

Center for Strategic and International Studies

TRANSCRIPT
Online Event
“Overcoming Gender-Related Barriers to Immunization Services”

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FEATURING
Wendy Abbey
Technical Officer, JSI

Roopa Dhatt
Executive Director, Women in Global Health

Ellyn Ogden
Worldwide Polio Eradication Coordinator, USAID

Aboubacar Kampo
Director of Health Programmes, UNICEF Headquarters

CSIS EXPERTS
Katherine E. Bliss
Senior Fellow and Director, Immunizations and Health Systems Resilience, Global Health Policy Center, CSIS

Transcript By
Superior Transcriptions LLC
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Katherine E. Bliss:

Hello, and welcome to today's event on "Overcoming Gender-Related Barriers to Immunization Services."

I'm Katherine Bliss, senior fellow and director for immunizations and health systems resilience at the CSIS Global Health Policy Center. And it's really my pleasure to moderate this session today in which our four expert speakers will share their views on how we can improve health outcomes, particularly, access to and uptake of vaccines when we are deliberate in thinking about gender relations and how gendered expectations of social roles for men and women and beliefs about boys and girls shape access to health care.

Now, today is also International Women's Day with the theme in 2022 of "breaking the bias." Now, it's fitting that our panelists will also be talking about the ways in which forms of bias or discrimination against female health workers and discrimination against girls when it comes to vaccines play a role in undermining health outcomes.

We'll talk about what it means to examine data collection and monitoring of immunization services through a gender lens, and we'll discuss lessons the fields of child health and immunizations can learn from fields like family planning or prevention of mother-to-child transmission of HIV in thinking about gender in future programming efforts.

Now, here to share their views and expertise are Wendy Abbey, technical officer with the JSI Research and Training Institute in Accra, Ghana; Roopa Dhatt, executive director of Women in Global Health; Aboubacar Kampo, director of health programs at UNICEF; and Ellyn Ogden, worldwide polio eradication coordinator at USAID.

Now, we hope to have some time to address audience questions towards the end of this session. So please do use the "ask live questions here" button or box on the CSIS event webpage to submit thoughts or questions at any point during the conversation and we'll try to get to those at the end.

So, Abou Kampo, let me start with you. When health specialists talk about gender-related barriers to immunization services, what do they really mean? You know, are they referring to sex differences in immunization coverage or in vaccine effects?

Are they talking about cultural or social norms related to vaccines? And, you know, could you say a bit about how UNICEF is really seeing gender dynamics play out in terms of vaccine access and demand?

Aboubacar Kampo:

Thank you, Katherine, for the questions and thank you for having UNICEF with these other distinguished panelists for this very important topic.

Various gender-related factors on both the demand or supply side can affect the likelihood of childhood or adolescent immunization and also undermine sometimes immunization programs' achievements. Gender also interacts with socioeconomic factors such as wealth, education, ethnicity, or sometimes caste in some of the countries' regions, geographic settings, migration status, you know, to shape disparities and mediate, you know, immunization outcomes.

What do we mean by that? Some of the factors, you know, or side factors such as – needs to be taken to account. Mothers are typically the primary caregiver, you know, for the childrens. But their lower status in some countries, you know, in their households or in community limits their capacity to act on their own or on the child's behalf, whether or not a mother has the autonomy, you know, of making the decisions about taking the child for immunizations or any other services as well.

Poor health literacy can also impact, you know, the decision-making process of valuing immunization or any other health services. And then we have, you know, woman's experience of quality of services within the facilities themselves.

You know, when women are showing up at health facilities if the caregivers in the facilities have an inappropriate behaviors or not cautious behaviors might be, you know, influencing the decision-making process for womans to, basically, bring their childrens for immunization.

On the supply side, even though, you know, females present probably – I mean, womans are representing probably 70 percent of the work health force. They're still facing, even at their work, you know, multiple gender-related barriers, you know, such as, you know, fewer opportunities to make it to senior management and leadership roles, you know, which can also impact, you know, the mood of the healthcare workers themselves. Womans are also juggling between household and their professional responsibilities, which is not necessarily the case for men. We have gender pay gaps, you know, in some of the – some of the countries as well, and then there's as well the prevalence of sexual harassment or abuse of authority, you know, at the workplace as well.

So these are the kind of things which can – where gender plays a very important role of affecting immunization of childrens or the programs in itself.

I must say – and I'll put this a little bit in between brackets – you know, we have seen that the COVID pandemic, you know, even though that this is not a disease not necessary immunization itself, has affected woman more than men. You know, I think it was more likely that women will be losing their job

because of school closures. You know, it was also women who will be staying at home more likely than men to care for their childrens as well.

So I think the pandemic in itself, you know, has also been, you know, impacted on woman theirself. And this didn't really matter if they were vaccinated or not. You know, these are, really, just the outcome of the pandemic.

Nevertheless – and this will be my last point, Katherine – would be, we should also look at immunization program as an opportunity to enhance gender equity so not everything could be bad. You know, as I mentioned before, 70 percent of community health workers are woman who are critical to immunization programs. Sixty to 70 percent of health workers in facilities are woman, depending on which countries you are.

So investing in immunization programs will mean that we can put more community health worker – more health workers – actually on payroll so that they can earn a salary. And I think just putting them on their salary will give them – will give more womans, basically, the financial empowerment to be able also to be – probably enabling them to be much more part in the decision-making process, whether it's at the household level or whether it's at community level.

We also have seen quite a – very strong correlations when women do earn money that they are much more inclined of getting educated if they haven't been educated before because of the disparities within this – in the society themself, which will enhance, basically, literacy.

So I think investing in an immunization program could, technically, lead to a bit of more gender parity, gender equity, and not just better health for populations, which is notable, and, ultimately, lead, you know, to socioeconomic development.

So having programs with a gender equity perspective is, actually, in UNICEF eyes, extremely good for socioeconomic development and better health for everyone.

Dr. Bliss:

Thank you. I mean, so it sounds like, you know, we're talking less about any kind of sex difference in terms of reaction to vaccines and, really, much more about the receptivity – you know, being treated with dignity, you know, within the context of the health center that mothers feel comfortable bringing their children there, they're overcoming some of the transportation and financial barriers that may be in place at the household level to bring children into the clinic, but also that there's kind of a two-way street in terms of investing in health workers to improve service delivery but also

improving service delivery as a way of further investing in and to helping foster leadership and long-term career paths for those same health workers themselves.

Roopa Dhatt, you know, the organization you lead, Women in Global Health, really focuses to a very great extent on the engagement of women worldwide within the health workforce, and, you know, I wanted to ask you to, you know, talk a little bit about – you know, Abou has already, you know, begun to talk about the importance of investing in health workers.

But, you know, why is it important, in particular, to, you know, really invest in and develop career paths to retain female health workers, you know, over their period of professional development both in terms of services and, you know, in terms of the kind of messaging or, you know, advice that they can provide to families seeking to, you know, develop or access health services for their children?

Roopa Dhatt:

Well, Katherine, it's great to follow after Aboubacar because he's already stated some of the big numbers that I began with, which is when you take a look at the health sector and the health workforce, women are 70 percent of the health and care workers. So that means that they're critical at driving health services and vaccines and diagnostics.

But when it comes to community health workers, they are also – really need to be enabled with information, training, resources, so that they can deliver vaccines and diagnostics, and address both vaccine hesitancy and stigma around the disease status.

We know we're facing a lot of challenges when it comes to immunizations and vaccinations, and I know the panel will go into some of these things. But we also need to think about that women health workers are needed to reach women and children in their homes. In some settings, only women health workers can access women in their households to immunize children. In other cultural contexts, women may be unable to access care from a male health worker, so even in a public space.

So we really need to acknowledge that women, universally, as they make up half of the world's population in many settings, as already expressed, they're the key drivers of health in their communities. There are a lot of gender aspects to consider, and, you know, your question really probed on, you know, what are the working conditions.

So to give you some numbers here, when we take a look at the health workforce, there are physicians, there's nurses and midwives, and other health professionals who are recognized as part of the formal health workforce, but, particularly, in the space of immunization and vaccination,

we really depend on what are called community health workers. In most countries, they are not recognized as part of the formal health workforce. What that means is that they are not getting living wages. They're not getting opportunities for career development and, oftentimes, they're a volunteer cadre that are given stipends, and this also means that they're not getting the needs that many health workers already have unmet, that they are, you know, at the bottom of that pyramid when it comes to leadership and power in the health system.

So it means that many of them are working without the protection that they need. Access to personal protective equipment is the last – they're often the last to even receive vaccinations when – you know, when you take a look at the pandemic.

So they're working in very tough situations, and when you think about that we're depending on these community health workers who are often 90 percent if not a hundred percent women in most settings, we are asking the most marginalized women, the poorest women, to subsidize care and go into tough, hostile circumstances without protection.

I didn't even talk about the violence that they're facing. But we were starting to see already going into this pandemic reports of bullying, harassment, sexual violence, taking place for health workers and we know that into the pandemic they're facing even more and more of that.

So why do we need female health workers? Well, if we want to achieve the universal health coverage agenda, if we want to reach the targets we've set for immunization and just the more broader health agenda to achieve our sustainable development goal SDG 3, regardless of which health service, we do need our health workers.

But if we want them to be able to do their jobs and be supported, we really need to think about this as an entire ecosystem where it begins from training and investing but making sure that training and investing also matches with decent jobs and jobs that actually create what we call gender transformative environments, addressing the root drivers of gender-inequities, making sure that women health workers have opportunities for leadership.

I'm sure we're going to get into that a little bit more. But, really, even fair pay. We're struggling with equal pay in the health sector. Women currently earn less than men for the same work, but we also know that the gender pay gap is 28 percent compared to other sectors, which they tend to be around 20 percent.

We also, you know, talked about the violence aspect of it and this violence comes in many forms – physical, sexual, verbal. It's going up. Yet, very few

health systems want to even acknowledge this and address this, and then when we talk about the decent work agenda it also includes having workplaces that are free and, really, enabling to provide mental health support, having access to PPE.

So these are some of the issues that are needed to retain the health workforce and, currently, we're seeing a great resignation. This is a universal resignation that's taking place, especially in high income countries with a 20 to 30 percent of the health workers – majority women – saying they're leaving from the fields such as nursing, and we know that has implications on global migration and we know that health workers in lower and middle income countries are also leaving.

And so this ecosystem must address the gender inequities if we really want a workforce that can support and address the needs of our entire population.

Thank you.

Dr. Bliss: Thank you. So, you know, it sounds like we need to envision a move from a reliance – you know, really kind of using this volunteer group as the basis for health. I mean, really, create professional pathways for them to continue to gain training and to move forward in their work, you know, continuing to serve the communities where they are or, perhaps, moving if that is something that becomes available to them, really, supporting that engagement with health in a formal kind of way.

Dr. Dhatt: And, Katherine, if I could just chime in and really blast on that point, it's also a return on investment. When women are given decent jobs, we call it the triple gender dividend. There is a health return, so we achieve our health agenda and health goals, immunization in this case. We also see a gender dividend. So when women have formal jobs and they're part of the formal sector they have an increase in economic empowerment and that means that they're able to use their resources.

And the third part of it is it's also a development agenda. Every time you formalize and create a formal health job, it creates two to three other health-related jobs in broader economic growth. So, really, looking at this as not a cost but an investment and an opportunity for economic growth but in a gender transformative way.

Dr. Bliss: So long-term investments to retain and really improve gender equity and health outcomes in the longer term.

So, Ellyn Ogden, you have been deeply engaged on U.S. efforts to support immunizations, particularly polio vaccines and polio eradication, over the last 25 years, and I just want to ask you to reflect on how you've seen this

recognition or awareness of, you know, the links between gender and gender-related barriers to immunizations at the operational level change over time.

And, you know, when you think about operations, you know, with respect to delivering polio vaccines, for example, you know, why is it important to look at some of those activities, whether it's delivery of vaccines or collection of data or monitoring? Why is it important to look at those activities through a gender lens?

Ellyn Ogden:

Thank you, Katherine, and thanks for inviting me to participate on this great panel. I've been working in polio eradication for over 25 years and a lot of that has been spent out in the field actually observing polio campaigns and vaccinators going house to house.

It's been part of the micro planning and training. It's been looking at data and how you craft tailored messages to continue to reach more children and convince people. Vaccine hesitancy is going up, so understanding the drivers of that.

There have been many occasions where I've been in the field and the planning did not take into account the fact that we were working in conservative areas. So the majority of the workforce were men and they told me, I have refusal neighborhoods. So I said, take me to refusal neighborhoods. And we got the mothers to open the doors and explain to us that they were not allowed to open the door for men.

And so when I came back and debriefed with the ministries of health and other people, it really, over time, was a shift from 75 percent male workforce to about 95 percent women and that made a huge difference in our ability to get into the households and vaccinate children.

In many countries, there's a cultural practice of keeping newborns inside the house for the first 40 days. So in order to go inside the house and vaccinate children to make sure they get their early doses and their birth dose of vaccine, you really need women to enter the house and find the newborns, the sleeping kids, the sick kids, and if you don't have enough women vaccinators you lose that whole birth cohort. So that's become really important.

I mentioned messaging and communication. It's not enough to bring the vaccine to the family. The family also has to accept vaccination, and decision-making around getting a child vaccinated is the responsibility of both the mother and the father, and there needs to be a commonality of whether we're going to vaccinate or not.

And so our tailored messaging on why mothers may accept, fathers might refuse, or vice versa, we need to look at the data in more detail over what is driving their beliefs, who's driving decision-making, what really are the root causes of vaccine hesitancy, and using that data you can develop specific messages and develop community groups and work with religious and traditional leaders, work with sports figures, other influencers within the community, to try to make sure both mothers and fathers are willing to accept vaccination.

But if you don't collect the data in a way that disaggregates male-female answers to questions, their decision-making patterns, it becomes very, very challenging. We have also learned in polio – we do a lot of campaign monitoring between the rounds, after the rounds. We do lab-quality assurance sampling.

If your monitors are not women, they can't double check the work of the vaccinators by going into the houses. And so all of this adds up into our ability to have a true picture of what's happening if we don't appreciate the gender issues in data collection, in planning the campaigns, in looking at the workforce.

In more recent years, there's been a few other things we're seeing. As we shift to mobile money and other ways of paying vaccinators, there's often jealousies if the woman gets a cell phone or gets a bank account, and the husbands don't always appreciate that. And so there's quite a lot of discussion to – just to make it, you know, a thing that women can accept – their families can accept them to take this job because they get a little bit of status that other members of their household may not get.

We're also dealing with more and more violence against health workers. Many polio workers have been shot. Many of them have been targeted in killing women, and so that discourages them from participating not only in the mass campaigns but in immunization, in general.

And it's always been challenging for women to go out, say, on mobile clinics. If they have to stay overnight, there may not be a safe place or a place their families are comfortable with them staying. They may not have a bathroom. They may not have any privacy when they go out. And so, really, trying to make sure not just routine services, that mobile services or health camps or mass campaigns take into account gender is all going to – is very, very important for making sure we have the maximum uptake possible.

Dr. Bliss:

Thank you.

You know, so Wendy Abbey, you know, Ellyn has, really, outlined here some observations around the importance of, you know, engaging at the

community level, understanding what the customs and different approaches are, you know, at that and, really, undertaking that kind of micro planning to understand what messages may resonate and how a campaign, you know, may be likely to be successful or not.

I want to ask you, you know, drawing on your work with JSI in and around the Accra region in Ghana, what have you seen to be some of the most effective methods in the communities where you've been working for addressing gender-related obstacles to immunization?

And, in particular, I was going to ask you to say a bit about the role of trusted messengers, and, you know, to the extent that you can share messages or approaches that seem to work well and also just if there are lessons from other areas of engagement, you know, on gender and health, whether through family planning or PMTCT work or others that you've been able to incorporate in some of the efforts in Ghana.

Wendy Abbey: Thank you very much, Katherine.

Yes, we've had the opportunity to work with a lot of women, particularly, in urban populations, urban communities, and those found on the outskirts of Accra, and what we have – we found out is that it's important, particularly, on addressing gender-related bias to specifically look at community involvement, and so involving community leaders and traditional leaders in the conversation on immunization, most importantly, how they mobilize the community to make decisions regarding immunization services.

And so community involvement is important and engagement is very critical in terms of addressing gender-related bias and, particularly, because when it comes to health choices, they are known as the custodians of health in various communities. They determine traditionally what sort of response is required to address particular interventions when it comes to health needs and issues.

And so you can have a traditional leader who would double as a traditional medicine practitioner and would subscribe a particular treatment to a particular health issue. And so once you get these leaders in the conversation, mobilizing them, engaging them, and having them target their women for immunization services, then you are moving forward in terms of improving demand for immunization amongst women.

The other thing also is that within the specific areas, working with and, particularly, the Ghana Health Service, there's been a lot of push in, particularly, primary health care where what we'll call the community-based health planning compound, which is a chief's compound, has been instituted, and in this regard, you have community members opening up their doors to

encourage health workers to come into their communities to provide services and they sort of provide a cost share intervention for the services that are provided at the primary health care level.

And so you have, for example, a chief that would open up his space, use the palace as an outreach center for child welfare clinics. You would have an assemblyman, for example, deciding to provide logistics, provide chairs and canopies, for community members to access services. And so this level of interaction where community leaders are highly engaged becomes critical in addressing the gender-related issues.

We have also learned that, particularly for JSI, bringing innovations around using human-centered design approaches to address immunization service experience amongst these women. Particularly around second year of life immunization and recently on COVID-19 vaccination, we have involved a group of teenage girls who work within the Accra metropolis and some of the business capitals around the country to be involved in micro planning together with district health officers.

So we are talking about young teenage girls who cart food to the markets being invited to sit with health workers to discuss the various barriers to accessing COVID-19 vaccination. For example, some of them who mentioned that they have not heard any jingle or awareness-raising information on COVID-19 in their local language, and so they are not aware that services are targeting them.

We have mothers coming in to tell us that in their particular communities they are in, in the greater Accra region for example, they have community male leaders who would have to give them permission to go for services. They even have older women who will determine at what point they take their children to get immunized.

And so this kind of structure has been translated or transported from their original communities into the central business capitals and they continue to move in this direction. And it's influencing their choices and decisions when it comes to health services, generally, and then immunization services.

And so bringing them around the table, targeting the caregivers themselves, using the people-centered approaches such as human-centered design, community appraisal approaches, coming – calling them onto the table – around the table to engage in discourse, how to reach their own peers, has become one of the tools we are using.

And, of course, what we call the peer-to-peer learning or peer leadership. And so we have kayayei, or young women, who will take up vaccines or other health services. And, for that matter, they will end up showing for it, telling

and showing their compatriots that, look, I have a healthy child I've given birth to and I've been able to manage the health of this child over a long period because I've been involved in following the routine immunization services.

And so we have these young ladies being involved in orientation on immunization services within the JSI intervention and getting them to be involved in peer education of their own compatriots. And so we are taking some of these learnings, for example, from the family planning interventions we have in Ghana, particularly, around use of contraceptives for young girls and seen a lot of – we've seen a lot of peer education ongoing.

There are other interventions, for example, male involvement, where male partners have been asked to set up their own groups to encourage each other and to discuss the various barriers they face as males in supporting their spouses to go for services.

There have been situations where jingles have used – over the period have used male voices to produce jingles in some health intervention such as family planning and HIV/AIDS, all in the name of portraying that men can support their partners to go for immunization – sorry, family planning services, HIV/AIDS, or mother-to-child transmission services and all that.

And so it is critical that people-centered approaches are used. We do more targeted outreach, just reaching out to these women in their various communities. And I must add that there's also the need to invest a lot more in these interventions. Most of the women in the community appreciate interpersonal communication where they are opened to conversations around having a female worker coming to them and having discussions with them.

And so we have a lot of community health volunteers being women who are taking the initiative to volunteer their time and support primary health care services including immunization services to their communities to get these women to access services.

And so I must say that these are the approaches we have learned and we are using in the various areas we are working with, and we know that once investment is made in this direction, there's potential to have a lot more women come in to play their role and then also to get them to be the advocates for immunization services in their communities.

Dr. Bliss: Thank you so much.

Aboubacar Kampo, let me turn back to you for a second. You know, we've really been talking to a large extent – not exclusively, but largely – about

routine immunizations for children so far in this conversation. But, you know, UNICEF is also very focused on procurement of COVID-19 vaccines and, you know, supporting many of the different efforts within the ACT-A process and others in response to COVID.

And so I wanted to ask how, you know, UNICEF is working with countries, if you could speak of it, to – in the – any – the efforts to help countries be aware of possible gender disparities. You know, we know that women have been a little bit less likely than men to access some of the COVID vaccines in a number of countries. And how has the organization really had to adapt, in some ways, to think about working with adults as well?

Dr. Kampo:

Thank you. Thank you, Katherine, for these excellent questions.

I would like, maybe, to tackle it from two fronts because I think whatever – you know, sitting on this panel here, I'm actually realizing that, you know, the real agents for change are the woman on this panel here who speak much more eloquently about the immunization program than I do here.

I think what Ellyn just has said and Wendy and also Roopa, I think, makes perfect sense and it doesn't really matter if it's just for adults. I know we know that – or for children. I think the principle is still the same. It doesn't really change for immunization.

I would even say, you know, when it comes to supply side, in particular, for COVID-19 vaccines, we have looked at total populations and the number of people which needs to be vaccinated. So we didn't necessarily have agenda issues when it comes to the quantifications in terms of commodities and so on and so forth.

What really matters is not the immunization activity in itself, and as it was explained, it's, really, going from the concept that you need to work with communities so you have this acceptance.

I mean, Wendy laid it out, I think. You can't do the planning just outside without the community because there are really dynamics which exists within the community which needs to be taken into account and you need to listen to those communities to really make sure that those who should be receiving the vaccines can access the vaccines, based on the dynamics which – basically, which exist within those community themselves. This is why we are engaging – this is why we haven't done something more for the COVID-19 vaccines, in particular, but we have applied this same principle as what we're utilizing for children because the dynamic is exactly the same.

So what did we do? I think, for any services in regards to health, I think, in the long term we need to think long term and not just to address the COVID-

19 pandemic. We need to advocate for more educations for girls so that they'll become literate adults – (inaudible) – because this matters. It makes a difference in terms of attitudes towards health services in itself.

But then for the different campaigns in those countries for increased – to increase the demand of COVID-19 vaccines and reduce hesitancy, in particular, yes, we had to go out to community leaders, discuss with them, look at their dynamics. They will then give us the roadmap of what can be done.

In those discussions, we will – we have been highlighting the issues in terms of what about woman, what about girls, those who are – should be accessing those vaccines, how should we be going about it. It is about, you know, really listening to those communities.

Now, it's also important to understand that in many of those communities which Ellyn has referred to or Wendy in Accra, you know, immunization might not be the number-one priority. You know, they might be coming up with something completely different, and this needs to be taken to account.

So if water is a problem, you know, we need to somehow discuss the water issue, somehow bring a solution towards this. And then we have those communities who have been disenfranchised for a very long time, which is even more complicated, because you have more suspicions in those communities. Just vaccinating or just bringing up agenda – the agenda issue might not necessarily be helpful.

So we need to be really listening to those communities and addressing multiple fronts. So this is where you see in some instances where we come in with a different program which has nothing to do with immunization, but this is the opener. It's the door opener for us to bring, basically, immunization services as an additive later on in the discussion.

So I think it is about communication, it is about education, and I really liked the last point from Wendy. You know, a lot of work which woman are doing, you know, for immunizations, the broader agenda, not just COVID-19, is voluntary work, and this is why I say there needs to be bigger investments in the health sectors.

I mean, this is – we are asking for some of those volunteers to do full time jobs and, yet, we do not want to remunerate them, and that's very discouraging. And, yet, then you have males or men in the same position who are growing in their positions, getting to higher positions within the health system itself and getting better paid.

This can be frustrating. It's not helping in the – I mean, the immunization agenda or the health agenda at all. So I think we need to think a little bit bigger, you know, and I really go back to the message investments in health matters. It is not just for better health. It is an insurance for the future. It creates bigger dividends, as Roopa said, in terms of gender dynamics and as well as socioeconomic development.

So just going back to your questions, we just emphasize on the points which Wendy and Ellyn has been saying. That's exactly how we are approaching immunizations. Also, for COVID, we haven't done anything special. This is the basic which needs to be applying to really bring out the gender dynamics, whether that's for COVID or that's for routine immunization.

Dr. Bliss: You know, this issue of community engagement has come up, you know, and several of you have spoken and, Wendy, I want to come back to you for a second here. You know, you've talked about, in particular, engaging with the kayayei around Accra and some of the other major cities in central Ghana and, you know, really, this kind of micro level planning to understand local conditions and, really, kind of provide tailored approaches.

But I just – you know, I wanted to ask, as we also think about this period that we're in where we're trying to scale up delivery of COVID-19 vaccines very quickly, also trying to kind of close the gap in terms of some of the losses with routine immunizations over the past couple of years, is there any tension between these kinds of micro level tailored approaches and this push to scale services? And what are some of the ways that the important qualities from that kind of intense community engagement can inform district, regional, and national approaches?

Ms. Abbey: MS. ABBEY: Thank you very much. Yes, most communities or districts – (inaudible) – have been innovative to extend services beyond their normal working hours.

(Audio break.)

Dr. Bliss: I'm afraid Wendy may have frozen for a second, so maybe we'll come back to that. We'll come back to that.

Oh, there you are.

Ms. Abbey: So, particularly, in Ghana you have immunization– (inaudible) – the economic activities, they will tell you that they can only be available – (audio break) – to actually juggle their timetable or schedule – (inaudible). And so there's a lot of attention at issue in terms of managers at that level trying to develop their own schedule while having in mind that they need to stay

within the status quo of working five days in a week. And they are doing their own – they're having their own innovations in order to make room for these women in their communities because they actually form parts of their targets – their large targets in a particular period.

And so they are making the innovations on the smaller scale within particular health service – health centers. But then the challenge now is how do we extend this to other parts of the country. We have such women and others in the business – central capital business cities where there's a need to involve other partners, especially looking at how to engage policy around this population.

And so specific communities, together with health directorates, are innovating to get services to these women. But then on a larger scale, much is not done about it. And so the position would be that we look at how to invest in evidence to show – the evidence generation to show that once we have these innovations happening at this level of service delivery there is a need to have a policy direction to it where there's a public service initiative to expand services formally and adjust services to fit into the schedule of these populations and other women who needs them.

There's also the need to ensure that a lot of communication, awareness raising goes on around this to highlight the needs of these women in different communities. Most often then not, when comes to immunization services or even health services, they are often not targeted. And so, for example, like I mentioned, a COVID-19 vaccination microplan actually helped, for example, using human-centered design. They were not around the table, whether districts or directorates.

And so once there's a policy direction in that regard, you have district health management teams coming into play to have discussions with service providers. You have the populations themselves being invited to discuss the different initiatives in order to reach their compatriots with services.

And so this is a way to look at it, having evidence from the small pockets or locations that this innovation is happening and to inform policy decisions or actions around this area so that we can upscale the intervention, because it is working and we are noticing that even with small interventions coming from partners like JSI and all that we are seeing some improvement happening in these particular locations. And so there's a need to generate more evidence and then inform communication around this to get the needed policy direction in that regard.

Thank you very much.

Dr. Bliss: So going from kind of the local and district level to kind of a more global sense, you know, Roopa, let me turn back to you for a second.

You know, you've talked about the importance of, really, supporting female health workers with equal pay and career incentives to help strengthen outcomes. But I want to ask you to kind of look into the future, if you will. Look into your crystal ball.

But, you know, if we were to, really, take – use – apply a gendered lens to pandemic preparedness and, you know, really, thinking about some of the issues that we've learned during this current pandemic around vaccine hesitancy, around immunization services, and the like, you know, if we were to, really, seriously apply a gender lens to some of those questions of preparedness, what would look different? What would things look like?

Dr. Dhatt: Thank you.

Well, there is so much I'd like my crystal ball – (laughs) – to be able to say and predict. But I'm going to really focus on three key examples. Laying down what our current pyramid looks like when it's women leading in global health, we know 70 percent of the health and care workforce are women. Only 25 percent of senior leaders in global health are women.

When we take a look at what's happened during this pandemic, women expertise has been sidelined, and, currently, if you look at COVID-19 task teams from around the world, Women in Global Health did a survey looking at over 115 task teams and found only 5 percent of them had gender parity.

And so I'm telling you what the grim picture right now is. But let's now imagine, as we are reflecting on International Women's Day – at Women in Global Health we're calling for a year of action to achieve gender equality – I really imagine and – what it would look like if we, truly, had women from diverse backgrounds, women from Global South, lower and middle income countries, from diverse backgrounds even within those countries, at leadership influencing decision-making at all levels – global, regional, national, subnational – because it is really looking at the ecosystem that drives the health agenda and health decision-making.

There are three things that I know would be different. The first example I want to give is that during the pandemic one of the top services that were stopped was family planning and access to family planning services. Women, regardless if you were in Germany or in West Africa or Nigeria, were told to give birth at home.

So fast forward. If women were at decision-making at all levels of health systems, I'm confident that sexually productive health services, family

planning services, access to maternal and neonatal care, would not have stopped at any point in time.

The second example is related to looking at how health systems are designed for men by men and not for women. We've heard other panelists give really concrete examples of in country. But if you look even universally, we just did a survey at Women in Global Health looking at personal protective equipment and we found, looking at a survey that had over a thousand responses from around the world from women health workers, less than two-thirds of them reported that majority of their PPE was actually not fitting for their body. So PPE was not being designed for female bodies.

That's an example of how health systems continue to fail to recognize a majority of their health workforce are women. So when they are ordering protection, they're ordering it in ill-fitting sizes, not designed for female bodies, female hygienic needs.

And so in a future forward-looking crystal ball, I would imagine that women leading at all levels, especially when it comes to looking at the supply chain and procurement of PPE, that we would, truly, have PPE designed for women, enabling and protecting them.

The third example I'd like to really pick on is the broader issues of how women have been facing the pandemic. We've heard examples of women being – you know, facing increased amount of violence – gender-based violence has increased in society – but also the care responsibilities have increased for women, and women health and care workers are facing not only a shift at the hospital or a double shift at the hospital, but a triple shift at home whether they're just taking care of children, elderly people, or community members. We know that they have left the workforce in higher numbers. Many of them are part time positions, increasing their vulnerability.

In a forward future outlook, women leading would be able to create the enabling environments to support women to be able to take care of their care responsibilities, to work on transforming gender norms so that care is, really, seen as everybody's responsibility, not just women but that of all genders, and, really, all of society – whole of society seeing care as a critical aspect of supporting their people, and we know we're far away from that.

So if I have to say, those are the three examples, and we know that when women are in leadership roles they are going to be putting forward greater investments into social protections. They're less likely to have divisive approaches to communication. They're more likely to build a public trust, and many of these learnings have been captured when you take a look at,

you know, studies that have looked at how women that have headed the pandemic response have done.

Unfortunately, when you look at the numbers, very few women have been able to lead a COVID-19 task team at the national level. We're very fortunate that we just had our managing director join us at Women in Global Health, who is one of the few women who leads the COVID-19 response in Guinea Bissau. But I've been told that there's 18 countries right now that currently have all-male COVID-19 task forces leading the pandemic response. So we must change that.

And at the global level, WHO's governance system, which is driven by member states – countries – just announced their international intergovernmental negotiating body for pandemics and only one out of six positions are occupied by women. So I'm really worried about this future. It looks grim unless we actually are intentional and use intentional policies such as quotas and, really, those of you tuning in, our government leaders, don't just have it as a passive policy. Make it part of your diplomacy. Make it part of your programming. Set the quotas and ensure there's diversity at every level of health decision-making.

Dr. Bliss: Well, thank you. I mean, it sounds like really focusing at the country level and encouraging that internal debate and then discussion with international partners can be a helpful way to continue moving this conversation.

Ellyn Ogden, you know, I want to come back to you. You know, USAID and other organizations internationally are trying to move, you know, further toward a kind of localization agenda focused on community engagement, empowering and working with local organizations.

So I wanted to ask you to reflect on the lessons from addressing polio and gender relations at the community level that can inform that kind of localization agenda and, you know, to reflect, more broadly, you know, just in terms of where you see U.S. support – United States government support – for immunizations and primary health care kind of more broadly taking gender relations into account as future policies are developed and implemented.

Ms. Ogden: Thanks, Katherine. That's a great question, and my first point will – I think, will also answer one of the questions in the chat. You know, USAID has been supporting a network of civil society organizations to work in polio for the last 23 years, and we work with international NGOs as well as civil society groups at the community level. We've worked in about 12 countries so far, and we're in the most remote and most difficult and challenging places.

And one of the early things that we learned was that, you know, when we saw discrepancies in the data we would ask the people that worked in our community projects why did we see differences, and for the most part, in routine systems there weren't a lot of differences between boys and girls getting vaccinated.

Where we saw it in campaigns, believe it or not, it wasn't that there were more boys being vaccinated but there were more girls being vaccinated and that seemed odd to us. So we started to ask the questions. What they told us was that if there was any fear about the vaccine, if it would sterilize or harm anybody, they would prefer to give up their girl children for vaccination than their precious boys.

And so it raised to us this whole issue of really understanding the role of gender and how you interpret data and analyze data and how important it is to understand from the communities what the context and the dynamics are for understanding what's happening.

We have relied very heavily on our local immunization teams and civil society groups out there. They are our best communicators. They are often illiterate. They are, predominantly, women. It is very challenging, even though we have their best interests, to try to get them into paid positions. It's extremely difficult. But, yet, they are an important adjunct to the formal health sector and are really doing a remarkable job building trust in communities and explaining and answering people's questions and bringing in influencers.

That kind of localization and detailed knowledge settlement by settlement, household by household, is, increasingly, important if you want to break the stagnation of immunization coverage, whether it's through routine or campaigns, really, truly understanding what are the drivers of acceptance and access.

At the global level, we are taking this new partnership initiative and trying to work with civil society and local groups even more. It's, increasingly, successful in our malaria and HIV programs. We are holding our implementing partners accountable. They all have gender equity in policies. We ask them to report on it. We want to see how much funding is going to it. We are trying to hold feet to the fire.

At the more global level, we're trying to encourage, and more than encourage – we're actually trying to embarrass them, to a degree, to get more women on technical advisory committees and in those middle and senior management positions. It is a constant struggle but one that we are very aware of and working actively towards.

You know, these are some of the ways that U.S. aid is working. But we are very, very serious about it and working with all partners to really make a difference, and thanks to everybody on the panel for their hard work on this.

Dr. Bliss: Well, thank you very much.

You know, we're getting close to the end of our time here. And, Ellyn, thank you for incorporating. We had a question that had come through the chat, you know, on some of these differences, you know, in terms of access. So thank you for putting that forward.

I just – as we wrap up, I want to ask each of our panelists to kind of think ahead, I guess. You know, we're two-plus years into this pandemic with all of its different implications for adult vaccines, COVID-19 vaccines, but also the impacts that we've seen on different immunization programs.

And as you look ahead – let's look ahead another year or so into the future – what would be sort of one measure or one indicator that you would hope to see that, you know, really, taking gender into account had removed, you know, some kind of obstacle? What would be a positive indicator you would see, you know, a year into the future that things were going in the right direction as far as gender and immunization programs?

Aboubacar Kampo, let me start with you.

Dr. Kampo: Thanks, Katherine, for the question.

So I don't think that I have just one indicator. I would have a couple of them, you know, which – I mean, I think if you could have maternal mortality as one of the markers, you know, for measuring health systems, you know, this would definitely trigger quite a number of additional responses – how we look at the health system as a whole and, definitely put, you know, more agenda focus of how we should be, basically, addressing maternal mortality. That would be number one.

And then the second one for me is, really – I said it before but there needs to be more investment into the health sector. More investments, for me, means that we are able to put – you know, whether you're literate or not literate, if you're working for the health system you should be receiving equal pay for the work which you are doing, and I think if we can achieve those two things, not only we will be pushing the agenda for immunization but we will also, you know, push the agenda on gender equality, equity, polity. You name it what you want.

But I think, for me, these are key essential things. If we can make a very strong push on that, I think we will be in good shape for a better world.

Dr. Bliss: Great. Thank you.

Wendy Abbey, what are one or two indicators that you would see as showing that we've moved the bar in terms of gender and immunizations?

Ms. Abbey: Right. Thank you very much, Katherine.

I would want to see increase in female representation when it comes to co-creating interventions and designing these, particularly, to reduce zero dose and under immunized children, and so we have a lot more females welcomed around the table to have discussions around how to reach under immunized children.

And, secondly, I would want to see that there's a lot of partnership with trusted local organizations who have expertise at the community level and district levels, working with these women, having a lot of investment with these women in local organizations, women-led organizations, actually, working in these communities to support us which children who are under immunized and for us to reduce zero dose – target zero dose immunization.

Dr. Bliss: All right. Thank you.

Ellyn Ogden, let me turn to you. In one year from now, what would be a clear indicator to you that polio eradication and immunizations, more broadly, were really taking gender issues into account?

Ms. Ogden: Oh, my goodness. In polio eradication, I would definitely like to see more women in senior and middle management positions. I think they're well represented at the local level and in immunization programs. My thoughts were actually more broad in thinking about COVID and a little bit more broadly. We need more data – more disaggregated data on who is missed and why. We need evidence-based approaches to design our interactions and communications and to be effective. Who are our best communicators? What are those specific messages? How do you tailor things? And we don't really have the data to do that yet.

And maybe thinking beyond a year or two. I mean, ultimately, all of these interventions would result in reductions in morbidity and mortality. So to the extent that our surveillance systems and our broader health systems and metrics are actually reflecting our investments, vaccination along the life course, being successful means all of the things people have talked about today are happening and being done well and with quality. You know, it would add up to significant reductions in morbidity and mortality for women over the next, you know, generation.

So I'd like to think even beyond the next year. Over.

Dr. Bliss: Right.

Roopa Dhatt, over the next year and beyond, what would be two or three key indicators that, you know, things are really moving in a direction of better taking gender relations and gender equality into account when it comes to immunizations but, you know, the COVID situation, more broadly?

Dr. Dhatt: And Katherine, it's always a great panel when your co-panelists have said everything you'd want to.

But in a— bringing it all together, I'd say we need women to lead the health systems they know best. We can't go back to gender inequity as usual. We can't afford to lose a single health worker. The shortage is 18 million health workers. So looking at that indicator, what I would say is we need a new social contract with safe and decent work where women have an equal say in leadership. So I'd like to see women in equal numbers have decision-making at all levels of health systems but also global health, governance, and decision-making.

We must see an end to unpaid work. Currently, women provide \$1.5 trillion U.S. annually in unpaid work. I'd like to see that number reach zero, and this is essential for us to achieve universal health coverage, to have global health security, pandemic preparedness and response, and as we've talked about today, it's critical to achieving the immunization agenda.

Dr. Bliss: Well, Aboubacar Kampo, Roopa Dhatt, Wendy Abbey, and Ellyn Ogden, thank you so much for joining me today on International Women's Day to discuss gender-related obstacles to immunization services.

It's been a pleasure having – learning from you and, really, benefiting from your expertise and real experience in the field and, really, thinking about these issues at a broad national and international level as well.

I want to thank Mackenzie Burke from the CSIS Global Health Policy Center, and Mary Wright and Stefan Welsh from the CSIS audio/visual team for their help today.

And we are adjourned. Thank you all very much.