most settings, however, can contribute to a misunderstanding that there are no “gender issues” in polio eradication.

In fact, research has demonstrated that there are multiple ways in which gender roles, norms, and relations influence immunization delivery and uptake. Gender roles, in particular, are central to polio eradication strategies and related research: As women carry primary responsibility for childcare, research into factors affecting caregivers’ behaviors focuses almost entirely on women in their role as mothers. That research has identified a variety of gendered factors that enable or constrain mothers in vaccinating their children. There is also evidence of how healthcare services are gendered, in their design and management, and through the impacts of gender on individual healthcare providers and their performance.

Community-based surveillance

Community-based surveillance (CBS) is the core strategy in the AFENET program. It is an active process of community participation in detecting, reporting, responding to, and monitoring health events in the community. Local community members (such as traditional healers, traditional birth attendants, elders, religious leaders, teachers, social mobilizers, community health workers, and others) are trained to recognize cases of the targeted diseases and how to report them. Involving community members complements existing facility-based surveillance systems, making it possible to identify cases earlier and to identify cases among those who seek out alternative forms of healthcare, rather than going to a formal health facility.^{9 10}

With CBS, polio programs engage volunteers to monitor, and report suspected AFP cases so that healthcare professionals can follow up. Effective CBS systems are extremely important for areas at elevated risk of polio and where health systems are weak, particularly in inaccessible and hard-to-reach areas. Volunteers can also mobilize their communities and raise awareness on disease prevention and treatment.¹¹

There is limited research that looks specifically at the gendered dimensions of CBS; however, the relevance of gender analysis to effective CBS is clear. The performance of CBS volunteers, like healthcare providers, will be affected by gender norms and gendered practices in their households and communities. In addition, many of the people involved in CBS play significant roles in shaping and enforcing community expectations about the entitlements and appropriate behaviors of women and men. The way that these community roles interact with their role as CBS volunteers will affect the results achieved. Understanding gender relations and norms in the community, and addressing gender barriers facing volunteers, is critical for effective CBS.

⁹ Perry, H.B., et al. (2019). Lessons Learned from the CORE Group Polio Project and Their Relevance for Other Global Health Priorities. *American Journal of Tropical Medicine and Hygiene*, 101 (Suppl 4), 2019, pp. 107–112. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6776095/pdf/tpmd190036.pdf>

¹⁰ Guerra, J., Acharya, P., Barnadas, C. (2019). Community-based surveillance: A scoping review. *PLoS ONE* 14(4): e0215278. <https://doi.org/10.1371/journal.pone.0215278>

¹¹ Catholic Relief Services. Civil Society Organization Platforms Contribute to National Immunization Programs Promising Practices 2012–2018, 2019. Available at: https://www.crs.org/sites/default/files/tools-research/promising_practices_a4_final_rev071119_online.pdf

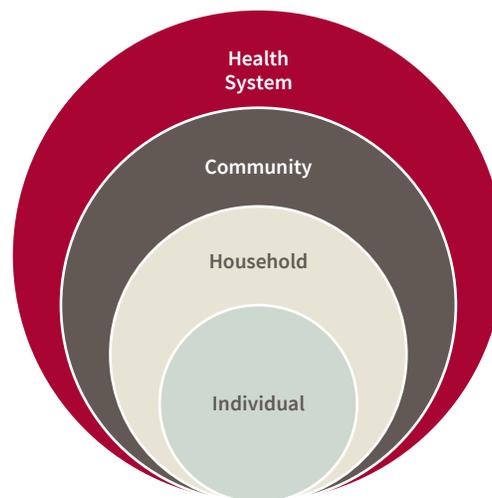
Analytical Framework to Understand Gender Enablers and Barriers

Many different gender analysis frameworks have been applied to understand the gendered aspects of various health issues. Several of the studies into gender and immunization look at how gender affects individual caregivers and service providers, the demand and supply sides. CBS is not easily analyzed through this lens, and the focus on individual behaviors can obscure the ways that the social environment—community dynamics or the health system, for example—influences individual decisions about immunization.

An ecological framework (see Figure 1) has been used to understand the social dimensions of diverse health issues.¹² This approach recognizes that gender inequality affects health outcomes through complex pathways, including individual attitudes and capacities; interpersonal relationships, particularly in the household, that affect decision-making and resources; community structures and norms; and the health system.¹³ It captures both the demand and supply side of immunization services, recognizes the importance of the context, and enables analysis of how gender norms and relations can affect community networks and volunteers involved in surveillance. The ecological framework is also effective for capturing the multiple and intersecting hierarchies that can affect health outcomes.

For these reasons, the gender dimensions of polio eradication are discussed next in terms of enablers and constraints at the individual, household, community, and health system levels.

FIGURE 1: **Ecological framework for understanding the gender dimensions of polio eradication**



Source: Heise, 1998

¹² Heise (1998) is most commonly associated with the ecological framework, which she used to understand gender-based violence. It has since been used widely, mainly in the health sector, to understand social determinants of health. For example, see WHO (2021) <https://www.who.int/violenceprevention/approach/ecology/en/>

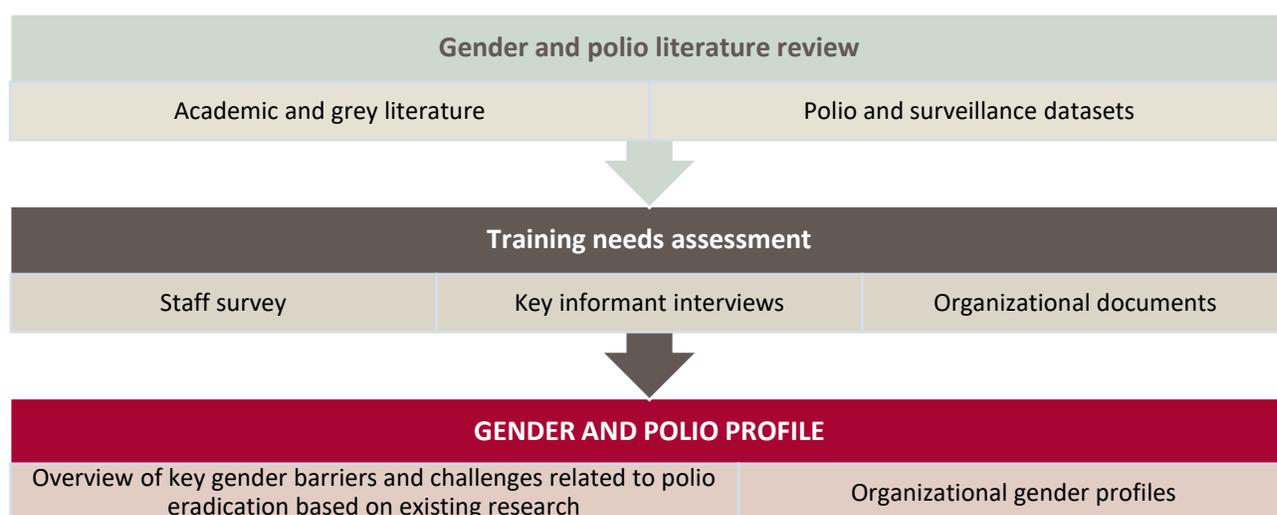
¹³ The outermost level of the ecological framework, capturing the broader institutional or policy environment, has not been included because it is outside the scope of the AFENET program and this evidence review.

Developing the Gender and Polio Profile

The Gender and Polio Profile draws on a review of relevant academic and grey literature related to gender and polio, including evidence on the gender dimensions of vaccination, child health outcomes, and health-seeking behavior.

In addition to a literature review, the Gender and Polio Profile provides existing primary vaccination and AFP datasets and polio staff front-line-worker project data. These sources are complemented by a review of relevant organizational documents, such as organizational policies, strategies, and guidelines that partner organizations shared with GenderTech. The profile also draws on the results from an anonymous online project staff training needs assessment survey. This survey was conducted to identify current capacities, practices, and attitudes in relation to gender, polio, and gender mainstreaming, and was augmented by key informant interviews with select AFENET and CBO staff (see Figure 2).

FIGURE 2: **Steps in the development of the Gender and Polio Profile**



There is limited literature on community-based surveillance (CBS), and even less that addresses gender. As a result, implications for CBS were identified from literature exploring gender and community participation in health. Priority was given to literature from West and Central Africa and supplemented with evidence from other regions in Africa, as well as Asia, the Caribbean, and South America, given the relative lack of research from West and Central Africa. As a result, some evidence comes from contexts that vary significantly from the project countries. Lastly, the literature search was limited to English language publications.

3. Gender Enablers and Barriers in Polio Eradication

Using the ecological framework, this profile now provides an overview of gender enablers and barriers in polio eradication at individual, household, community, and health system levels. Implications for practice are mentioned throughout and summarized at the end of each sub-section.

The Individual Level

This sub-section focuses on four main gender barriers of education and literacy, time as a resource, experience with the health system, and financial constraints.

Education and literacy

Low education levels and illiteracy of parents have been linked to inadequate vaccination of children by a wide range of studies. Most research, however, focuses on the mother as the primary caregiver, and research in diverse settings has found a strong link between maternal education, child health, and positive immunization outcomes.^{14 15 16 17}

Education and/or literacy may relate to childhood immunization and other health issues in several ways. Low education status is often closely correlated with low socioeconomic status, and as discussed further below, lack of resources is commonly cited as a barrier to accessing health services, including immunization. Conversely, women in more affluent households tend to have higher education levels and often reside in areas with better access to health services.^{18 19} For example, a study in Nigeria found that maternal literacy had a more significant effect on immunization status than socio-economic status. Women with more years of education were more likely to be literate, but when education and literacy were considered separately, it was literacy that explained the link to immunization. It was not that women with more years of schooling had learned about health issues. Rather it was that literacy enabled women to access health information, including through mass media.²⁰

¹⁴ Op cit. Feletto.

¹⁵ Kravdal, O. (2004). Child mortality in India: the community-level effect of education. *Population Studies* 2004; 58:177–92.

¹⁶ Parashar, S. (2005). Moving beyond the mother-child dyad: women’s education, child immunization, and the importance of context in rural India. *Soc Sci Med* 2005;61:989–1000.

¹⁷ Rainey, J.J., et al. (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. 46, 2011, *Vaccine*, Vol. 29, pp. 8215–8221.

¹⁸ Balogun, S.A., et al. (2017). Maternal education and child immunization: the mediating roles of maternal literacy and socioeconomic status. *PanAfrican Medical Journal* 26:217.

¹⁹ Vikram, K., Vanneman, R., and Desao, S. (2012). Linkages between Maternal Education and Childhood Immunization in India. *Social Science & Medicine* 75(2): 331–339.

²⁰ Balogun, S.A., et al. (2017) Maternal education and child immunization: the mediating roles of maternal literacy and socioeconomic status. *PanAfrican Medical Journal* 26:217.

The impact of gender gaps in literacy and education have far-reaching implications for the project’s programming area, where gender gaps in literacy across the project’s programming countries range from 11% in Cameroon to 23% in DRC (see Table 1).

TABLE 1: Literacy rates of women and men (15 years of age and older)

	Women	Men
Cameroon (DHS 2018)	72%	83%
Chad (DHS 2014-15)	14%	31%
DRC (DHS 2013-14)	66%	89%
Niger (DHS 2012)	27%	44%

Source: <https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS>

While women who are more literate, regardless of their educational level, are more likely to vaccinate their children in both urban and rural settings,²¹ other research concluded that “health literacy” of mothers is more relevant for childhood immunization than education status. Health literacy is not dependent on the ability to read but refers instead to “the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.”²² A study in rural and urban areas of India found that mothers’ health literacy was an especially strong determinant of childhood vaccination in areas with weaker health and/or education systems.²³ Findings from a review of grey literature on immunization in Africa did not refer to health literacy in particular, but the findings are related. For example, a review concluded that parental understanding of the scientific basis of vaccination was not as important as “parents’ belief that vaccination is good for their child’s health and prevents various diseases, and their practical knowledge about services; that multiple visits are required for protection, and when and where the child needs to go.”²⁴

These findings about health literacy suggest a useful entry point for improving polio vaccination rates. Health literacy can be improved more quickly than education levels and through interactions in everyday settings including, potentially, with CBS volunteers.²⁵ “Spillover effects,” in which education or literacy rates for women in a community appear to improve vaccination rates (and other health-seeking behaviors) for all women regardless of literacy²⁶ may also be relevant for health literacy.²⁷

²¹ Op cit. Feletto.

²² Dodson, S., Good, S., Osborne, R.H. Health literacy toolkit for low- and middle-income countries: a series of information sheets to empower communities and strengthen health systems. New Delhi: World Health Organization, Regional Office for South-East Asia, 2015. Available at <https://apps.who.int/iris/handle/10665/205244>

²³ Johri, M., Subramanian, S.V., Sylvestre, M., et al. Association between maternal health literacy and child vaccination in India: a cross-sectional study *J Epidemiol Community Health* 2015;69:849–857. Available at: <https://jech.bmj.com/content/69/9/849>

²⁴ Favin, M., Steinglass, R., Fields, R., Banerjee, K., Sawhney, M. Why children are not vaccinated: a review of the grey literature, *International Health*, Volume 4, Issue 4, 2012, pp. 229–238. Available at: <https://www.sciencedirect.com/science/article/pii/S1876341312000496>

²⁵ Op cit. Feletto.

²⁶ See for example Kravdal Øystein, Kravdal, O. Child mortality in India: the community level effect of education. *Popul Stud* 2004;58:177–92; and Parashar, S. Moving beyond the mother-child dyad: women’s education, child immunization, and the importance of context in rural India. *Soc Sci Med* 2005;61:989–1000.

²⁷ There is evidence that a spillover effect is a local phenomenon. Olorunsaiye and Degge (2016), investigating links between women’s socioeconomic status and child immunization in Nigeria, found that state-level literacy rates for women were not associated with childhood immunization. This may indicate that group literacy or education rates make more difference when other socio-economic factors are consistent, and that communities are likely to be more homogenous than states in terms of socio-economic status.

Time: A limited resource

Time is a resource that is in short supply for many women, and the need to juggle competing obligations can create barriers to immunization. Women are generally responsible for the majority of household work, as well as taking care of the family, with tasks ranging from cooking, cleaning, and taking care of children and sick family members to collecting water and firewood. Globally, women perform on average three times as much unpaid care and domestic work as men.²⁸ Women also do productive work, whether waged or unwaged (for example, subsistence agriculture). A study of women's and men's time use in Kenya, Nigeria, Nepal, and Uganda found that, considering both domestic and productive work, women worked between 1 to 3 hours per day more than men in their communities.²⁹ Not surprisingly, studies in Bangladesh, China, and Gabon have pointed to time constraints limiting women's opportunities for health-seeking and access to health services.³⁰ The time for travel to the immunization clinic and waiting times add to women's overall time poverty and impose costs on women by reducing their opportunity to earn income.³¹ This has a particular impact on single mothers and those in low-income households in rural areas.³²

The demands on women's time are driven by gender roles and responsibilities and are affected by factors such as household composition, economic status, livelihoods, and environmental conditions, among others. Weak social and physical infrastructure (such as poor transportation, poor access to safe water, or lack of community services) is likely to have the greatest effect on women in remote or conflict-affected areas, whereas demands of employment outside the household is a more common constraint on the women's time in urban areas.³³ Recognizing that many women are dealing with "time poverty" has implications for the organization and management of health services and community outreach, as discussed below.

Experience with the health system

Several studies have linked women's use of maternal health services to an increased likelihood of child immunization. In Ethiopia, women who had received ante-natal care were significantly more likely to have their children partially or fully immunized.³⁴ In Nigeria, state levels of maternal tetanus vaccination (during pregnancy) were associated with higher levels of childhood immunization.³⁵ These results may indicate that access to healthcare during pregnancy supports women's familiarity with health services and possibly also improves their understanding of the importance of childhood vaccines, in effect contributing to their health literacy. The findings also suggest that gender barriers women face in accessing healthcare for themselves will also affect access to childhood immunization services. The findings in Ethiopia may also reflect that women who have more say in decisions about their own health are also more able to ensure

²⁸ UN Women (2020) Snapshot—Gender equality: Women's rights in review 25 years after Beijing. Available at: <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/gender-equality-womens-rights-in-review-key-facts-and-figures-en.pdf?la=en&vs=935>

²⁹ Budlender, D. and Moussié, R. *Making Care Visible: Women's unpaid care work in Nepal, Nigeria, Uganda and Kenya*, ActionAid, February 2013. Available at: <https://www.empowerwomen.org/en/resources/documents/2015/6/making-care-visible-womens-unpaid-care-work-in-nepal-nigeria-uganda-and-kenya?lang=en>

³⁰ Merten, S., et al. (2015) Gender determinants of vaccination status in children: Evidence from a meta-ethnographic systematic review PLoS ONE 10(8).

³¹ Ibid.

³² Op cit. Feletto.

³³ Op cit. Feletto.

³⁴ Ebot, J.O. (2015). "Girl Power!": The Relationship between Women's Autonomy and Children's Immunization Coverage in Ethiopia. *J Health Popul Nutr* 33, 18.

³⁵ Olorunsaiye and Degge.

healthcare for their children.³⁶ The gendered dynamics and impact of intra-household decision-making are explored further in the next section.

A different aspect of healthcare experiences is that women who experience discriminatory treatment or are stigmatized as bad mothers because of sick or malnourished children may be reluctant to seek out health services in the future. This is discussed further under the healthcare system.

Financial constraints

Financial barriers are a frequently cited barrier to health services, including vaccination. Both men and women may lack financial resources, but women tend to have less money than men in the same household. Women are generally paid less than men doing the same work and are significantly overrepresented in unpaid productive work. More than one-third (34.9%) of working women in sub-Saharan Africa are unpaid family workers, compared to 17% of men.³⁷ Although immunization services are usually free of charge, transportation adds a “hidden” cost in many settings. Women who are not close to health services, and who do not have their own transportation, need to raise resources or otherwise mobilize a means of transport to take children for vaccinations. In Nigeria, for example, the most reported barrier to accessing healthcare was the lack of financial resources, followed by distance to health services (which has financial implications). Both barriers were found to be significant in explaining differences in childhood immunization rates among Nigerian states.³⁸ Studies in Kenya, Liberia, Mozambique, and Senegal also identified distance to services and associated transportation requirements as a main barrier to full immunization.³⁹

When there are conflicting demands for limited resources, subsistence will take precedence over most health services, and particularly over preventive services such as vaccines.⁴⁰ Women from poorer households that often depend on the day-to-day acquisition of food will likely find themselves in this position more often. Even when a household has sufficient funds to cover costs associated with vaccination, women may not have access. Household resources, particularly money, are often controlled by men, as discussed below.

Implications for programming

- Initiatives to build women’s health literacy, including practical knowledge of the importance of vaccines, the main steps they need to take, and how the services work, can help increase vaccination. The information needs to be accessible to women regardless of literacy and could be delivered by CBS volunteers and/or through community meetings.
- In communities where clinics are further away and/or where fewer women access antenatal care, outreach from health workers could increase women’s familiarity with health services. Initiatives such as providing transportation and/or scheduling times when several women from the same community attend the clinic could help overcome financial barriers.

³⁶ See for example Woldemicael, G. (2007). Do women with higher autonomy seek more maternal and child healthcare? Evidence from Ethiopia and Eritrea.

³⁷ International Labour Organization (2016). Women at work: Trends 2016. Geneva: ILO. Available at:

https://www.ilo.org/gender/Informationresources/Publications/WCMS_457317/lang-en/index.htm

³⁸ Variations in the Uptake of Routine Immunization in Nigeria: Examining Determinants of Inequitable Access. Olorunsaiye, C.Z. and Degge, H. 1, 2016, *Global Health Communication*, Vol. 2, pp. 19–29.

³⁹ Favin, M., Steinglass, R., Fields, R., Banerjee, K., Sawhney, M. Why children are not vaccinated: a review of the grey literature, *International Health*, Volume 4, Issue 4, 2012, pages 229–238. Available at:

<https://www.sciencedirect.com/science/article/pii/S1876341312000496>

⁴⁰ Op cit. Merten.

- It is important for CBS volunteers to be aware of barriers that women face and that affect immunization so that they do not blame women but focus on supporting solutions.
- CBS volunteers or local women’s groups can share information with AFENET partners and health services about the financial, time, and other constraints affecting women in a specific community. Community meetings or household visits should be scheduled at times that work best for women.
- Social (such as childcare or access points for information), as well as physical infrastructure (such as public transport, or improved water sources), can reduce women’s time poverty. AFENET and partners could look for opportunities to build these supports into programming and identify gender gaps in social or physical infrastructure to other stakeholders that can take action.

Household Decision-Making and Women’s Autonomy

This section focuses on decision-making at the household level, given the household is a central focus for interventions to increase childhood immunization. It is also a critical site in the creation and maintenance of gender inequalities. The different roles and status assigned to women and men in the household affect women’s control over resources and the decisions they can make, including those related to healthcare.⁴¹ Generally, while gender roles and responsibilities within households tend to render women the designated caregivers for children, men are assigned as the heads of household and main providers, with the power to make decisions on behalf of other household members.

Women’s lack of decision-making power can undermine their ability to look after their own health and the health of their children. For example, if women have no say over household expenditures, they will need permission from their husband or others to meet any costs associated with health services. Decisions related to seeking healthcare may also be made by the husband or need to be negotiated within the household and extended family. Women’s ability to travel to services outside their household or immediate community may be controlled by husbands or other family members. The most recent Demographic Health Surveys (DHS) data from project countries found that a majority of women lack a say in one or more of these decisions (See Table 2).

TABLE 2: **Proportion of women with a final say in all three decisions⁴² (major household expenditures, own healthcare, and visits to family/friends)**

Cameroon (DHS 2018)	46.7 %
Chad (DHS 2014-15)	17.4 %
DRC (DHS 2013-14)	33.5 %
Niger (DHS 2012)	12.3 %

Source: <https://dhsprogram.com/topics/gender/index.cfm>

⁴¹ WHO EMRO (2001). Mainstreaming Gender Equity in Health: Madrid Statement. Available at: http://www.euro.who.int/_data/assets/pdf_file/0008/76508/A75328.pdf

⁴² ‘Final say’ means that they on their own or jointly with their husband (or other family member) make the final decision on these three items.

Research in Ethiopia and Eritrea⁴³, Nigeria⁴⁴, and Gabon⁴⁵, as well as Haiti, Bolivia, and India provides statistical evidence that women having a say in household decision-making contributes to better immunization status for children. Exactly which decisions women can and cannot take, and the ways this affects child immunization varies by context. For example, women in Gabon and Ekiti State Nigeria have primary responsibility for decisions and costs associated with child health. However, if more financial resources are needed (for example, if transportation is expensive), then the decision must be made by the husband. Similarly, while most women in Ekiti State can seek out child health services without permission, if the services require them to travel far from their household and be away for longer, they may need their husband's permission.⁴⁶

Certain types of decision-making seem to have stronger links to childhood immunization than others in particular contexts. For example, in a national study in Nigeria, women's say over their husband's earnings did not affect immunization outcomes, but their involvement in decisions about healthcare, household purchases, and visits to family and friends were strongly associated with full immunization.⁴⁷ Women's freedom to visit family or friends without permission was also significantly associated with vaccinating their children in Ethiopia and Eritrea, but their control over daily purchases was only important for immunization in Ethiopia.⁴⁸ These findings may reflect gender norms that are specific to the context: If certain decisions are considered part of women's responsibilities, then women making those decisions may demonstrate compliance with gender norms, rather than be an indication of autonomy. The link between specific decisions and immunization may also relate to the practical steps required to access vaccinations in a specific area. Where health services are farther from communities, for example, women's ability to make decisions about travel will be directly linked to their ability to access immunization services.

How decisions are taken can also influence vaccination. A study in Ethiopia found that women who made financial decisions jointly with their husbands were even more likely to get their children vaccinated, compared with women who made financial decisions independently.⁴⁹ The author suggests that joint decision-making may indicate a more collaborative partnership between the husband and wife, and a sharing of responsibilities for child health.

Some studies found that taking certain socio-economic factors into account, in particular women's and men's education levels, weakened (but did not eliminate) the association between women's autonomy and childhood immunization. One explanation is that, in contexts where women's autonomy is generally low, socio-economic factors have more impact on health-seeking behaviors.⁵⁰ A more recent study in Ethiopia, however, concluded that "for Ethiopian women, education was not a substitute for autonomy. That is, Ethiopian women's household autonomy is not solely created through access to education but through greater freedom to make decisions concerning their livelihoods."⁵¹

⁴³ Singh et al. 2012; Woldemicael, 2007.

⁴⁴ Antai et al. 2012; Olorunsaiye and Degge, 2016; Oluwadare, 2009.

⁴⁵ Schwarz, N.G., Gysels, M., Pell, C., et al. Reasons for non-adherence to vaccination at mother and childcare clinics (MCCs) in Lambaréné, Gabon. *Vaccine*. 2009 Aug;27(39):5371–5375. DOI: 10.1016/j.vaccine.2009.06.100

⁴⁶ Oluwadare, C. The Social Determinants of Routine Immunisation in Ekiti State of Nigeria. *Stud Ethno-Med*. 2009; 3(1):49–56; Schwarz, N.G., Gysels, M., Pell, C., Gabor, J., Schlie, M., Issifou, S., Lell, B., Kremsner, P.G., Grobusch, M.P., Pool, R. Reasons for non-adherence to vaccination at mother and childcare clinics (MCCs) in Lambaréné, Gabon. *Vaccine*. 2009 Aug 27;27(39):5371–5. doi: 10.1016/j.vaccine.2009.06.100 Epub 2009 Jul 17. PMID: 19616497.

⁴⁷ Singh et al. 2012.

⁴⁸ Op cit. Woldemicael.

⁴⁹ Ebot, J.O. (2015), "Girl Power!": The Relationship between Women's Autonomy and Children's Immunization Coverage in Ethiopia. *J Health Popul Nutr* 33, 18.

⁵⁰ Op cit. Woldemicael.

⁵¹ Op cit. Ebot.

There is evidence that women’s decision-making power may influence child health outcomes beyond their own household. A study using DHS data from 12 countries⁵² found that communities where women have greater decision-making authority also had better rates of childhood vaccination. In fact, the community average for women’s say in decision-making had more effect on immunization outcomes than the decision-making power of the individual mothers.⁵³ One possible explanation is that women who can make decisions at home, but live in communities that do not accept women’s right to make decisions, may face barriers from community members and service providers. Another possibility is that community attitudes and norms are even more important in determining health outcomes than are individual attitudes. The impact of community gender norms and ideologies for polio eradication are discussed further below.

Some studies have also used women’s attitudes toward gender-based violence as a measure of their autonomy. This is based on the assumption that women with more autonomy would not accept that there is any justification for a man to beat his wife, believing that a woman has the right to argue with her husband, visit family without permission, and refuse sex.⁵⁴ Studies in Nigeria and Ethiopia found that women who rejected the belief that gender-based violence (GBV) is acceptable within the household were also more likely to have immunized children.⁵⁵ The prevalence of GBV and community attitudes may also affect childhood immunization, as discussed in the next section.

Implications for programming

- Reaching men, to build their understanding of the importance of vaccination and the steps required (such as multiple trips to the clinic) can encourage household decisions in favor of immunization.
- Gender-transformative initiatives that engage men to support more equitable sharing of resources and decision-making within households, and those that facilitate the empowerment of women, will contribute to positive health outcomes over time, including progress in eradicating polio. Linking to local gender equality initiatives could inform AFENET and partners about the local context and provide more immediate entry points for addressing specific gender barriers.

⁵² Including Benin, Malawi, Mali, Uganda, and Zimbabwe.

⁵³ Desai, S. and Johnson, K. (2005). Women’s Decision-Making and Child Health: Familial and Social Hierarchies. A focus on gender: Collected papers on Gender using DHS data. USAID. Available at: <https://dhsprogram.com/pubs/pdf/OD32/OD32.pdf#page=61>

⁵⁴ Op cit. Woldemicael.

⁵⁵ Singh, K., Haney, E., Olorunsaiye, C. (2013). Maternal autonomy and attitudes toward gender norms: associations with childhood immunization in Nigeria. *Maternal Child Health J.* 2013; 17:837–41. And Antai, D., Gender inequities, relationship power, and childhood immunization uptake in Nigeria: a population-based cross-sectional study. *Int J Infect Dis.* 2012; 16:e136–e145.

Community-Level Gendered Enabling and Constraining Factors

Community context impacts women's and men's opportunities and constraints in a variety of ways that are relevant to polio eradication strategies. Social hierarchies based on ethnicity, socio-economic status, gender, and other social markers affect the status of households and individuals, influencing their access to services and participation in collective processes. Groups of people may be marginalized in a community based on social identities, such as migrants or members of a minority ethnic or religious group. Women from socially excluded groups may lack social connections that make going to a health facility easier, such as knowing the health workers or being able to travel with other women or access support for childcare or other household needs.

Social hierarchies can also affect the status and power of entire villages or regions. Status differences between communities can be reflected in poorer infrastructure, lack of services, less investment, or lack of representation in decision-making.

Community enforcement of gender norms

Communities shape and uphold gender norms, the unwritten rules about what it means to be a woman or a man. These community norms influence household decisions and actions.⁵⁶ Religious or cultural norms about gender influence women's mobility and the interactions expected or permitted between women and men. In certain socio-cultural contexts, such as the Nigerian Hausa for example, unrelated men may not speak to women without permission from their husbands.⁵⁷

Women are judged on how they live up to community standards about what it means to be a good wife or mother, where the health of a child may be taken as an indication of her capacity as a mother to maintain and nurture her child. Women's performance as mothers and wives may be taken as a reflection on the entire family's status. In this context, if a child is not thriving, the mother might avoid immunization to avoid scrutiny. Poor mothers may avoid health services for fear of being judged because their children have dirty clothes, skin irritations, or signs of malnutrition.⁵⁸ Fear of being judged an inadequate mother could also be a barrier to reporting a child's illness to a community health volunteer (such as for CBS).

The specifics of gender norms can vary significantly from one community to another. Health services that are based on a solid understanding of the gendered context, and are designed to address gender barriers, can make a significant difference in health outcomes. An example is from an area of Northern Ghana that had particularly low levels of vaccination and poor child health outcomes. Qualitative research documented the community beliefs and norms as they affected health-seeking behavior and women's autonomy. The community norms, based on religious beliefs, established the head of multi-household compounds as spiritual leaders and gatekeepers for healthcare. Women explained that seeking healthcare without the approval of the compound head could lead to more illness or even death of the child, and accusations of witchcraft against the mother. The other level of gatekeepers were husbands who, having paid a bride price, are considered owners of their wives and retain full control over household resources. Attending health services, therefore, requires approval from two levels of male decision-makers. The study also found that one community had been assigned a nurse, who lived in the community and visited all

⁵⁶ Heise, L., Greene, M.E., Opper, N., et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* (London, England). 2019 Jun;393(10189):2440–2454. DOI: 10.1016/s0140-6736(19)30652-x

⁵⁷ Op cit. Singh.

⁵⁸ Op cit. Merten.

compounds regularly to provide family planning information and hygiene education and treat minor ailments. Over time, the community nurse has become the first point of contact for health concerns and was able to refer more serious cases to a clinic. The research found that this progress was possible because the community was consulted about moving the nurse from a health facility to the village, participated in building the dwelling, and had input into how the service was delivered.⁵⁹

Community gender norms can affect the actions of volunteers recruited to support CBS. Community members with high status, such as religious leaders, traditional healers, or community elders, have local credibility but generally can play a role in enforcing gender norms, including norms that restrict women's autonomy. So while involving key community members can also be an opportunity to contribute to gender equality, CBS programs need to set clear gender equality standards and provide opportunities for training and dialogue on the importance of gender equality to improving health for everyone. Similarly, women CBS volunteers may also contribute to enforcing gender norms, while at the same time those very norms may also constrain their ability to carry out some aspects of the role. CBS programs need strategies to reduce or overcome those constraints.

Acceptability of immunization services

Cultural and religious beliefs affect how disease is understood and how preventive measures are valued, and the impacts of these beliefs are often gendered. In the example from Northern Ghana (above), the community believed that people fall sick because of supernatural forces or disobeying the ancestors. Before any treatment can be effective, the man who is the head of the compound must consult the ancestors. Women have no part in this process and face severe sanctions if they seek healthcare without consultation.⁶⁰

Remote or isolated communities are more likely to have beliefs that differ from the majority. Those communities also often have lower levels of education in general. Lack of education and limited exposure to information from other communities, combined with subordinate status, may make it even harder for women in those communities to challenge practices that prevent them from seeking health services for their children.

In addition, where there is a lack of trust in authorities, such as in communities that have faced discrimination or in conflict-affected areas, trust in vaccine clinics may be reduced.⁶¹ This may also affect reporting and surveillance. Research has found that organized resistance to vaccination has mostly been led by men, as the main political actors in communities. "When politically based rumors circulate, men get engaged in immunization."⁶² In these situations, if women want to get children vaccinated, they risk negative consequences from men in their household and community. As Merten et al. quote from a case study in Uganda: "Distrust toward vaccinations was mainly purported by men, while some women explicitly encouraged others to disregard their husband's refusal to vaccinate. Strikingly, men's views were predominantly represented in research when immunization had become a political issue."⁶³

⁵⁹ Ngom, P., et al. (2003). Gate-keeping and women's health-seeking behavior in Navrongo, Northern Ghana. *African Journal of Reproductive Health*, 7:17–26.

⁶⁰ Ibid.

⁶¹ Okwo-Bele, J.M., Conner, R., McIlvaine, B., Rowley, E., Bernson, J. (2018). Tackling inequities in immunization outcomes in conflict contexts. ERG Discussion Paper 6. Available at: <https://sites.google.com/view/erg4immunisation/discussion-papers>

⁶² Op cit. Merten. p. 10.

⁶³ Ibid.

Participation and representation

Women’s opportunity to voice their concerns, and power to influence decisions and community programming around health, is often limited by gender roles and structural gender inequality. Family wealth, caste/ethnicity, and religion also affect how women can occupy public space, and the community roles they can play.⁶⁴ A review of literature on the effectiveness of community involvement in health facility committees found that “economic and cultural hierarchies, including male domination, helped prevent health committees from adequately representing the interests of the entire community and hindered full community participation in the delivery of primary healthcare.”⁶⁵ Research into village health committees in rural Northern India found that although women and men were involved based on traditional gender roles (women as caregivers and men as decision-makers), and men dominated in meetings, the committees created opportunities to challenge gender norms and led to women speaking out at committee meetings and on a range of other non-health issues in other settings. The facilitation of NGO staff supported women to make those shifts in roles and provided them some protection from community censure for breaching gender norms. Some women, however, still faced resistance from their household and ended up withdrawing from the committee.⁶⁶

These insights raise considerations for AFENET and partners on how involving local women in the design, management, and monitoring of CBS might strengthen project effectiveness. Meaningful involvement of women in CBS could also contribute to building women’s involvement in decision-making more generally, which (as discussed above) is associated with improved childhood immunization rates. It is important to recognize that while women may be excluded from community decision-making, they may still be expected to participate in or carry out activities they were not consulted about.

Gender-based violence (GBV)

One in three women experience gender-based violence in their lifetime.⁶⁷ GBV takes many forms, from harassment in public spaces, schools, and workplaces to sexual assaults to intimate partner violence (IPV) and other forms of gendered violence in the household. Community norms about the appropriate roles and behaviors for men and women, and attitudes toward violence, are important factors in the type and extent of violence perpetrated against women and girls.⁶⁸ Other aspects of the social context also affect GBV. Conflict and displacement often exacerbate intimate partner violence and non-partner violence, as well as exposing women and girls to new forms of violence, such as sexual exploitation, forced prostitution, and forced marriage.⁶⁹ Crises, such as disasters or the COVID-19 pandemic, have also been shown to increase GBV.⁷⁰

⁶⁴ Op cit. Feletto.

⁶⁵ McCoy, D.C., Hall, J.A., Ridge, M. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy Plan.* 2012 Sep;27(6):449–66. doi: 10.1093/heapol/czr077. Epub 2011 Dec 8. PMID: 22155589.

⁶⁶ Scott, K., George, A.S., Harvey, S.A., et al. Negotiating power relations, gender equality, and collective agency: are village health committees transformative social spaces in Northern India? *Int J Equity Health* 2017;16:84.

⁶⁷ WHO (2021) Violence against Women Prevalence Estimates 2018. Available at: https://cdn.who.int/media/docs/default-source/documents/violence-prevention/vaw_report_web_09032021_oleksandr.pdf?sfvrsn=a82ef89c_5&download=true

⁶⁸ Heise et al. 2019.

⁶⁹ WHO (2017). Violence against Women: Key Facts. Available at: <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>

⁷⁰ Ibid.

Apart from being a serious human rights violation rooted in gender inequality, GBV has multiple negative effects on women's and girls' physical, psychological, sexual, and reproductive health. GBV has also been shown to contribute to adverse child health outcomes.⁷¹ Studies in India found a significantly decreased likelihood of full immunization among children whose mothers reported physical or sexual violence from intimate partners in the past year.⁷²

There is limited research into the pathways through which women's experience of violence affects child health outcomes and vaccination rates. One mechanism may be that GBV affects women's access to health services for themselves, such as reproductive and maternal health services⁷³, or their children. Women who experience violence from their spouse generally also report controlling behaviors by their husband, such as not permitting her to meet her female friends or visit her family, accusing her of being unfaithful, needing to know where she is all the time, or not trusting her with money. These controls by the husband would limit women's mobility and access to resources. Women may also avoid health services to avoid healthcare workers finding out about the violence and therefore damaging the reputation of their husband and family.⁷⁴ The threat of violence in community spaces is a common rationale for households or communities to limit women's mobility, which can affect women's access to health services and be a barrier to women becoming community health workers.

GBV has far-reaching implications for the project, given the high prevalence in the polio project countries. Latest estimates show that of all women aged 15 to 49 in the DRC, 47% have experienced physical and/or sexual intimate partner violence in their lifetime. This is 29% for Chad and 39% for Cameroon.⁷⁵

Child marriage

Child marriage, a form of GBV, also has a direct impact on girls' and women's access to, and utilization of, health services, including immunization. A study exploring the effect of early marriage on women's and children's health in sub-Saharan Africa found that the probability of children receiving basic vaccinations is twice as high if their mothers married between ages 15 and 17 instead of between ages 10 and 14.⁷⁶ Adolescent girls forced into early marriage are less likely to have knowledge about health, and are more likely to experience violence from their spouse (and sometimes in-laws), unwanted pregnancies and maternal morbidity and mortality, while gender norms restrict their mobility.⁷⁷ Child marriages are heavily associated with low education levels, as girls who are denied educational opportunities are more likely to marry young, and girls who are married usually drop out of school. Their age, lack of education, and limited livelihood options weaken their bargaining power, including on health decisions.

⁷¹ Sabarwal, S., McCormick, M.C., Silverman, J.G., Subramanian, S.V., Association Between Maternal Intimate Partner Violence Victimization and Childhood Immunization in India, *Journal of Tropical Paediatrics*, Volume 58, Issue 2, April 2012, pp. 107–113, <https://doi.org/10.1093/tropej/fmr052>

⁷² Muralidharan, A., et al. (2015). Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries. Washington DC: Futures Group, Health Policy Project.

⁷⁴ Umubyeyi, A., et al. (2016). Gender Inequality Prevents Abused Women from Seeking Care Despite Protection Given in Gender-Based Violence Legislation: A Qualitative Study from Rwanda. *PLoS ONE* 11(5).

⁷⁵ WHO (2021). Violence against Women Prevalence Estimates 2018. Data for Niger is unavailable.

⁷⁶ Delprato, M., Akyeampong, K. (2017). The Effect of Early Marriage Timing on Women's and Children's Health in Sub-Saharan Africa and Southwest Asia. *Annals of Global Health*. May–Aug; 83(3-4): 557–567.

⁷⁷ WHO (2011). Early marriages, adolescent and young pregnancies. Available at: https://apps.who.int/gb/ebwha/pdf_files/EB130/B130_12-en.pdf

Currently, in the least-developed countries, 40% of girls are married before the age of 18 and 12% of girls are married before age 15.⁷⁸ Rates for child and early marriage are high in the AFENET project countries as well. For example, in Niger, 76% of women age 20 to 24 were married by age 18, while the figure is 68% in Chad.⁷⁹

Implications for programming

- When pockets of significant under-immunization are identified, a community-level gender analysis of barriers to vaccination and health-seeking behaviors can help to identify underlying problems and suggest strategies.
- Sharing findings from gender analyses with managers and frontline health workers in nearby health clinics may contribute to more gender-intentional health services.
- Where organized or community-wide resistance to vaccination is identified, it is important to engage with men and community leaders to understand and address any misinformation. There may also be opportunities to support local women's groups with information and a platform to encourage immunization.
- CBS programs need to set clear gender equality standards and provide opportunities for training and dialogue with volunteers on how gender barriers affect polio eradication and what that means for their roles. This will support effective surveillance and, because of the leadership roles of CBS volunteers, contribute to longer-term changes toward gender equality and improving health for everyone.
- Maintain ongoing dialogue with female CBS volunteers to help identify and overcome any gender barriers that constrain their work.
- Create opportunities for meaningful participation of community women in the design, management, and monitoring of CBS initiatives. This will support more effective surveillance and contribute to strengthening women's representation in community decision-making.
- Linking with, and supporting, organizations working to end gender-based violence will contribute to gender equality and better health outcomes for children over the longer term. In communities where gender-based violence or fear of violence is a barrier to women attending health services, strategies to support safe travel for women, and safe movement for female CBS volunteers, may lead to shorter-term improvements in immunization rates.
- Consider designing outreach specifically for young women who were married as children and may therefore have less access to information or social networks and less power within their households. Involving them in a group can support their health literacy and build their support network.

The Health System

This section reviews main gender enablers and barriers within the health system, which, as a gendered system, impacts the health of women, men, and children. As Hay et al. note, “20 years of cross-national research from high-income countries and low-income and middle-income countries shows that gender inequalities are embedded in our health systems, are rarely addressed, and impede our capacity to achieve universal health coverage” (p 2535).

⁷⁸ UNFPA (2020). Child Marriage. Available at: <https://www.unfpa.org/child-marriage>

⁷⁹ ICRW and UNICEF (2015). Child Marriage, Adolescent Pregnancy and Family Formation in West and Central Africa. Available at: <https://www.unicef.org/wca/media/1171/file/English%20PDF.pdf>

Design and management of health services

Child health and immunization are based on gender norms, in particular the assumption that women are responsible for the care and well-being of children. Services that recognize the gendered division of labor that puts responsibility for childcare on mothers, and explicitly address the barriers that they may face because of their gender, may be effective in reaching women and children. Some of those gender barriers, such as women's lack of control over resources and exclusion from some household decision-making, highlight the importance of reaching fathers and other gatekeepers with health education messages.⁸⁰ To the extent that these messages are gender intentional, addressing parents' shared responsibility for children and avoiding harmful gender stereotypes, can challenge gender inequalities while also supporting better child health outcomes.

There is also evidence that gender barriers are not consistently considered in the design and management of health services. Examples include immunization hours that do not take into account other demands on women's time and the challenge of transportation, especially for remote communities. A review of published research found that 45% of reasons for under-vaccination related to the immunization system and included missed opportunities for vaccination.⁸¹ Many examples of missed opportunities, such as not assessing immunization status when a child is brought in for another treatment and lack of integration with maternal health services, demonstrate a lack of attention to gender barriers, such as women's time poverty, constrained access to financial resources, and possibly low levels of education or health literacy.

Human resources in healthcare

Increasing women's meaningful participation in polio eradication is important not only in terms of promoting equality, but in many settings women's increased participation affects the reach and effectiveness of polio eradication efforts. In areas where women's seclusion and restricted mobility are prevalent—for example, where socio-cultural and/or religious norms and practices restrict social and physical contact between men and women—women may not seek care for themselves or even for their children unless they have access to a woman health worker. Literature has documented, however, gender barriers to women entering the health workforce, progressing in a career, and working to their full potential.

Women's position in the health system reflects social hierarchies: they are underrepresented at the top of the system and in national systems and health ministries, as well as in healthcare facilities, and most represented at the bottom—for example, nurses, midwives, and community health workers (CHWs). Nurses and other front-line health workers generally have lower status and lower pay and often face harassment and disrespectful treatment at work. That women tend to dominate among unpaid health workers is an extension of dominant gender roles. For example, a policy in Sierra Leone, intended to improve the working conditions for CHWs by giving them a salary, led to more men than women taking these roles, as gender norms dictated that paid employment was the entitlement of men.⁸²

⁸⁰ Op cit. Merten.

⁸¹ Rainey, J.J., et al. (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. 46, 2011, *Vaccine*, Vol. 29, pp. 8215–8221.

⁸² Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., Kharel, C., Silverman, J.G., Raj, A. Gender Equality, Norms, and Health Steering Committee. Disrupting gender norms in health systems: making the case for change. *Lancet*. 2019 Jun 22;393(10190):2535–2549.

Hay et al. link gender inequalities in the health workforce to a “cure versus care” dichotomy: “[C]ommunities look to physicians and specialists to cure, nurses and community health workers are expected to care, with services from nurses and community health workers viewed as less skilled, less deserving of remuneration, and more aligned with women’s traditional gender role as caregivers.”⁸³ Research suggests that lack of respect and overwork of nurses can contribute to poor quality of care, particularly for “the most socially marginalized patients and communities, typically women,”—particularly rural, poor, or young women who have the fewest resources to demand or expect respectful treatment.⁸⁴ The impact of interactions between health workers and mothers is discussed further below.

Even among health workers at the community level, gender inequalities within the health system and the community are obstacles to recruiting and retaining women. A study on gender and AFP surveillance in Nigeria found an overall shortage of women in public health. Surveillance personnel were dominated by men at senior levels and in northern states. The lack of women workers in the north was attributed in part to lower education levels and lack of literacy for women in those areas; however, the authors also noted the impact of harmful stereotypes and social norms that devalue women. The underrepresentation of women impacted the quality of the surveillance: In settings where social and religious norms restrict contact between women and men, male workers had no access to mothers, and men in the family were less able to provide reliable information on children’s health.⁸⁵

Research in DRC, Liberia, and Sierra Leone provides insights into how the selection and recruitment processes of CHWs may be gendered. Education requirements can disadvantage women, as they often have lower education levels and less access and control over educational resources. This seemed to be particularly the case in settings where earlier conflict had disrupted children’s education. Gender norms and roles also hamper women’s selection as CHWs and access to employment in general. For example, women’s ability to work as CHWs can be constrained by family and community expectations that they still carry full responsibility for childcare, care for the sick and elderly, and other domestic tasks. Qualitative research in DRC found that married women were reported as often being late due to childcare responsibilities. In that case, the program looked for more flexible ways to manage scheduling to accommodate the pressures CHWs faced because of gender roles and responsibilities.⁸⁶

Unequal decision-making in communities and health facilities can also create gender barriers in recruitment. In Sierra Leone and Liberia, for example, CHWs are selected by the community, who favored the selection of men. A female manager of a health facility in Liberia explained the difficulty of challenging community choices, because it is community members who need to feel comfortable with the person selected. One reason that more men were selected was the lack of women’s participation in community processes, including meetings that select CHWs. As discussed in the community section above, there are many gender barriers to women’s representation and voice in community decision-making. The same study found that CHW selection criteria in DRC promoted equal opportunities for women and men. This, combined with the involvement of women’s groups, contributed to equal numbers of female and male CHWs.⁸⁷

⁸³ Ibid.

⁸⁴ Ibid. p. 2541.

⁸⁵ Hamisu, A., et al. (2017). Gender Dimensions of Acute Flaccid Paralysis Surveillance in Nigeria. *International Journal of Gender and Women’s Studies* Vol. 5, No. 2, pp. 80–87.

⁸⁶ Steege, R., et al. (2018). Gender and Community Health Worker programmes in fragile and conflict-affected settings. Findings from Sierra Leone, the Democratic Republic of the Congo, and Liberia. Brief published by ReBUILD and RinGs.

⁸⁷ Ibid.

Gender barriers faced by health workers

Women front-line workers, including vaccinators, social mobilizers, surveillance officers, and focal points, live and work within the same gender norms and power relations that influence the households, communities, and societies they serve.

Research from many countries has found that family support is essential to the productivity and effectiveness of women health workers, especially those working at the community level, and a lack of family support was a common barrier to recruitment.⁸⁸ In some cases, the volunteer status or low pay of community health workers reduced family support. In Kenya, for example, a study found that husbands and children of female volunteer community health providers saw the work as of low economic value to the family, and this negatively affected women's participation. If the woman's health work produces little or no economic benefit for the household, men may be unwilling to give up control over their wives' time and may be concerned that women's work might lead to neglect of family responsibilities. In contexts with very conservative gender norms, families may be reluctant to support women as health workers because that role will bring them in contact with men outside of the family.⁸⁹

Real and perceived insecurity is another reason families may object to women becoming community-based health workers. It is also a barrier to women choosing to take positions and continuing in those roles. Studies from many countries demonstrate that women CHWs are often subject to sexual harassment while carrying out their work. In areas affected by conflict, the threat of sexual violence against women and girls often increases. The low status, mobility, and profile of CHWs may additionally increase their vulnerability to violence in conflict-affected areas. For example, in the DRC, CHWs were more vulnerable to sexual violence than other cadres of health staff because many of the richer and more senior cadres of the health system could leave their posts when war broke out. CHWs who were unable to leave took on the responsibility for healthcare provision, and this increased their vulnerability to violence.⁹⁰

Health system response

The quality, acceptability, and accessibility of health services may deter women from attending immunization services for themselves and their children. These obstacles include, for instance, negative provider attitudes, skills, and behavior; lack of adolescent-friendly services; long distances; long waiting times or lack of appropriate opening hours; weak confidentiality measures; lack of separate waiting areas and sanitation facilities; and the absence of women healthcare providers. Disrespectful treatment of women not only discourages those women from returning to the clinic; it can also affect the health-seeking behavior of others in the same social networks and reinforces harmful gender norms.

There is evidence that healthcare providers sometimes accept and reinforce social expectations of what it means to be a good mother, judging women on how well they meet these standards, and failing to recognize the gender barriers that affect them. A review of qualitative research on gender and immunization notes:

Gendered responsibilities and blame often compound on women who may be publicly scolded because of their inability to overcome structural constraints. Particularly striking were the accounts of impoverished

⁸⁸ Steege, R., Taegtmeier, M., McCollum, R., Hawkins, K., Ormel, H., Kok, M., Rashid, S., Otiso, L., Sidat, M., Chikaphupha, K., Gemechu Datiko, D., Ahmed, R., Tolhurst, R., Gomez, W., Theobald, S. How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework, *Social Science & Medicine*, Volume 209, 2018, pp. 1–13,

⁸⁹ Ibid.

⁹⁰ Op cit. Steege.

women who were publicly accused by health professionals of neglecting their children, a humiliation reinforcing their already low social status and general vulnerability. In contrast, the right of the father to deny a mother the resources to take a child for immunization is not challenged.^{91 92}

The interaction between health workers and mothers can be influenced by their different positions in social hierarchies. Healthcare workers will often be more educated and may be from a higher socio-economic class or a dominant ethnicity. At the same time, front-line health workers, often predominantly women, are among the lowest status in the health system. This may lead some workers “to reinforce their own status by denigrating others, particularly the poor, unwashed, uneducated, ethnic-minority mothers who don’t speak the national language.”⁹³

Health education and information

Health information and education is an essential component of immunization programs, primarily designed to reach women because of their socially assigned responsibility for childcare.⁹⁴ Yet, lack of parental knowledge has been identified as an important reason for under-vaccination in a systematic review of published research.⁹⁵ That review also identified problems related to communication or information, including lack of community outreach by health services, language barriers, inadequate or poorly targeted media messages, and inaccurate or insensitive delivery of information from health workers.

Some of the challenges may be that material needs to be re-designed to better reach women with low literacy, who represent a significant part of the female population in project countries (as detailed earlier). Customizing health education materials for women from ethnic and linguistic minorities may mean going beyond translation and addressing gender norms and/or health-related beliefs that might be specific to those communities. In addition, involving women’s groups in sharing health information may be a useful strategy for reaching women more effectively, as well as supporting them to act on that information. Women’s groups can provide a safe space for women’s dialogue that helps builds confidence and social supports.⁹⁶

The credibility and perceived power of the source of information also affect how that information is received. “For example, for young mothers, elderly women may be a more authoritative and reliable source of knowledge and information than health professionals.”⁹⁷ When community leaders or the male head of household promote a particular view, a woman may not be in the position to challenge that by acting on conflicting information from a health worker.

This also raises the need for more health information designed to reach men and other household decision-makers. Communications related to child health often put all the responsibility on women and can reinforce harmful gender stereotypes, including implying that mothers are to blame for any poor health outcomes.⁹⁸ Recognizing that fathers (and sometimes elder women in the household) often act as gatekeepers for healthcare, health education could aim to build their understanding of the importance of vaccination and encourage them to share responsibility with mothers in making sure that their children are

⁹¹ Op cit. Merten.

⁹² See also Favin et al. 2012, who related similar findings from a review of grey literature on barriers to vaccination in Bangladesh, Benin, Ethiopia, Gabon, Kenya, Niger, Nigeria, Syria, Uganda, Zimbabwe, and a regional study in West Africa.

⁹³ Ibid.

⁹⁴ Op cit. Feletto.

⁹⁵ Rainey et al. 2011.

⁹⁶ Op cit. Feletto.

⁹⁷ Op cit. Merten.

⁹⁸ Ibid. Feletto.

protected. It is important that any information intended for men, or community elders, be gender intentional, avoiding harmful gender stereotypes and depicting women as equally entitled to a say over decisions affecting them, the family and the community.

Implications for programming

- Linkages between AFENET and partners and different levels of the health system can be used to share insights on gender barriers to immunization and health services more generally as well as information gathered through CBS. At local levels, AFENET partners could facilitate dialogue and information sharing between CBS volunteers, local women's organizations and health workers for the purpose of identifying problems (for example missed opportunities for vaccination, opportunities for integrating services or issues affecting women's trust in services) and finding solutions.
- Consider the gender balance in CBS volunteers and in the leadership of CBS initiatives. It is important to involve both women and men at all levels, and to build skills at all levels to carry out their roles in ways that reduce gender barriers and role model gender-intentional outreach and surveillance.
- Consider what steps are needed to ensure that any community involvement in selecting or monitoring CBS volunteers reduces gender barriers and challenges rather than reinforces harmful gender norms. This may mean creating separate opportunities for women to speak out about their interests, providing educational information to women and men, or setting standards for the selection of volunteers that guarantee equal (or, if needed, greater) numbers of women are selected.
- Identify and provide the supports women may need to carry out CBS activities given gender barriers in their context.
- As discussed earlier, support health education for men and male leaders as well as for women. Ensure that the material is accessible to local literacy levels and languages, addresses context-specific gender barriers, avoids reinforcing gender stereotypes, and promotes gender equitable sharing of work, resources, and decisions linked to better health outcomes for children and adults

4. Gender Profiles of Project Organizations

This section provides profiles of the project organizations, AFENET, IMC, SANRU, Caritas, ASRADD, and BEFEN. It is based on data provided by the project partners, including organizational and administrative documentation and results of the training needs assessment survey.⁹⁹

Organizational Strategies and Policies

Project partners were asked to provide relevant organizational documentation in order to understand how they are institutionally addressing gender issues. The following provides an overview based on the four organizations providing the following documents:

- AFENET: Strategic Plan (2017-2022) and Human Resource Manual (2015)
- ASRADD: Organizational Charter, Code of Conduct and Ethics, Strategies for Scientific Research and Interventions for Sustainable Development (2015-2025)
- BEFEN: Protocol Agreement between the Government of Niger and BEFEN, Development Plan (2015-2018), and BEFEN Project Plan (2011-2015)
- IMC Capability Statements for DRC and Cameroon

For the three partners that provided organization-related documentation, non-discrimination and equal opportunity are included. For example, the ASRADD Organizational Charter emphasizes zero-discrimination as one of the organization's nine organizational core principles stating that "...ASRADD does not accept discrimination based on race, sex, ethnicity, religion, nationality, opinion or class." Its Code of Conduct commits to not engaging in discriminatory practices based on ethnicity, age, sexual orientation, disability, or any other form of discrimination.

The charter also guarantees gender equality in staff recruitment and management and indicates that a new policy will be developed to support the organization's efforts to consider and mainstream gender in its practices. It explicitly states that the organization will pay particular attention to gender equity, support the fight against gender-based violence, and encourage the participation of women in the process of designing, implementing, and evaluating programs. Furthermore, ASRADD's Code of Conduct and Ethics states that equality between men and women, as well as gender equality, are among the organization's core values, along with zero tolerance of harassment and abuse. The gender equality policy states ASRADD's commitment to the Beijing Declaration.

AFENET's HR manual includes a specific harassment and Discrimination policy, which refers to discrimination on the basis of sex and gender, as well as a zero-tolerance approach to harassment and disruption toward its staff. Disciplinary action and dispute and grievance resolution policies are also outlined, as well as a whistleblowing policy for staff. The organization states it is an equal opportunities employer and does not tolerate discrimination based on "sex, gender, ethnic origin, age, color, marital

⁹⁹ This section provides aggregate data from the TNA. See Annex B for a breakdown by partner organizations.

status, physical ability and health, HIV/AIDS status, culture, beliefs and social background and any other characteristic protected under the law.”

The BEFEN Protocol Agreement with the Government of Niger includes a provision (Article 8) that refers to equal opportunity policy and hiring practices concerning gender, race, religion, or political opinion, and that the NGO actively considers gender and people with disabilities in their program activities.

Two organizations, AFENET and ASRADD, submitted organizational strategies that provide opportunities to be more gender intentional in their references to equity. For example, the AFENET strategic plan refers to equitable health service delivery in its objectives and key performance indicators, which could be expanded on, particularly in reference to internal policy and standard operating procedures for institutional development, as well as supporting field epidemiology training programs to contribute to policy development and evidence-based decision-making. ASRADD’s Strategies for Scientific Research and Interventions for Sustainable Development during 2015-2025 acknowledges the lack of women researchers and refers to ensuring “gender equality, respect and equity.”

Both BEFEN’s and IMC’s organizational plans make specific reference to gender issues. For example, BEFEN’s Development Plan (2015-2018) states that guaranteeing equal opportunities, regardless of sex, race, age, ethnicity, religion, or political affiliation, is one of their core humanitarian principles. The CBO explicitly recognizes the significance of empowerment of women and women’s equal access to education, work, healthcare, and decision-making in achieving the UN MDGs, and carrying out projects strengthening the purchasing power of rural women in particular. It commits to increasing partnership development and network engagement in delivering the organization’s work around women’s health, where women are mentioned more in terms of beneficiaries/recipients of the work.

IMC’s Capability Statements for DRC and Cameroon acknowledge that women and girls are especially vulnerable to GBV and have little decision-making power. IMC’s approach includes GBV prevention and protection, including training to local healthcare providers, ensuring psychosocial support is available to survivors and other vulnerable women and girls, and that the community is aware of the risks and consequences of GBV.

In sum, project partners collectively have opportunities to integrate gender concerns in their organizations’ strategies and policies. In particular, we described later in the TNA results, addressing the many gender barriers to achieving gender equitable staff ratios seems to be the major challenge as well as opportunity. As one key informant respondent reflected: *In total, the project has around 30-35% of women as community facilitators. This is a challenge for the project because community facilitators are mainly men and they are not always welcome in households to talk to women. There are cases where husbands simply ask them to get out of the house as they don’t want them to interact with their wives.*

Staff Composition of Project CBOs

Gender ratios of project staff across the partners range from 7% women and 93% men in IMC-DRC to 69% women and 31% men with ASRADD (see Figure 3). Of all program/project manager or coordination positions, women comprise 33%. For CBOs that provided CHW data, there is also variation across the partners: SANRU had 68% women and 32% men CHWs, while ASRADD had 17% women and 83% men CHWs (see Figure 4). In Caritas, women make up 15% of health zone focal points, while this is 36% at SANRU and 82% at ASRADD.

FIGURE 3: Gender staff ratios by organization

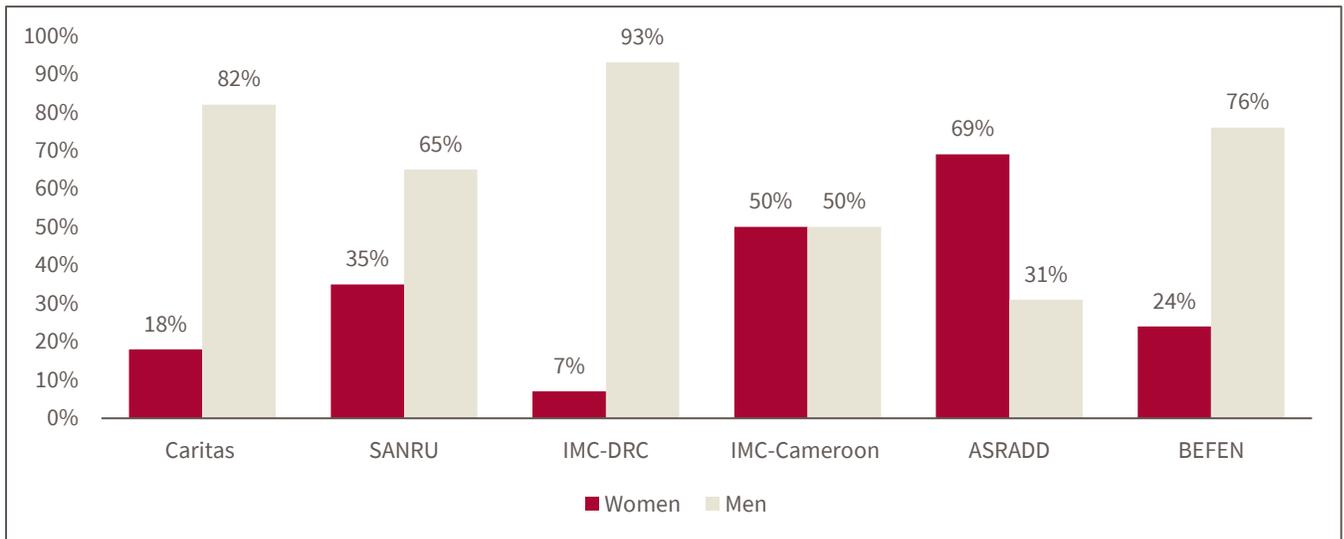
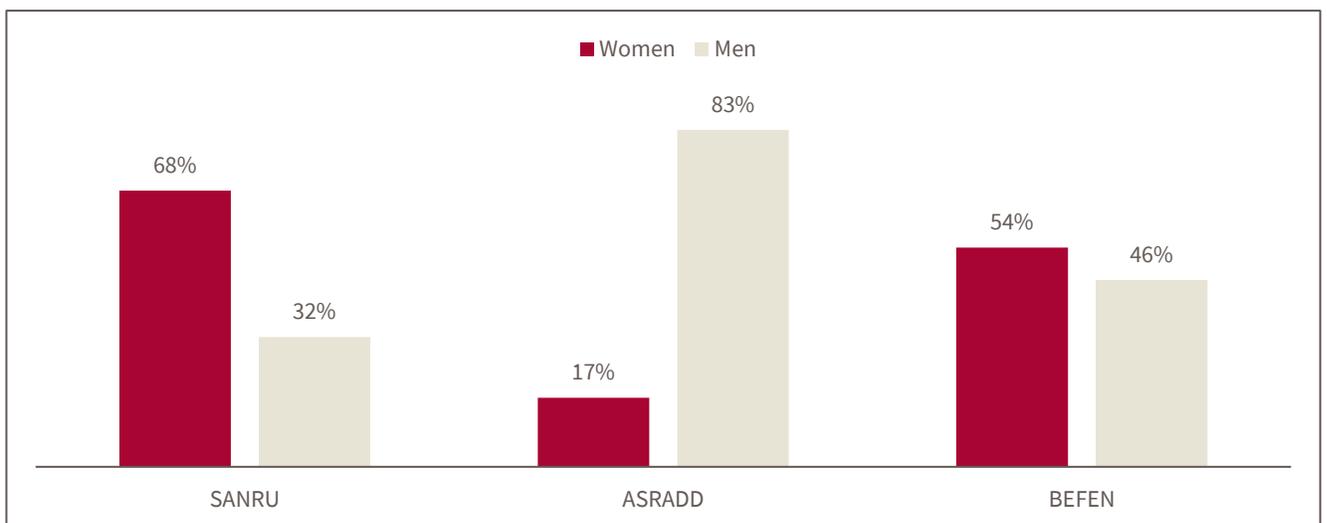


FIGURE 4: Gender CHW staff ratios



Results of Training Needs Assessment and Key Informant Interviews

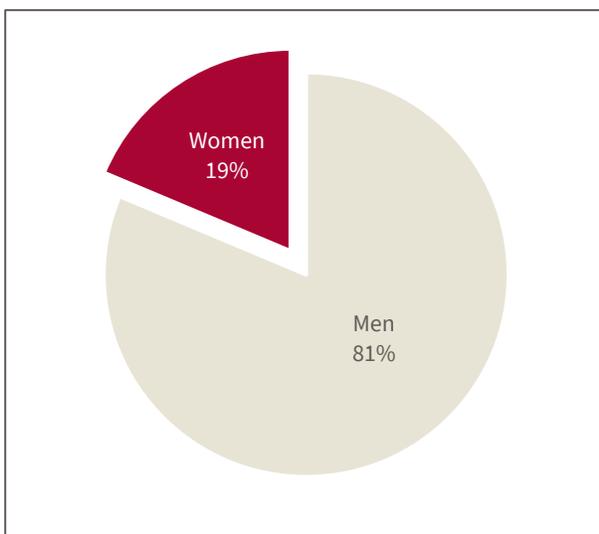
The anonymous online survey consisted of 33 closed and open-ended questions focusing on the existing capacity of staff to integrate gender into their work, as well as exploring challenges and obstacles related to gender integration, along with gender and organizational issues of AFENET and partner organizations. The survey responses were gathered during February 2021.

To complement the staff survey, GenderTech conducted key informant interviews, in French, with six staff of CBOs (see Figure 5).

Organization	Country	Position Title	Sex	Total
Caritas	DRC	Program Manager	Male	1
SANRU	DRC	Project Manager	Female	1
IMC	DRC	Program Manager	Female	1
IMC	Cameroon	PI	Female	1
ASRADD	Chad	Project Manager	Male	1
BEFEN	Niger	Project Coordinator	Male	1
				6

Survey respondents' profile

FIGURE 5: Gender of survey respondents (N=75)



A total of 75 staff members from AFENET, ASRADD, BEFEN, SANRU, Caritas, IMC in DRC and Cameroon responded to the anonymous online survey conducted in February 2021. Women comprised 19% of all respondents and men 81% (see Figures 5-7). Managers made up 51% of all respondents (see Figure 8). Of all respondents, 36% were age 18 to 35, while 41% were between ages 36 and 45, 19% were between 46 and 55, and 4% were over 55 years old. In terms of length of time worked in polio eradication programming, 49% had worked in polio between 1 and 5 years, 7% between 6 and 10 years, 17% for over 10 years, and 27% less than 1 year.

FIGURE 6: Survey respondents by gender (%) (N=75)

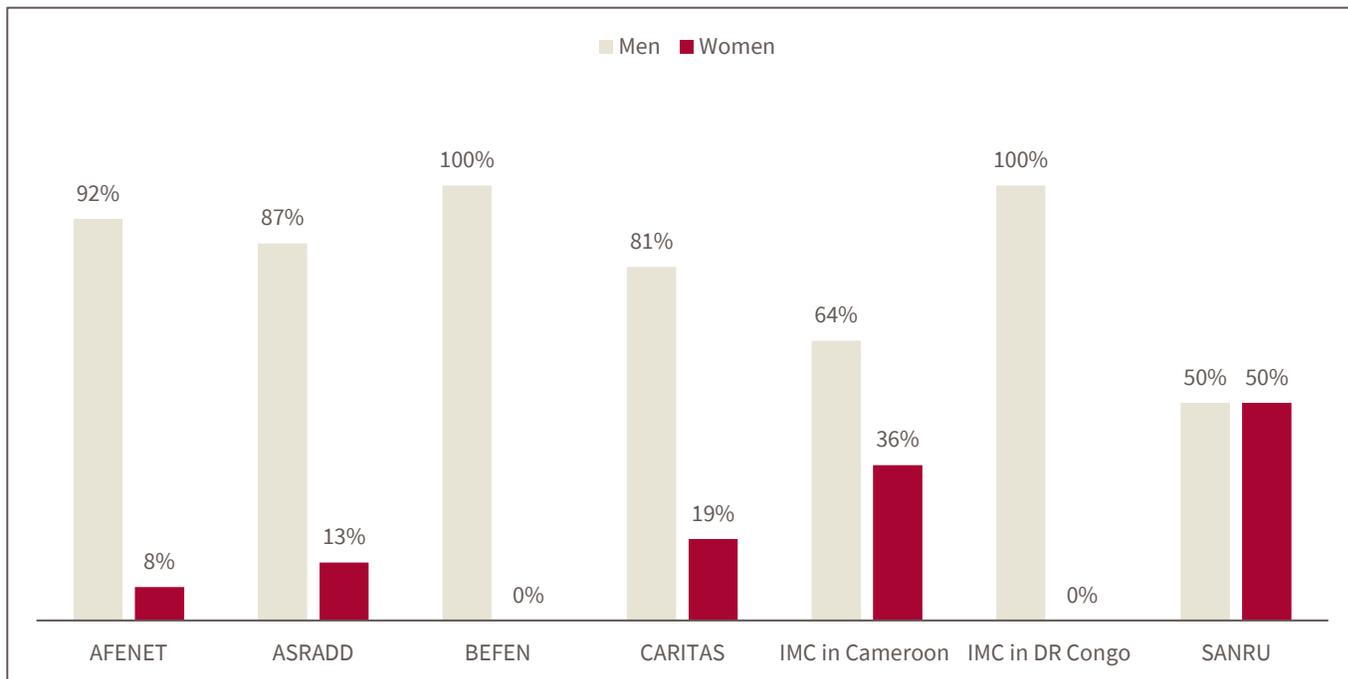


FIGURE 7: Survey respondents by gender (raw numbers N=75)

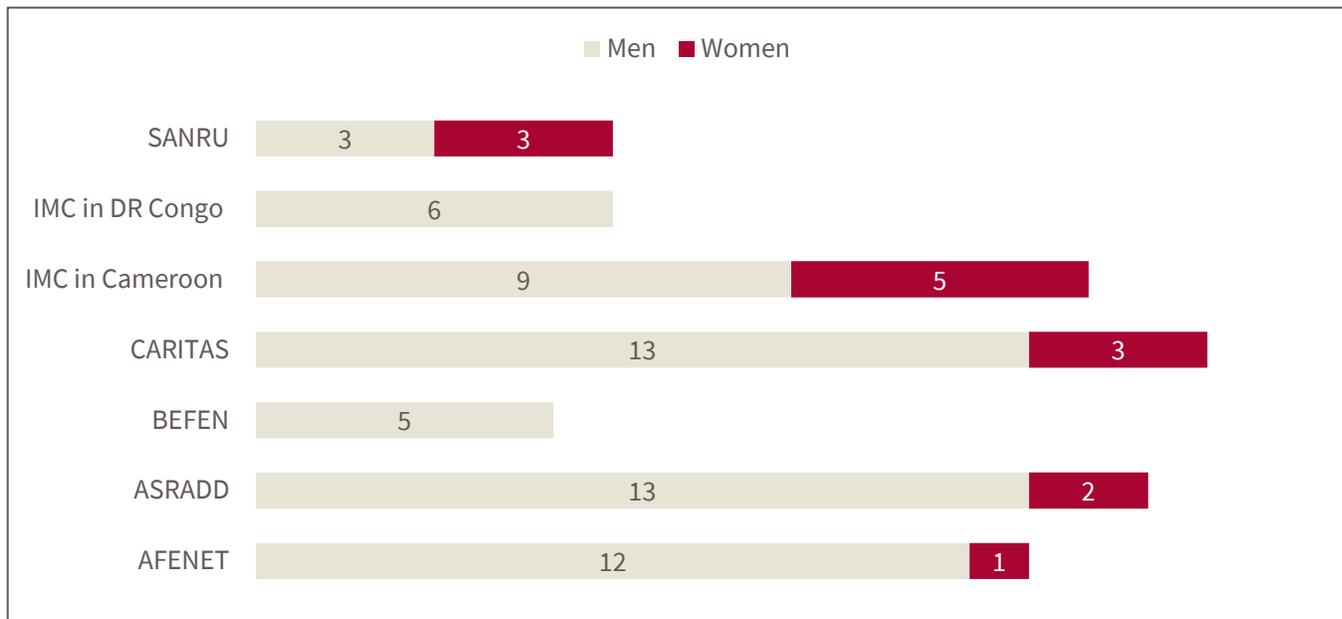
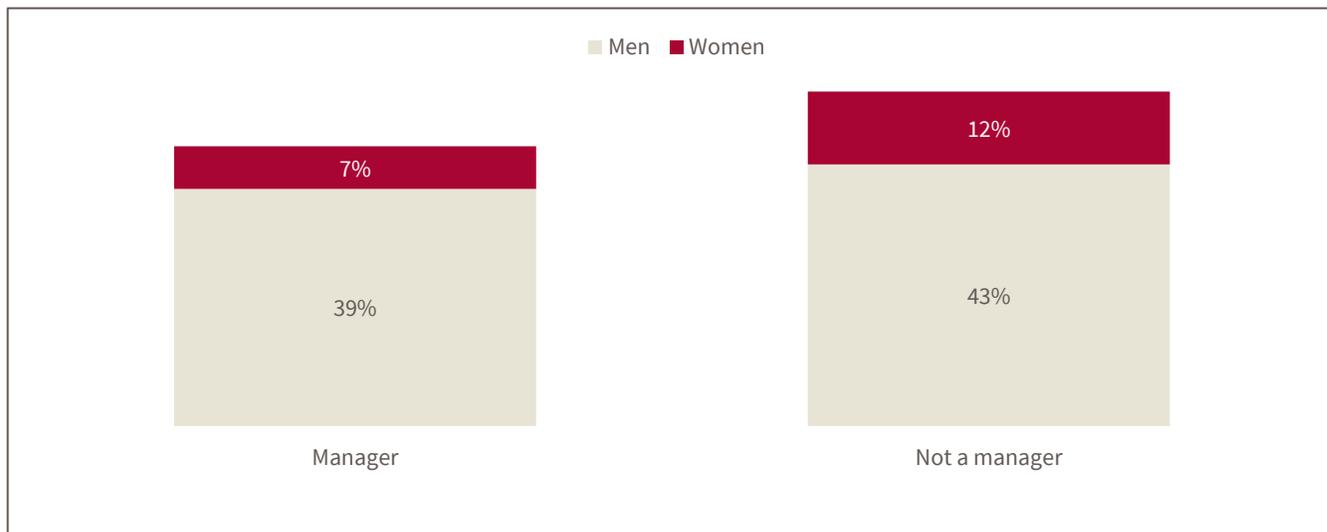
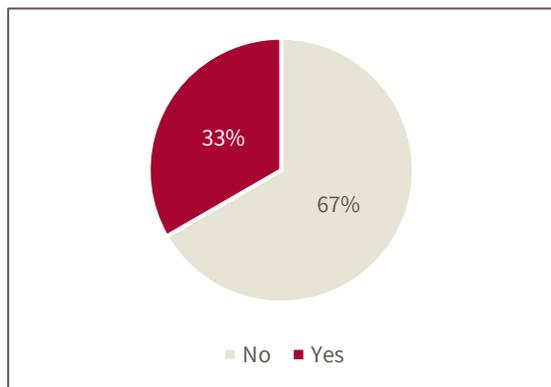


FIGURE 8: Organizational role of survey respondents (N=75)



Capacity, practices, and challenges

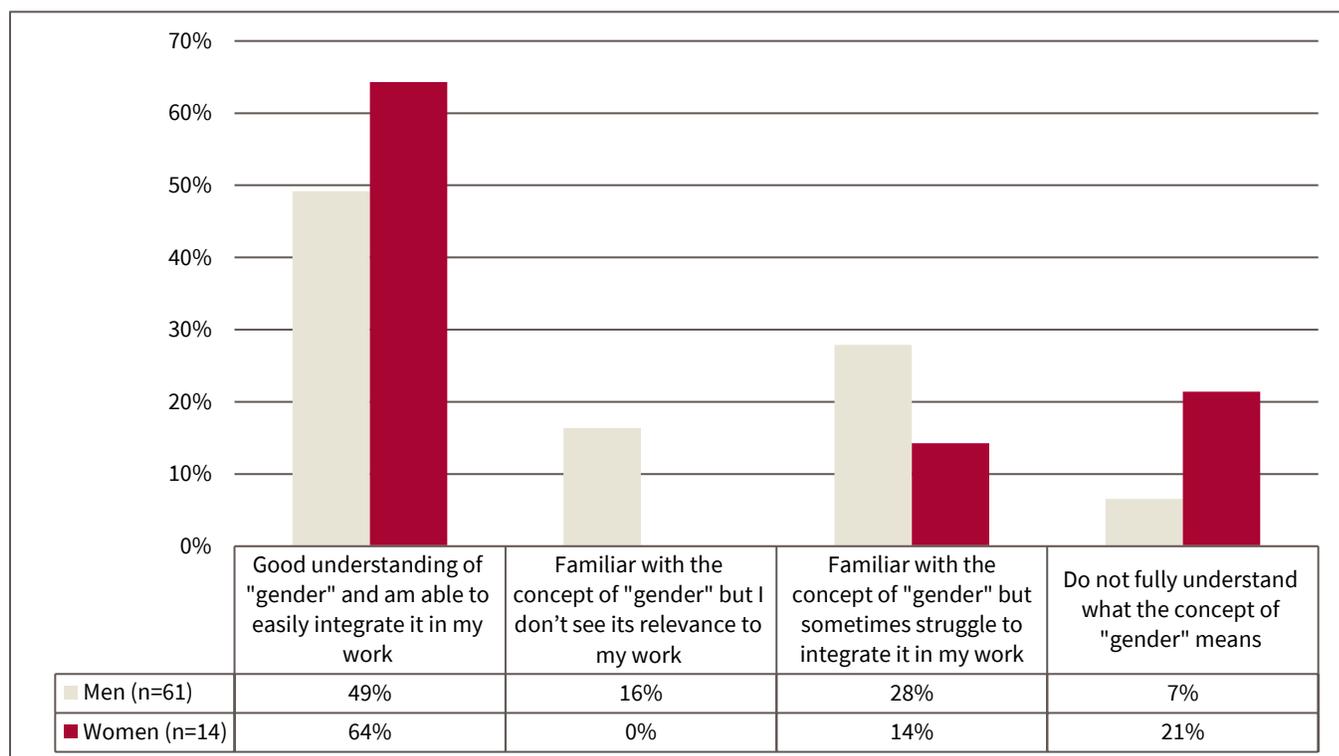
FIGURE 9: Ever attended a gender training (N=75)



Of all respondents, 33% previously have attended a gender training—this was 33% of women and 36% of men respondents (see Figure 9). Thirteen respondents provided further details of the training received—the topics mentioned include a UNFPA training on gender-based violence, a World Vision training on women in decision-making, training on prevention of sexual harassment and abuse, and a gender and development training at the Université Abdou Moumouni de Niamey, among others.

Of all respondents, 52% reported having a good understanding of “gender” and being able to easily integrate gender into their work. Overall, 25% of respondents indicated being familiar with the concept of “gender” but sometimes struggling to integrate it into their work. Of all respondents, 9% indicated not fully understanding what the concept of gender means—this was 7% for men and 21% for women. Of all respondents, 13% (all men) felt that while they are familiar with the concept of “gender,” they did not see its relevance to their work. See Figure 10.

FIGURE 10: Familiarity with gender as a concept by gender (N=75)



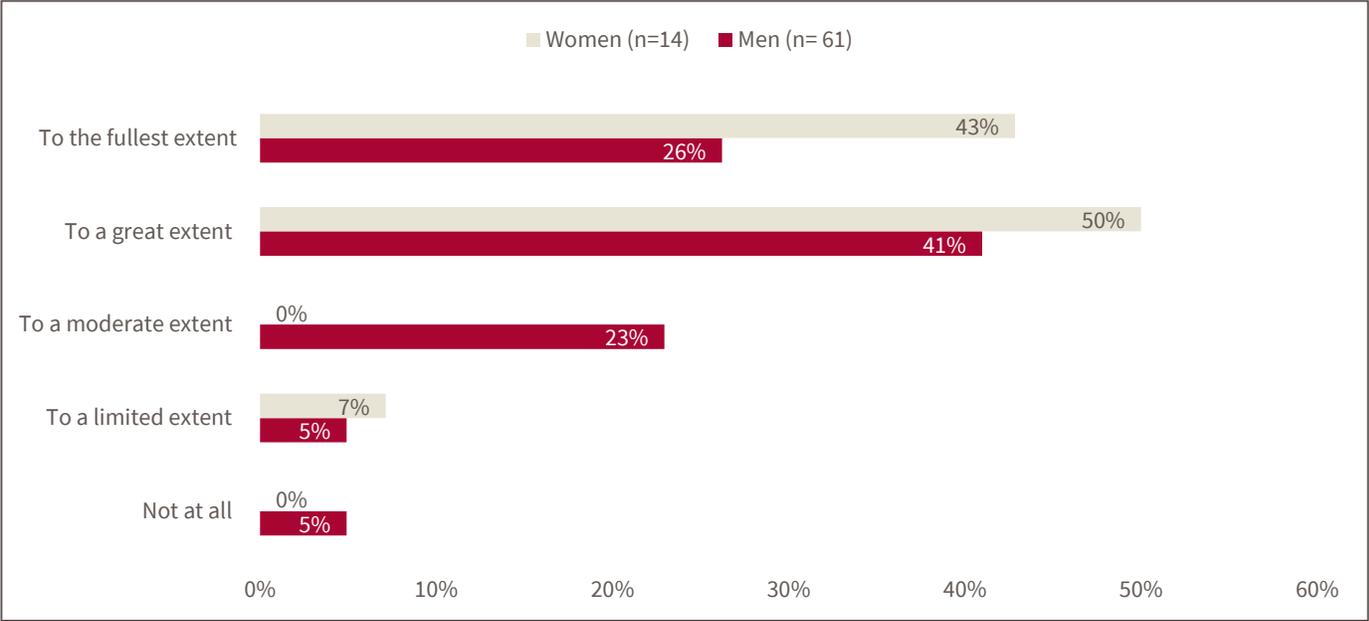
When asked about familiarity with gender issues in relation to health and polio programming, 17% of respondents reported not being at all familiar, while 13% reported being familiar “to a great extent.” Of all respondents, 33% reported being familiar to a limited extent and 32% to a moderate extent, while 4% indicated being familiar with gender issues to the fullest extent.

Respondents explained how gender norms are relevant to polio eradication programs. This included:

- Women have more access to households in the community—women are needed to reach the maximum of children who are potential cases because women have more access to households than men.
- Women have the power of persuasion and attitude that can influence the adoption of essential practices, particularly vaccination—useful for confronting and convincing vaccine-resistant communities and convincing mothers to access services if symptoms appear in their child.
- Women interact more with children and are in a position to more easily identify all primary symptoms of AFP, more so than men.
- Women can communicate easier with mothers—women find it easier to open up and connect to other women and express themselves better than to men, thus making it easier for more cases to be notified by women.
- For the eradication of polio, there is a need for men, women, and the entire community—each plays a role in the notification of AFP cases.

When asked about confidence in integrating a gender perspective (gender integration) in their work, 29% reported being confident to the fullest extent, 43% to a great extent, 19% to a moderate extent, and 5% to a limited extent, while 4% reported not being at all confident. Overall, women had more confidence in integrating gender into their work, with 93% of women reporting being confident “to a great or fullest extent,” compared with 67% of men. See Figure 11.

FIGURE 11: Confidence in integrating gender—by gender (N=75)



Respondents indicated a number of current gender integration practices, such as:

- Integrating gender-sensitive HR policies—salary treatment, access to work-related benefits, equal treatment under labor laws.
- Highlight the very strong importance of women in decision-making.
- Involving women in polio surveillance at the community level—reaching gender parity.
- The improved friendly atmosphere between staff at the CBO level.
- Supporting acceptance of women health workers within communities: the presence of women in my team made it possible to dispel reluctance in a village during an investigation of AFP cases; it helped the community to notify a lot of AFP cases.
- Increased acceptance of the project by the community—in particular, with other women in their homes.
- Mass sensitization with religious leaders on gender issues.
- Analyzing data by sex.

Respondents also indicated a number of challenges to integrate gender in their work. These included:

- Absence of women in the labor market, especially for positions such as logistics posts, and in health and nutrition.
- Time constraints to analyze data by sex.
- A complex of superiority on the part of men vis-à-vis women.
- Transport and security challenges—some positions entail travel to remote areas and security-challenged zones, and many women decline such positions; women who cannot ride a motorcycle cannot go to communities and don't have other means of transport.
- Women having family obligations are not very available, especially when they have minor children, and are not willing to displace from their family for work.
- Women are often left out of decision-making.
- Lack of knowledge on gender integration.
- Low funding for gender mainstreaming activities.

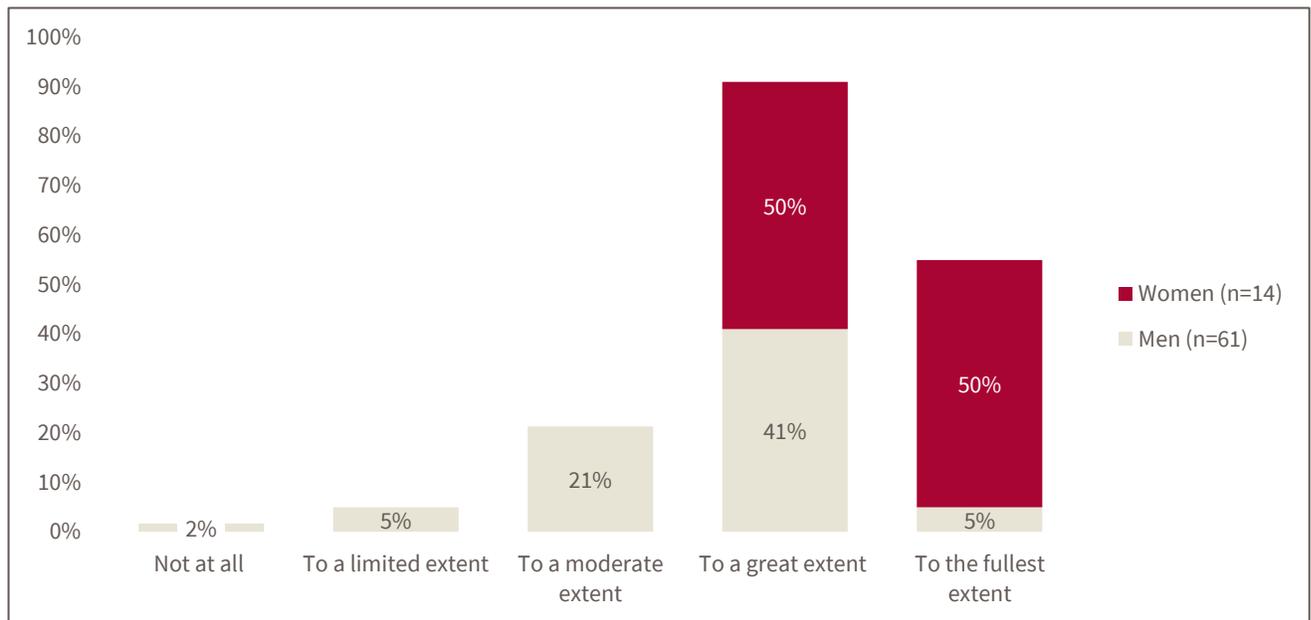
It is worth noting the diversity in views of women's and men's relative capacities. Some respondents demonstrated fairly essentialized gender views, while others understood these from different perspectives. For example, two key informants used the example of women using motorbikes but had different views. One, a man, viewed women using motorbikes as a vulnerability: *There are anticipated insecurity concerns around women using motorbikes as a means for transportation to do their work. It's expected that women won't be able to repair their motorbikes if they happen to break in the middle of nowhere and that would pose a safety issue for them.*

While another, a woman, emphasized their agency: *Otherwise, when enrolled, women CHW do the same job as men and they have no issues riding motorbikes and engaging with community members both men and women. Sometimes, it's possible that some men treat them with condescendence, but they know how to navigate such situations.*

Of all respondents, 77% felt that gender is relevant to their organization's work, either to a great or fullest extent. This also was evident in the key informant interviews where managers showed an understanding of the relationship between gender and health more generally and polio in particular, especially the importance of having women CHWs. As one interviewee recounted: *It's important to include a gender perspective in polio surveillance efforts especially at the community level. Every time women are included in the implementation; results are much better and it's true when it comes to vaccination. In 99% of cases, women are the ones who bring the children to get their vaccination.*

Conversely, only 4% of TNA respondents felt that gender is relevant only to a limited extent, with 1% (1 person, a man) stating that gender is not at all relevant. Women were more likely to feel that gender is relevant to their organization's work, with 50% of women respondents indicating it is relevant to a great extent and 50% indicating that it is so to the fullest extent. See Figure 12.

Figure 12: Relevance of gender to your work—by gender (%) (N=75)



When asked about examples and successes of integrating a gender perspective in work, many respondents (27) referred to examples centered on recruiting women in the program and increasing women’s participation:

- In the implementation of each project activity which is the participation of women*
- We have set ourselves objectives of parity in the recruitment of project staff and community actors*
- Recruitment of women*
- 2 women recruited from 5 Focal Points*
- Equitable distribution between women and men in jobs*
- The involvement of both sexes in our community activities*
- With the increase of women among community workers, the detection of cases and the issuance of AFP alerts by the community and the relays have considerably increased*

Some respondents also referred to examples focusing on wider gender integration efforts beyond women’s participation:

- By aggregating AFP performance indicators by gender*
- By bringing it closer to women’s organizations*
- I have successfully integrated gender in analyzing data by gender*
- Training on gender sensitiveness, ethic point, and code of conduct regarding mutual consideration, harassments in working place, PSEA in various projects*
- It helped the community to notify a lot of AFP cases*

The presence of women in my team made it possible to dispel reluctance in a village during an investigation of AFP cases

The gender approach allows us to approach the community; facilitates message transmission

One respondent also reflected on another practical activity related to gender integration at the workplace:

Separation of toilets, more confidence, security (toilet separation), less stress

In terms of challenges in integrating a gender perspective into polio eradication work, many respondents mentioned the low capacity and awareness of staff and program beneficiaries as the main challenges.

Low intellectual capacity in rural areas

Low gender awareness

Financial resources

The persistence of socio-cultural heaviness, especially at the community level, which limits the full participation of women in program activities

Incomprehension

Lack of knowledge on gender integration

Lack of means

Time constraints to analyze data by sex

Low funding for gender mainstreaming activities

Many respondents, and almost all key informants, also focused on the challenges involved in recruiting more women front-line workers for the program:

The absence of women in the labor market, especially for positions such as logistics

Women are few in the fields of health and nutrition

Very few women applying or are qualified for a position, some positions entail to remote areas and security challenged zones, and many women decline in such positions, women not willing to displace from their family

Insufficient number of women trained in surveillance, their availability

Women here seem to be less interested in many things including polio work

There is a negative social perception of women's work among men, degrading criticism and retrograde spirit in some communities vis-à-vis the women and men who work together

When asked about suggestions for gender integration, several respondents emphasized the need to invest more in training on gender-related issues and sensitization around gender.

To increase women's participation in the program, some respondents recommended instituting quotas for women FLWs, and to develop and implement more internal regulations and systems against harassment and abuse. In general, respondents encouraged more actions related to human resources to encourage

more women applicants. Respondents also called for the need to support training and advocacy within the communities, and at the provincial level, and to organize trainings on women’s leadership.

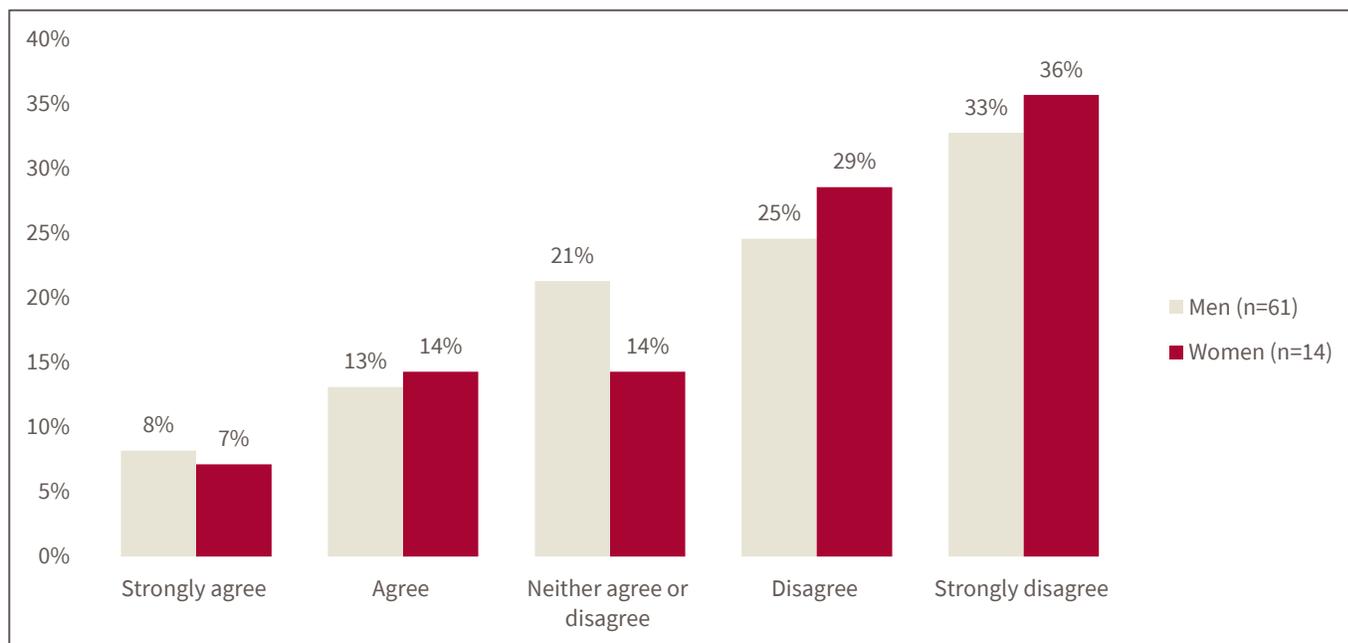
Continuous funding was also mentioned as an important factor. One respondent also noted that appointing gender focal points would be beneficial for improving overall gender integration. The importance of engaging men and fathers in polio eradication activities was also noted.

Gender in the organization

Of all respondents, 58% either agreed or strongly agreed that their organization encourages gender-sensitive behavior (for example, managers challenging sexist jokes). Women were more likely to agree with the statement—79% of women agreed or strongly agreed, compared to only 53% of men. Of all men, 33% disagreed or strongly disagreed, compared with 21% of women.

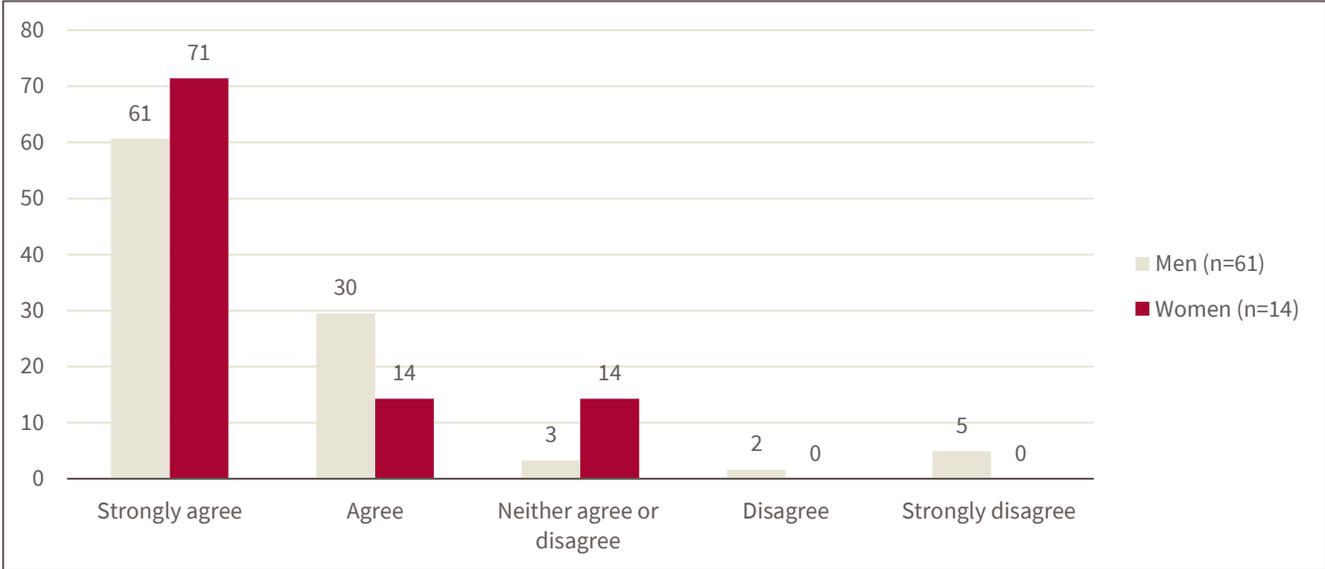
Of all respondents, 21% either agreed or strongly agreed with the statement that they “regularly observe harmful gender stereotypes from staff members in their organization,” while 59% of respondents disagreed or strongly disagreed with the statement. There were no major variations between women’s and men’s perceptions of observing harmful gender stereotypes from staff members. See Figure 13.

FIGURE 13: Regularly observing harmful gender stereotypes from staff members—by gender (N=75)



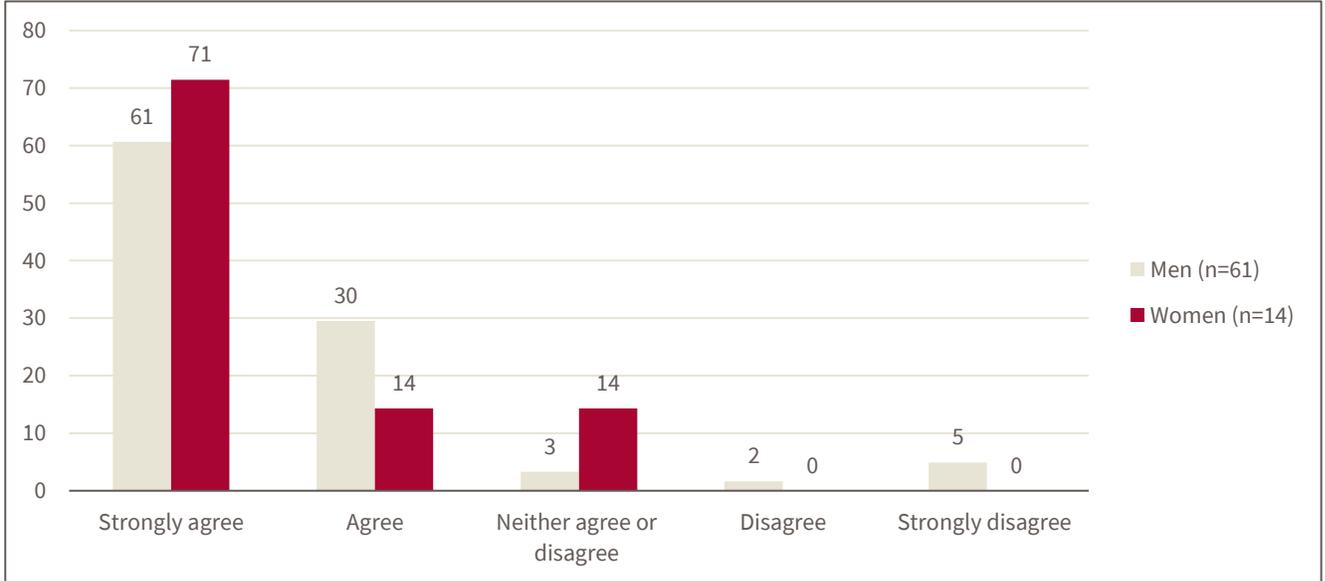
Perceptions about gender equality somewhat varied between the organizations and between women and men. Of all respondents, 73% strongly agreed that women and men should be treated equally and 21% agreed, while the rest neither agreed nor disagreed. Women overall were more likely to strongly agree with the statement. See Figure 14.

FIGURE 14: Women and men should be treated equally—by gender (N=75)



While 94% of respondents strongly agreed or agreed that women and men should be treated equally, 89% felt that women and men are treated equally in their organization. See Figure 15.

FIGURE 15: Women and men are treated equally—by gender (N=75)



Conclusion and Implications

The organizational profiles of project partners indicate that gender issues are relevant and present both formally in the organizations and in staff awareness and knowledge, particularly in terms of relevance of gender to polio eradication and the importance of gender equity in staffing. The TNA revealed overall strong self-assessments of respondents' capacities, as well as of their respective organizational contexts and addressing of gender-related issues. Further analysis will be required to better understand seeming paradoxes. For example, while in some cases the level of previous gender training was low, staff reported a relatively high understanding of gender concepts and capacity to integrate gender issues in their work. Similarly, while organizational policies and strategies to address internal gender issues seemed minimal, based on a limited sample of such documents, the promotion of gender equality internally seemed high.

Still, given staff awareness of gender barriers and the importance of addressing them in polio eradication work, particularly among project managers as revealed by the key informant interviews, there is a strong basis and potential from which to strengthen gender integration capacities. The introductory gender training provided by GenderTech is a start and will need to be followed up, particularly to address more hardened views of the limits of women's capacities, as revealed by some respondents.

The evidence review provides a number of areas for further consideration by project partners in order to further integrate gender issues in polio eradication. Broadly, these include:

Programming, data, and analysis

Efforts to systematically collect, analyze, and use polio and AFP data (qualitative and quantitative) disaggregated by sex and other factors (e.g., age, ethnicity, socio-economic background, and disabilities) whenever possible can provide a basis for identifying context-specific gender enablers and barriers. Using participatory methods in data collection, while ensuring equitable participation of women and men from diverse backgrounds, can contribute to community and women's empowerment.

Outreach and communication

Undertaking gender analysis of community engagement and social mobilization will support the development of gender-intentional outreach communication interventions that address gender barriers, such as literacy, and work within community dynamics. This can include ensuring the effective participation of women and men in the design, testing, and delivery of outreach tools and materials.

Capacity-building of CBO staff

GenderTech started the process of staff capacity-building, which lays the basis to extend efforts to other staff, as well as to deepen capacities targeted to particular project roles and needed gender competencies. Other mechanisms for support to gender integration may need to be considered, such as gender focal points, to augment capacity-building efforts.

Community-level staff

Working with women and men community surveillance workers/CHWs and front-line workers to undertake analysis of key challenges and barriers affecting their work will support addressing gender barriers, such as facilitating safe and convenient transport, capacity-strengthening and professional development (particularly in gender-sensitive communications), and safe work environments free from violence, harassment, and discrimination.

Annex A.

AFP Data for Chad, Cameroon, DRC, and Niger

The AFP data for Chad, Cameroon, DRC, and Niger do not show major sex-based discrepancies in terms of the number of polio vaccine doses received by children, or the timeliness of AFP surveillance. For example, in Chad in 2020, the percentage of zero-dose boys was 6%, while it was 5% for girls. Overall, 71% of AFP cases that were boys had received three or more doses of the OPV, compared to 76% of girls. Similar to Chad, in Cameroon, 89% of all AFP cases that were boys had received three or more doses of OPV, compared to 86% of girls. AFP data in DRC and Niger shows similar figures, while in DRC the proportion of children who had received three or more doses was lower (64% for boys, 62% girls) than in Niger, where 85% of boys and 88% of girls had received three or more polio vaccine doses. The percentage of zero-dose children in AFP cases in the four countries is between 2% and 9%, with no notable gender discrepancies.

Of all AFP cases in the four countries, girls made up between 42% and 46% of the cases, reflecting the regional average from 2019 and 2020 that shows that girls made up around 44% of all AFP cases in the WHO African Region. See Figure A-1.

FIGURE A-1: **2019 AFP data for Chad, Cameroon, DRC, and Niger**

Outcome	Indicator	Jan-June 2019		July-Dec 2019	
		Female	Male	Female	Male
CAMEROON					
Equal doses received	Median # doses F/M	5	6	4	5
	% F/M 0-dose	4.82	4.12	1.3	9.46
	% F/M 3+ doses	89.16	87.63	90.91	81.08
Equal timeliness of disease notification	Median # days disease notification	4	5	5	5
	% F/M <= 3 days	45.59	38.42	38.76	42.11
CHAD					
Equal doses received	Median # doses F/M	6	5	5	5
	% F/M 0-dose	0.78	3.05	0	0
	% F/M 3+ doses	95.35	92.07	92.37	91.5
Equal timeliness of disease notification	Median # days disease notification	5	5	6	6
	% F/M <= 3 days	34.81	34.06	30.32	30.04
DRC					
Equal doses received	Median # doses F/M	4	5	5	4
	% F/M 0-dose	4.23	3.84	6.23	5.23
	% F/M 3+ doses	81.73	80.06	79.49	80.32

Equal timeliness of disease notification	Median # days disease notification	6	6	6	6
	% F/M <= 3 days	30.05	27.22	28.64	27.84
NIGER					
Equal doses received	Median # doses F/M	9	10	9	10
	% F/M 0-dose	0	0.46	1.04	1.3
	% F/M 3+ doses	93.5	96.3	95.31	93.94
Equal timeliness of disease notification	Median # days disease notification	7	6	7	7
	% F/M <= 3 days	24.42	25	23.42	25.54

Source: GPEI Annual Report 2019

AFP data for 2020 for Chad, Cameroon, DRC, and Niger show no major gender-based discrepancies in terms of zero and 3+ dose children. Boys make up between 54%-58% of AFP cases in the project countries. (see Figure A-2). These are similar to 2020 AFP data for the AFRO region (see Figure A-3)

FIGURE A-2: 2020 AFP data for Chad, Cameroon, DRC, and Niger

2020	AFP cases Male	AFP cases Female	AFP cases Total	Zero dose Male	Zero dose Female	3+ doses Male	3+ doses Female
	Chad	537 (55%)	445 (45%)	982	32 (6%)	23 (5%)	389 (71%)
Cameroon	318 (54%)	274 (46%)	592	3 (9%)	4 (1%)	283 (89%)	235 (86%)
DRC	1812 (56%)	1410 (44%)	3222	99 (5%)	100 (7%)	1168 (64%)	878 (62%)
Niger	337 (58%)	243 (42%)	580	6 (2%)	5 (2%)	287 (85%)	213 (88%)

FIGURE A-3: WHO AFRO Region 2020

AFP cases Male	AFP cases Female
12820	9825
56%	44%

Source: WHO Gender AFP data dashboard, 2021