Gender Equality, Disability and Social Inclusiveness (GEDSI) Mentoring Session

PacMOSSI
Maxine Whittaker
June 12, 2025

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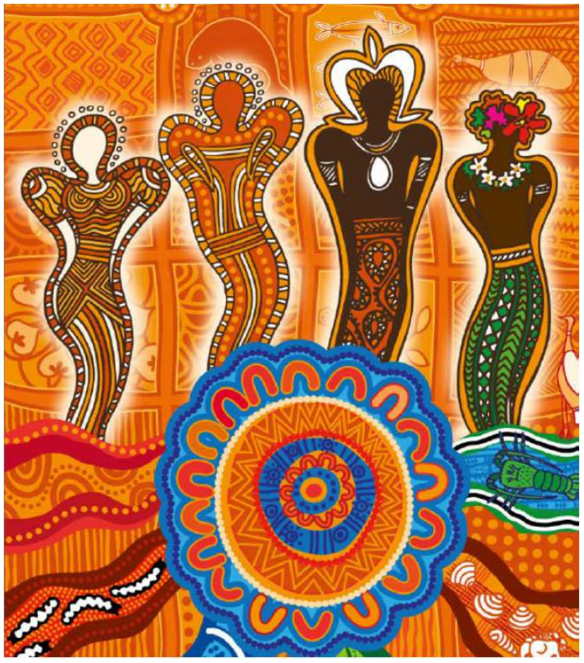

Acknowledgment of country

This original artwork was produced by Gilimbaa. Gilimbaa is an Indigenous creative agency accredited by Supply Nation.

https://nacchocommunique.com/wp-content/uploads/2016/11/natsihp-health-plan.pdf

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INCLUSION AND ACCESSIBILITY

- Please keep yourself on mute and video off if not speaking.
- Encourage use of video if you are speaking.
- Raise virtual hand if you wish to speak.
  - We will create pauses during the Q&A session to allow those without access to the raise hand function to take the floor.
- Introduce yourself before speaking.
- We welcome the use of the chat function – but reminder it won't be accessible to all.
  - We will read the chat aloud in addition to other visual content.
- Open (virtual) door policy.
- Recording and transcript will be available.
- If you experience any accessibility challenges, please reach out directly and we will seek to resolve as quickly as possible.

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Key issues that you would like addressed?

Open discussion/chat

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Today's session:

- Definitions Unpacked
- Frameworks
- Why GEDSI in VBD programmes?
- Exercise : Causes of delay
- Review GEDSI and barriers in VBD management
- Exercise: Approaches to address the GEDSI linked barriers
- Review : Approaches to address the GEDSI linked barriers
- Brief discussion : what does this mean for your work?
- Review findings of Survey
- Brief discussion: implications for work and workplace
- Open discussion

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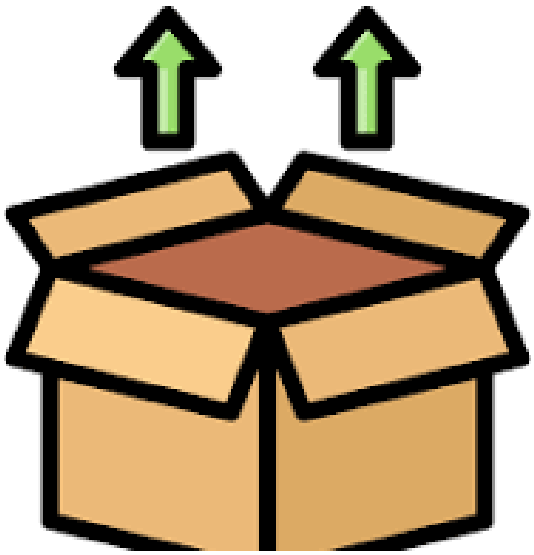
Definitions Unpacked



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Definitions

Gender: Gender: social, psychological, cultural and behavioral aspects of being a man, woman, or other gender identity; refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.
https://web.archive.org/web/20170130022356/https://apps.who.int/gender/whatisgender/en/

- **Persons living with disabilities** include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. 1 in 7 people living in the world have a disability
https://www.skillcast.com/blog/12-notorious-uk-discrimination-cases)

- **Marginalized groups**: Marginalized communities, peoples or populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions e.g.. poverty, ethnicity, literacy, remoteness (Ref: Glossary of essential health equity terms. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.)

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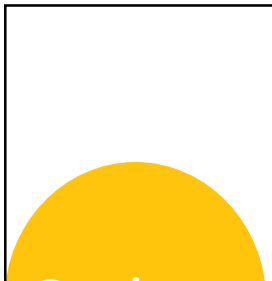

Source: WHO 2022 Inequality monitoring in HIV, tuberculosis and malaria course

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What is disability?

- "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

- **Physical:** performance of body functions e.g. walking, moving arms and legs, using hands, etc. *e.g. spinal cord injury, cerebral palsy, amputation*
- **Sensory:** seeing, hearing or communicating. *e.g. people who are Deaf, hard of hearing, blind or have low vision*
- **Psychosocial:** chronic severe mental disorders or psychosocial distress. *e.g. schizophrenia, depression, bipolar*
- **Intellectual:** language, reasoning, memory, personal care, etc. *e.g. Down syndrome, cognitive impairments/brain injuries*

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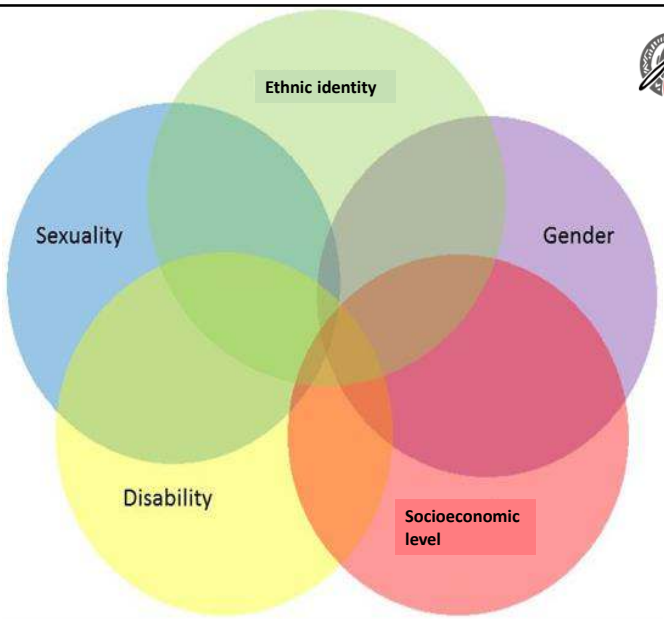
Remember intersections

Gender may be a cause of inequity compounded by other factors such as ethnicity, disability etc.



Modified from :https://www.womankind.org.uk/intersectionality-101-what-is-it-and-why-is-it-important/#:~:text=Intersectionality%20is%20the%20acknowledgement%20that,orientation%2C%20physical%20ability%2C%20etc.

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Disability is diverse

- People with disabilities are not all the same:
  - **Disability is diverse** - it can change over time and is different for every individual
  - **Disability can intersect with other identities and compound marginalisation.** For example, women and girls with a disability who live in poverty face triple discrimination: being female, having a disability and being among the poorest of the poor
  - It is important to **consult widely** to understand the diversity of experiences and barriers faced

Image: https://www.coe.int/en/web/campaign-free-to-speak-safe-to-learn/tackling-discrimination

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Frameworks

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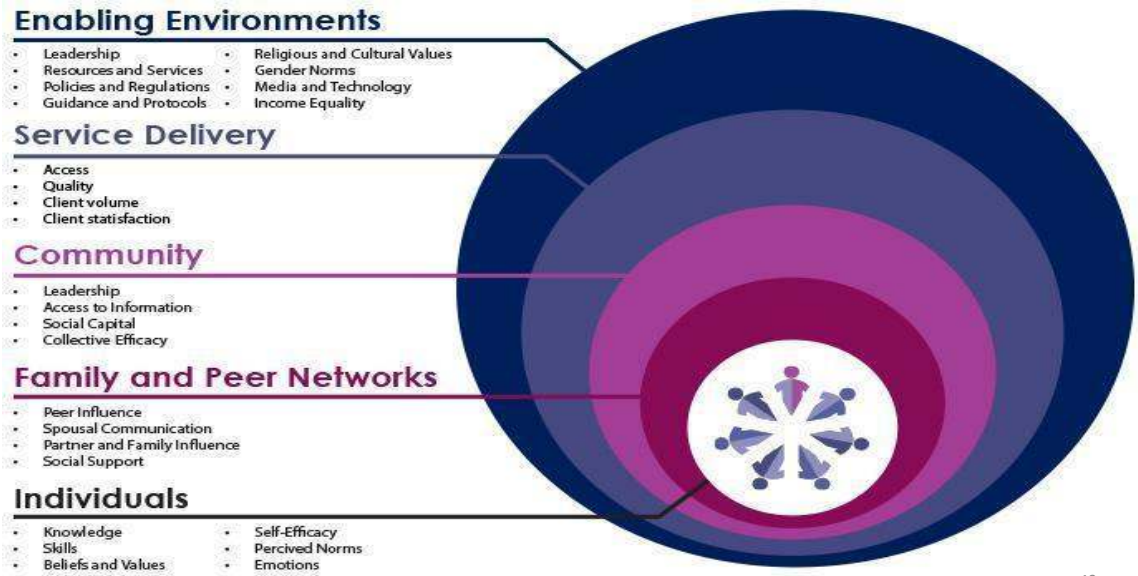
Socio-ecological model: framework for prevention

https://sbccimplementationkits.org/gender/sbcc-gender-models-and-frameworks/



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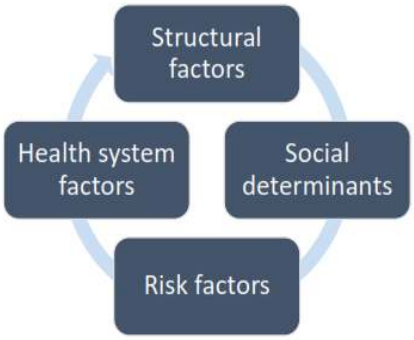
Contributing factors to health inequities

1. **Structural factors:** Stigma, discriminatory socioeconomic policies and practices.
2. **Social determinants of health:** Poverty, lack of education and employment, poor living conditions and violence. Impact of climate change.
3. **Disease risk factors:** low physical activity, drug and alcohol use, poor diet – and exclusion from public health interventions.
4. **Health system factors:** Barriers across the health system building blocks, such as lack of knowledge, skills, and competencies among health and care professionals; gaps in health insurance coverage; and poor disability data disaggregation.



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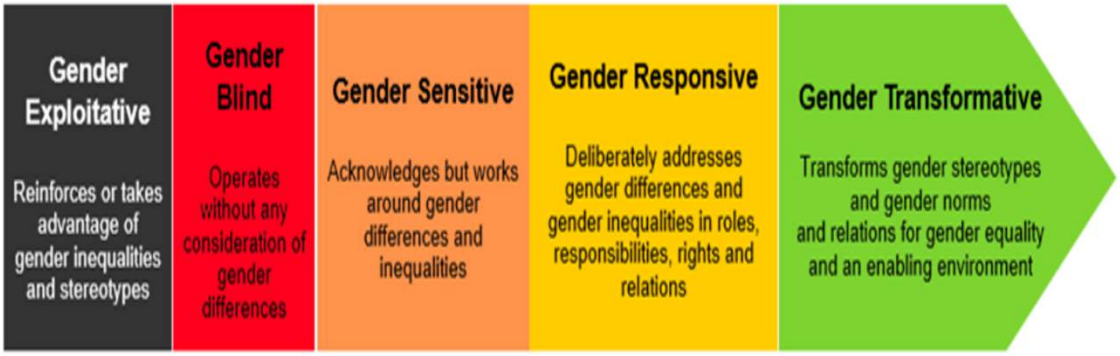
Gender blind to transformative spectrum
https://gendercoordinationandmainstreaming.unwomen.org/gender-marker-implementation-unicef



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Meaningful community engagement spectrum

- **INFORM** • Provides communities with information about intervention (one way communication)
- **CONSULT** • Information or feedback from the community sought, establishing some connections in the community
- **INVOLVE** • Community are involved in multiple aspects of the intervention, and the partnership visibly shows established cooperation between community and implementers.
- **COLLABORATE** • A trusting partnership is formed, with the community engaged on each aspect of the intervention (development to evaluation), with bi-directional communication
- **EMPOWER** • Highest degree of participation wherein communities collectively gain control over the actions and decision in the implementation process, taking control over the final decisions made, based on strong partnership structures and strong bidirectional trust between communities and implementers.

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The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life than impact health

Social determinants of health

SOCIAL DETERMINANTS OF HEALTH:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality

Source: WHO 2022 Inequality monitoring in HIV, tuberculosis and malaria course

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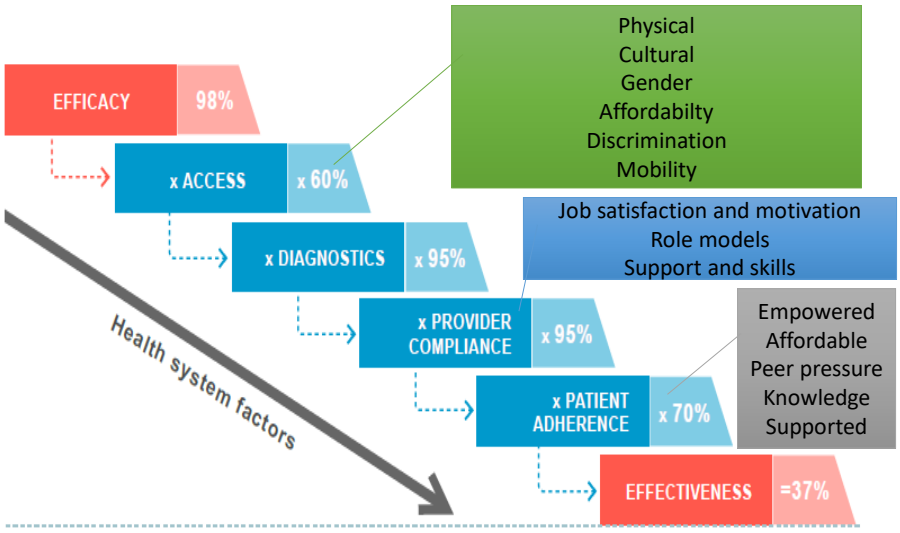
Health system and malaria



Effectiveness decay. (Modified from Source: The malERA Refresh Consultative Panel on Health Systems and Policy Research (2017)

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PacMOSSI Program Logic

DFAT Goal:	Pacific and Southeast Asian countries deliver better health outcomes for all						
Objective:	Australia is a trusted health partner in the Pacific and Southeast Asia, with stronger institutional linkages and high value placed on our public health expertise						
PacMOSSI goal:	To support Pacific Island Countries (PICs) to strengthen *vector surveillance and control* to prevent, contain and control mosquito-borne diseases to improve the health and wellbeing of communities						
End-of-program outcomes:	**1. Workforce development:** Vector surveillance and control staff form a cadre of skilled, equitably balanced, women and men professionals by end of 2027.		**2. Translation into policy and practice:** Partner country annual workplans are based on local knowledge and best-practice strategies that are GEDSI equitable.		**3. Enhanced vector surveillance and control:** Vector surveillance and control programs have enhanced capacity to protect all at risk populations including socially disadvantaged groups and people by end of 2027.		
Inter-mediate outcomes:	1.1 An equivalent number of women and men MoH staff are trained in vector surveillance and control operations using a sustainable online platform	1.2 Vector surveillance and control women and men staff and leaders are developed with practical hands-on training	2.1 Improved knowledge that optimizes the delivery of locally-adapted vector control	2.2 Country policy and strategies is aligned with WHO best practice to achieve equitable and inclusive coverage of effective vector control interventions and legitimately reflects specific requirements of socially disadvantaged people and groups	3.1 Vector surveillance and control operations are effectively led by women and men MoH leaders	3.2 Enhanced community engagement to provide equitable vector surveillance and control to all at risk populations including socially disadvantaged groups and people	3.3 Vector surveillance and control data proactively used in management
Outputs:	• Accessible online training provided to an equivalent number of women and men staff	• Practical training of women and men MoH staff provided through face-to-face workshops that build regional leaders	• Operational research supported to document the effectiveness of recommended strategies	• Country partners mentored to update strategic plans consistent with results of operational research and WHO best practice and are GEDSI equitable	• MoH led entomological surveillance is enhanced by mentoring and support • Effective proactive and outbreak vector control is enhanced by mentoring and supported	• Community-led citizen science model deployed • Proactive vector control that actively engages the at-risk population including socially disadvantaged groups and people is supported	• Vector surveillance data is efficiently managed electronically • Vector control stocks are effectively managed electronically
Program design outputs:	Strengthened partnerships and implementation adapted to country needs • Active network of vector staff engaged and provide feedback on country needs • Face-to-face meetings to exchange knowledge and provide feedback on the PacMOSSI program design and M&E framework				Vector surveillance and control capacity and equality of PICs is defined • Vector surveillance and control capacity is defined • The barriers and norms that restrict equitable and inclusive deployment of vector control are defined		
Cross cutting themes:	Community engagement	Gender equality, disability and social inclusion (GEDSI)		One Health		Climate change	
Consortium inputs:	• Existing online PacMOSSI training curriculum and knowledge regarding successful program implementation • Large and active network of partner countries and implementing partners experienced in building capacity • Significant in-kind contributions being made by many senior technical experts • The consortium partners provide strong linkages with other collaborators outside the network						

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Is GEDSI important to consider in VBD programmes?

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Why?

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Why GEDSI and VBDs?

	**Vulnerability** to VBDs
	**Awareness** of VBDs transmission, prevention & treatment
	Ability to **practice** preventative behaviours
	Ability to **seek** timely and quality treatment
	Ability to **access** timely and quality treatment
	Ability to **complete** treatment

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In settings where people with a disability or who are socially excluded or discriminated against (whatever reason, including gender) they may also have

- Less or little decision making power on
  - when to seek care,
  - access to means, including financial and mobility, to access care and
  - when they do seek care or have access to preventive and treatment services, these may not be acceptable to them or adjusted to meet their specific needs.
- Gender, ethnicity, socioeconomics, health literacy, and other factors can influence:
  - How people perceive symptoms and health conditions
  - When and how poeple seek care
  - People's expectations of care
  - People's preferences regarding procedures or treatments
  - People's willingness to follow health care provider recommendations or treatment plans
  - Who people believe should participate in making healthcare decisions.

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- Socioeconomic and cultural factors can cause both increased **risk**, e.g. behaviour leading to higher exposure to the vector, as well as physical, social, cultural or economic **barriers** to accessing quality healthcare (**vulnerabilities**).
- **Treatment seeking and utilization** is a complex process that varies according the social-cultural dynamics of the society and the family.
- **Treatment choice** may also depend on how individuals perceive the severity of the illness and previous experience of health services (including harassment)
- Access to information can be affected by gender norms and practices
- Health programming more effective led by and with the community and addressing broader determinants of health and power imbalances

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WHO Global Report on Health Equity for Persons with Disabilities

1.3 BILLION
people globally have significant disability

1 in 6 people

World Health Organization

Health inequities

Premature death:
- Up to 20 years earlier

Poorer health:
- More than double the risk for certain health conditions

More limitations in functioning:
- Health facilities are 6 times as hindering
- Transportation is 15 times as hindering

These health inequities are due to unfair and avoidable factors that affect people with disabilities disproportionately

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Why focus on:

People with disabilities:

- Are at **higher risk of acquiring infectious disease** due to:
- Living arrangements (e.g. cramped conditions, reliance on carers)
- WASH infrastructure lacking and/or inaccessible
- Lower access to health services
- Challenges in infection prevention and control, e.g. for those relying on personal assistance
- Are often unable to access health information or community awareness activities
- Are excluded from research, and in the planning and delivery of services
- Experience significant barriers to employment, training, and opportunities

Why is participation of people with disabilities important?

- People have a right to "full and effective participation" (UN CRPD)
- It addresses stigma and raises awareness
- People with disabilities know their own situation best –they are the experts!
- Involving community members is good development practice

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Exercise : Causes of delay

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The Four Delays: A GEDSI analysis

- In prevention
- Seeking care
- Reaching a facility/ provider
- Receiving care

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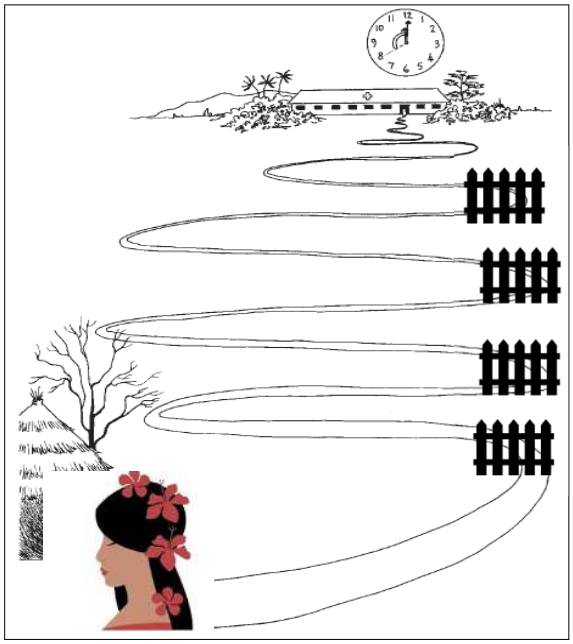

The Road to Prevention of Death and Disability from Dengue

4. Receiving

3. Reaching

2. Seeking

1. Preventing

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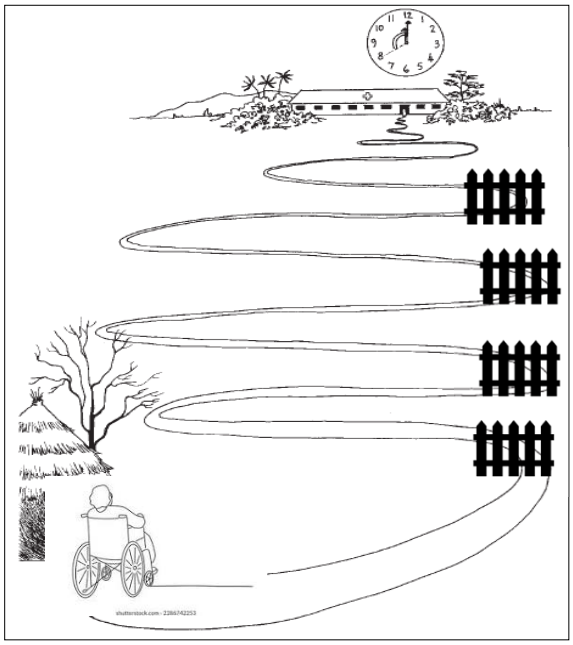

The Road to Prevention of Death and Disability from Dengue

4. Receiving

3. Reaching

2. Seeking

1. Preventing

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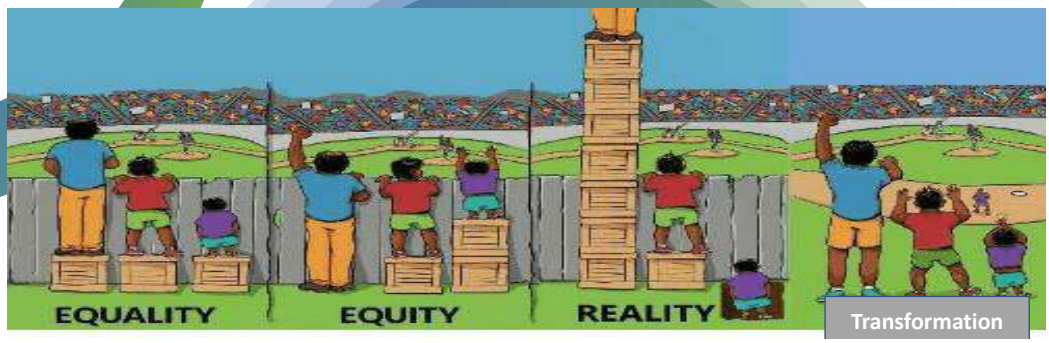

Review GEDSI and barriers in VBD management

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Types of barriers?

Attitudinal barriers :

- Stigma
- Discrimination
- Lack of awareness
- Low expectations of people's ability to contribute –e.g. ability to work, to contribute to programs

Physical barriers

- Facilities and equipment not accessible
- •Inaccessible latrines, water points
- •Inaccessible transport

Communication barriers

- Health information only in one format (e.g. written only, verbal only)
- Lack of sign language interpreters for trainings/meetings
- Research info and consent forms too complex

Institutional barriers

- Cost of health care
- Discriminatory laws, policies, practices (e.g. employment policies)
- Disability data not collected
- No budget or funding for disability inclusion (e.g. for reasonable accommodation)

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What are the potential barriers?

Biological: pregnant women have lower immunity to VBDs; poverty can compromise immune system

Social and Attitudinal: education and health literacy; expected roles and responsibilities and decision making; stigma;

Cultural: decision-making power, expected behaviours; beliefs and experiences

Economic: access to or control over use of resources

Structural/Institutional: decision-makers and program designers; policies; information systems; budget

Physical: location accessibility, transportation

Communication: language, literacy, format

i.e. VBDs and GEDSI are closely connected

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Exercise: Approaches to address the GEDSI linked barriers

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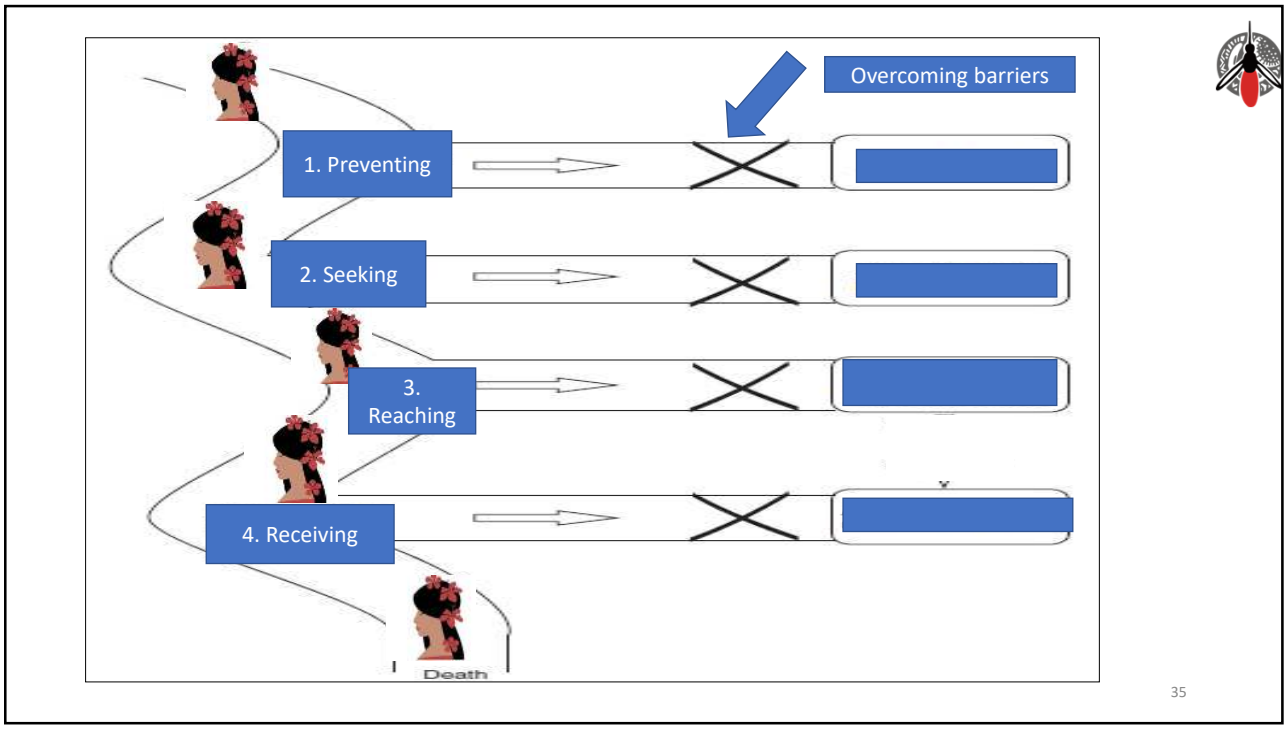
Overcoming barriers
1. Preventing
2. Seeking
3. Reaching
4. Receiving
Death
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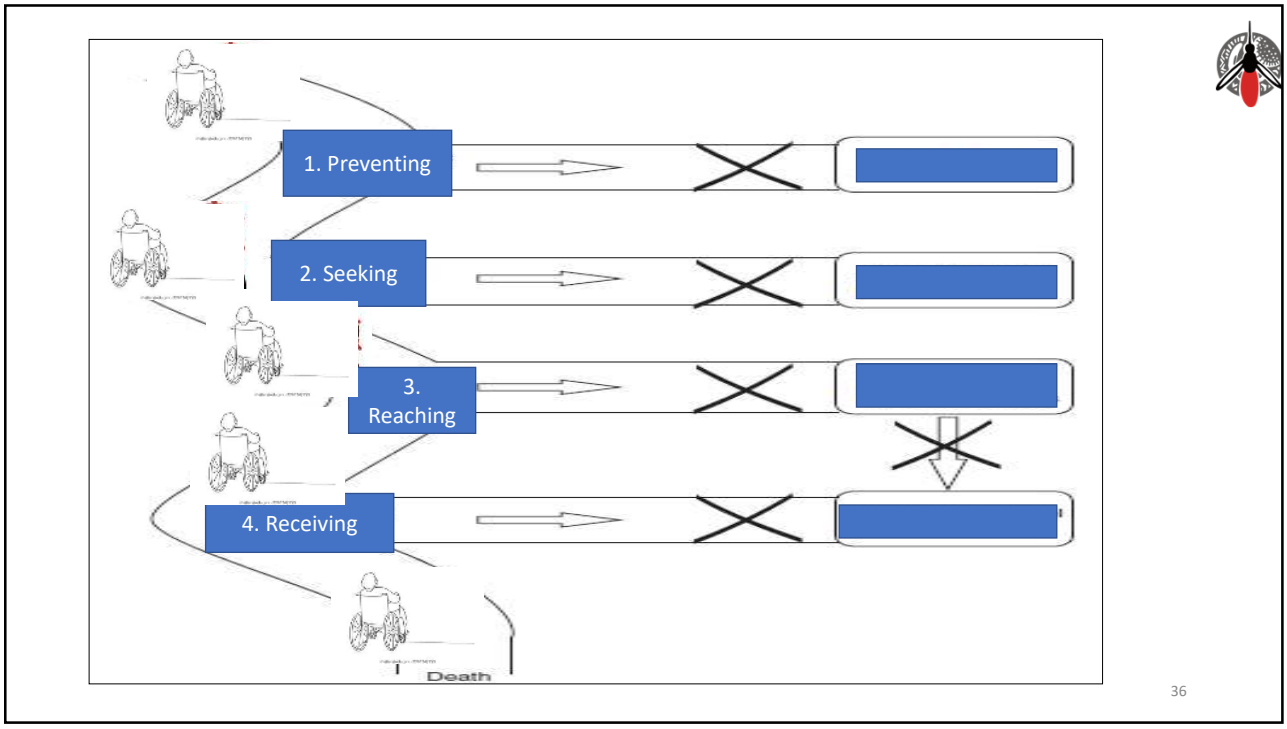
1. Preventing
2. Seeking
3. Reaching
4. Receiving
Death
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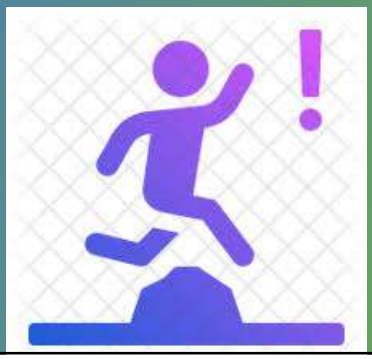
Review : Approaches to address the GEDSI linked barriers



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Types of barriers?

- **Attitudinal barriers**
- **Physical barriers**
- **Communication barriers**
- **Institutional barriers**

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Disability inclusive development

DID is process and outcome of including people with disabilities in development

Process - people with disabilities participate and are included in decision-making.

Outcome – achieved when all community members, including people with disabilities, benefit equally from a project or service.

Impairment + barriers = disability

Impairment + ba~~rs~~ = ~~dis~~ability

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Addressing barriers

Organisations of People with Disabilities (OPDs) are:
- Led by people with disabilities
- Established to promote the rights of people with disabilities
- Specific mandate and role recognised in the CRPD
- Variety of types of OPDs and scope

Attitudinal barriers
- Training in disability inclusion
- Employ people with disabilities e.g. in data collection
- Intentionally include people with disabilities in programs e.g. in advisory groups

Physical barriers
- Conduct accessibility audits of facilities
- Provide accessible transportation
- Choose accessible venues for events or meetings

Communication barriers
- Provide health Information in multiple formats: written, spoken, pictorial, video...
- Hire sign language interpreters for meetings and training
- Print information in Braille or large print format
- Prepare information and consent forms in simpler language

Institutional barriers
- Advocacy and awareness raising to decision-makers and staff
- Review policies (e.g. HR) to identify barriers to employment
- Collect and use disability data for planning
- Allocate budget for disability inclusion (e.g. for reasonable accommodation)

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How to measure?

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Gender analysis

UN Women defines **gender analysis** as "a critical examination of how differences in gender roles, activities, needs, opportunities and rights/entitlements affect men, women, girls and boys in certain situations or contexts.

E.g malaria risk for men who go to forests or women who work on farms. Access issues if women care for children and cannot leave home

Gender analysis examines the relationships between females and males and other genders their access to and control of resources and the constraints they face relative to each other.

A gender analysis should be integrated into all sector assessments or situational analyses to ensure that gender-based injustices and inequalities are not exacerbated by interventions, (including malaria services) and that where possible, greater equality and justice in gender relations are promoted."

https://archive.unescwa.org/gender-analysis

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Delay 1

Affected by:

- Gender
- Economic status
- Education status
- Characteristics of "illness"

Suggested questions to ask in a community

- Do people use health care facilities as often as they should? Men? Women?
- Who uses the health services most? Why?
- What prevents utilization?
- Who makes the decisions to seek services/care
- Does this sometimes cause delay?
- Does the status of women prevent them form making decisions?

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Delay 2

Affected by:

- Distance
- Transport
- Roads
- Cost
- Safety

Suggested questions to ask in a community

- How far do women have to travel to seek care?
- How do they get there?
- Do they think it is safe to travel?
- What is the cost?
- Who pays?

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Delay 3

Affected by:

Quality of care

Acceptability of services to them

Disrespectfulness

Discrimination

Stigma

Lack of resources to provide the care required e.g. drugs, tests, staff

Suggested questions to ask in a community

- What quality of care do women expect?
- Is this always what they receive?
- Do they feel respected and safe when they receive care?
- What else do they suggest would make the services meet their needs?

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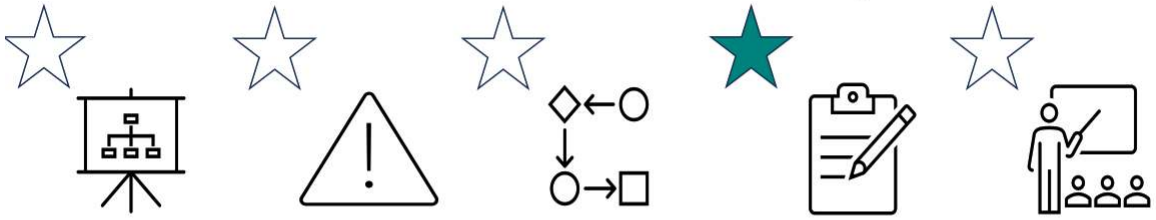
MEASURING PERFORMANCE ON GENDER EQUALITY



The use of Gender or GEDSI Analysis to ensure the investment is relevant and support decision-making	The identification, mitigation and management of gendered risks to ensure the investment does no harm and addresses gender gaps	The effectiveness of Gender Equality or GEDSI strategies in driving progress towards outcomes, including benefits for women and girls	Monitoring, evaluation and learning to provide accountability and support an evidence-based approach	The level and efficiency of resourcing to achieve gender equality objectives, including budget and expertise

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MEASURING PERFORMANCE ON DISABILITY EQUITY AND RIGHTS

Evidence of how the program has supported an active role of people with disabilities and/or organisations of persons with disabilities	Evidence that there have been efforts to identity and remove barriers to inclusion to support participation of people with diverse disabilities	Monitoring, evaluation and learning systems support the collection and use of data on participation of people with disabilities, including information on the barriers they face	Programs consider intersectionality with particular attention to the interaction between gender and disability

Credit: CBM Australia

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Project cycle stage	WHY collect information about disability?	WHAT do we want to know?	WHERE can we find this information?	HOW to collect it?	WHO should be participating?
Situation analysis and project design	• To better understand the local situation/context • To target programming where it will be most effective	• Who are the people with disabilities in our target communities? • What are their opinions, experiences and situations, and how do these differ among men, women, boys and girls? • What are the local understandings and attitudes about disability? • What disability organisations exist? • What barriers prevent people with disabilities from accessing programs/services and participating fully in their communities?	• Data on the prevalence, types and causes of disability • Qualitative information on people with disabilities' own experiences • Mapping of DPOs, services, laws, programs, etc • Evidence and analysis of attitudinal, physical, communication and institutional barriers to inclusion	• Participatory Learning and Action (PLA) tools • Focus group discussions (FGDs) • Household/baseline surveys • Key informant interviews • Existing data/info: public data, local DPO/community-based rehabilitation/service provider records	*At all stages of the project, engage with:* • Women, men, girls and boys with disabilities, including people with a variety of impairments (physical, vision, hearing, intellectual and psychosocial impairments) • Carers and household members of people with disabilities • Local or national DPOs or other groups of people with disabilities • Disability service providers or other disability-focused organisations • Other community members, local leaders, government duty bearers, civil society organisations, NGO staff
Planning, targeting and start-up	• To ensure the most marginalised communities/individuals are targeted and included • To plan for access and inclusion (including active decision making) within the project design and budget	• Who are the women, men, girls and boys with disabilities in our target communities? • What are the barriers to participation of people with disabilities in our project? • What are the enablers for people with disabilities to use their strengths and capacities to participate/contribute? • What strategies or adaptations are needed to ensure universal access? • Who needs to be explicitly involved in the project to ensure inclusion?	• Identification of people and households affected by disability • Views and opinions of people with disabilities about barriers and enablers • Assessment of barriers to participating in project activities • Analysis of key stakeholders • Identification and costing of required accessibility actions	• Existing data sources • PLA tools • FGDs • Baseline surveys (with questions to enable disaggregation) • Outreach/door to door visits • Key informant interviews • Screening participants • Accessibility/inclusion audit	
Implementation – monitoring, reflection and improvement	• To monitor who is participating/ benefiting and who is not – and why • To make adaptations and improvements to project activities to make them inclusive	• Who is participating and who is not? • Is participation of people with disabilities genuine and meaningful (not tokenistic)? • What enabling factors or barriers affect inclusion of people with disabilities? • How are the project outcomes working for people with disabilities? • What are the different experiences of women, men, girls and boys with disabilities? • What changes are needed to strengthen inclusion?	• Monitoring data on participation, access and outcomes for people with disabilities • Views and opinions of participating people with disabilities • Information from key stakeholders/ partners • Analysis and reflection on barriers/ challenges and enabling factors (in the project and external)	• Participants' stories and views • Staff/stakeholder/beneficiary feedback • Disaggregated monitoring data • Qualitative monitoring • Disability-specific indicators/ markers • Reflection processes	
End of program – evaluation, reflection and learning	• To evaluate what changes have taken place • To capture learning about inclusive practice	• What changes have taken place in terms of rights and inclusion of people with disabilities? • To what extent were people with disabilities included in the project? • What factors enabled or hindered inclusion? • What are the opinions, voices and views of women, men, girls and boys with disabilities about the project?	• Evidence of changes related to disability inclusion among rights holders, duty bearers, civil society and project staff • Views, opinions and experiences of people with disabilities • Analysis of project learnings related to inclusive practice	• Reflection processes • Endline surveys (with questions to enable disaggregation) • Key informant interviews • Disability-sensitive evaluation questions • Disability-specific indicators/ markers • Participants' stories and views	

Plan International Australia/CBM Australia-Nossal Institute Partnership for Disability Inclusive (2015)

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Table 3: Overview of methods and tools for collecting data to support disability inclusion

	Approach/method	What is it?	Advantages	Limitations	When to use it?
Disaggregation	**Disaggregating data by disability**	A process of breaking down data into subgroups and comparing data from each of these subgroups (e.g. men, women, boys and girls with and without disabilities) to learn about their different situations and experiences across a range of indicators or domains.	• Can highlight issues that might otherwise remain invisible in general community level data, particularly for marginalised community members • Enables comparison and analysis of diverse experiences • Can point to issues for further investigation using other methods	• First requires identifying people with disabilities (see below) • Can be seen as a reporting or compliance issue • Needs follow-up data analysis focused on learning about and responding to the diversity of situations and experiences of different groups	Applies to all data collection processes, particularly those with large numbers of participants such as surveys or project monitoring tools. Should be complemented with more in-depth methods to hear various perspectives and learn about why different groups have different experiences.
Methods for identifying people with disabilities	**Using measures of 'functioning'**	Various sets of questions that ask people about basic activities or major body functions, such as whether they have difficulty walking, seeing or communicating. These provide an approximate way to identify most people who might have a disability. (Examples: Washington Group Short Set and Extended Set of Questions on Functioning)	• Provides a more sensitive and accurate way to collect data on disability prevalence than directly asking if someone has a disability • Avoids using language such as 'disability' or 'handicap' or other words which might be seen as stigmatising • Can be undertaken by staff or community members with a small amount of training	• Provides only an indication of disability, not a diagnosis • On its own, does not provide information about the barriers a person faces in their community • Requires training of data collectors and care to avoid focusing on a person's limitations (particularly where staff are more familiar with medical approaches to disability)	To identify people who might have a disability in order to: • Disaggregate survey or other data; • Follow up to learn more about their situation and priorities; • IInclude people with disabilities in development projects or activitiesEstimate disability prevalence within a community; and/or • Refer people to specialist services.
	Tool: Washington Group (WG) Short Set of Questions	A set of 6 questions for identifying the most common types of functional difficulties and thereby providing an approximation of disability prevalence. It is the most widely used measure of functioning and is recommended by the UN for use in population-based surveys.	As above, plus: • Has already been tested and translated into many languages • Provides a standardised and internationally comparable method for estimating disability • Shorter and simpler to use than other measures of functioning	As above, plus: • Only identifies the most common types of functional difficulties (e.g. might miss mental health issues) • Has not been validated for use with children aged under 5; mainly designed for use with adults • Should be used exactly as developed to maintain validity	Can be incorporated into surveys, questionnaires, project registration sheets, monitoring tools, etc. to allow for disaggregating data or promoting individuals' participation in a project. Particularly relevant where there is a rationale for collecting population and project data using internationally standardised measures.
	Identifying childhood disability	Sets of questions to be used with parents/carers to identify childhood disability are still under development (as of 2015) by the Washington Group and UNICEF.	As for measures of functioning, plus: • Provides a standardised way of estimating disability at different stages of childhood development	As for measures of functioning, plus: • Parents/carers might not recognise or want to disclose disability • Should be complemented with child-friendly/participatory methods	Particularly relevant for projects targeting vulnerable children, and/ or which have a focus on learning and research on prevalence and experiences of childhood disability.
	Snowballing' and informal techniques	A process of locating people with disabilities by talking to key informants (e.g. health workers, village leaders or volunteers) and having them refer project staff on to other people with disabilities they are aware of through various networks.	• Puts value on (and benefits from) local knowledge, participation and informal networks • Can locate people who might be hidden/missed by formal surveys • Can be easily used at any stage of a project	• Does not use a standard definition of disability • Care should be taken to avoid labelling people as 'disabled' or causing stigma or shame	Particularly useful for projects where people with disabilities are a target group and where generating standardised data is not a priority. Can also be used as part of project efforts to strengthen local networks and relationships.

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Plan International Australia/CBM Australia-Nossal Institute Partnership for Disability Inclusive (2015)

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Findings from survey

What did you think about these findings?

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Survey

- Sent to 21 PICTS – 2 persons in each n= 42
- 16 persons replied but not all completed all parts.
- 5 countries replied:
  - Fiji 2,
  - Marianas 1
  - PNG 2
  - TL 1
  - Sol 2
- But cannot link data with country nor respondent (anonymous)

- 78% respondents were women
- 50% 31-45 years of age, (12% 21-30, 32% >45)
- 22% junior officers, 22% senior officer, 33% manager, 11% Director or deputy 11% prefer not to say ?
- Were all of these people able to answer all questions especially regarding senior management issues?

Takeaway: GEDSI is not only about women

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Findings (1)

- Engagement across the VBD programme cycle:
  - Main point of engagement (as defined by respondent) in the delivery/implementation, and mainly women (8 of 14). Most not included are people living with a disability 8 of 14). Volunteering in implementation mentioned.
  - Some involvement of women and others in design (always and sometimes) – but again people living with disabilities usually not or only sometimes. Less engagement of any group in evaluation.
  - *It is the policy to be inclusive but "lacks operational funding"*
- Barriers:
  - 6 respondents said barriers were never investigated for these groups. 3 said for women, 2 each of PLWD and other marginalized populations.
  - Response to any barriers found was said by 2 to be comprehensive and 3 some response.
  - Respondents stated they tried to aim for inclusion, protecting rights and reducing discrimination, and one respondent noted that they worked with groups and associations.

Takeaways:
Intent to be inclusive, but Not explicitly seeking to identify barriers, addressing barriers found nor fully engage across programme cycle
People living with disabilities more likely not included

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Findings (2)

Takeaways:
Some explicit gendered social norms
Limited engagement of people living with disabilities and other marginalised peoples

- There was some gender differentiation in what VBD related activities were done at household level.
  - Women more likely to look after sick persons, sleep under a bed net.
  - Men more likely to do mosquito surveillance.
  - Men and women equally participated in reference groups, health promotion and RCCE activities, organize community events, take people to clinic, work for the VBD program, have access to treatment, volunteer for community service and be involved in VBD program M and E.
  - People living with disabilities and other marginalized groups were reported as less likely to be involved. Notably people living with disabilities are more likely to rarely or never be engaged.

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Findings (3)

Takeaways:
Women are part of the national and subnational VBD workfroce, less so people living with disabilities and other marginalised. Often not in senior positions.

- At national level, there was a broad range of the % of all staff in the team who were women, people living with a disability and other marginalized groups although women were many times more likely to be there, especially than people living with disabilities.
  - Amongst these staff the average was that 10% were in senior management positions, and only 1 respondent said a senior staff person was living with a disability at national and one at subnational level. (only 2 responded to this question at all).
  - One respondent noted that for "entomology work mainly prefer men as this work is quite hard and always work in the forest as well"
  - And another that women in their country were more productive

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Findings (4)

Takeaways:
Some disaggregated data available and used – mainly by gender and location
Need to seek alternate sources for other variables of marginalisation from other sources

- Use of data for decision making (n=9)
  - Usual is RHIS, DHS, Sentinel surveillance, Trapping and/or larval surveys and Qualitative, environmental and climate data (not detailed)
    - Less likely census, MIS, social sector data
  - From these data sources it was noted data was usually disaggregated by location, and gender, but only 1 or 2 respondents noted disaggregation by income, education, literacy or disability.
    - Even if available only 4 said they always used disaggregated data and the other 5 sometimes to often
    - Barriers to accessing disaggregated data were noted as – not being collected, not easily accessed, not knowing if it is available, and not available digitally.

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Findings (5)

Takeaways:
Policies and strategies re inclusion and diversity mainly in place – broadly for country/health sector.
Implementation and capacity more varied

- Strategies and policies for inclusion and diversity
  - About half the respondents (n=6) reported that strategies to support women in leadership roles, ad addressing workplace diversity or in place. Two noted that policies/strategies to address workplace barriers for employing people with disabilities were available. There were a few respondents who were unsure on any of these issues,
    - When asked how addressed this was usually through the national strategy or health plan where GESI is discussed.
  - Just over half the respondents (n=14) said that there were policies to protect women form abuse and harassment in the workplace – and just over half (n=9) said training if provided to VBD staff on the policy.
  - All (n=8) said there was a code of conduct to promote fairness and inclusion in the workplace, and ¾ said staff were trained in that.
    - The majority said there was a complaint mechanism available, all said action was taken on complaints (no details provided)

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Respondents want…

- GEDSI Training
- GEDSI policy attended to in rollout of services
- Increase level of responsibility of individuals in programme for GEDSI

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What does this mean for your work in VBD programmes?

Impairment + barriers = disability

Impairment + barriers = disability

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What?

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(strategic)

Gender-responsive/GEDSI programming
Where gender/GEDSI inequities, norms, roles, relations, power dynamics and inequalities have been considered and measures have been taken to actively address them, with feasible, measurable and disaggregated targets and indicators.

Gender/GEDSI transformative programming
Address the causes of gender/GEDSI -based health inequity and include ways to transform harmful gender/GEDSI norms, roles and relations and foster equal power relationships between people of all genders/all marginalised people by promoting meaningful participation, decision making and empowerment.

Practical GEDSI needs are the needs of various groups that relate to responsibilities and tasks associated with their traditional community expected roles or to immediate perceived necessity.
Responding to practical needs can improve quality of life but does not challenge gender divisions or men's and women's position in society.
Practical needs generally involve issues of condition or access. E.g. Timing of meetings, ensuring access to training equitably Spraying women's menstrual huts, Location of services, Opening or operating times, Staff attitudes, Female staff security issues

Strategic GEDSI interests concern the position of various marginalised groups in relation to each other in a given society; may involve decision-making power or control over resources. Addressing these assists marginalised poeple to achieve greater equality and to change existing roles and stereotypes. Addressing GEDSI interests generally involve issues of position, control, and power. E.g. Equity in representation on decision making committees etc., Fair and equitable recruitment /promotion processes, Women in leadership focus, Evidence based advocacy for gender inclusiveness, Safeguarding policy to protect female workers

Source: The Global Fund 2022 Technical brief: equity, human rights, gender equality and malaria Allocation Period 2023-2025 Geneva: Switzerland
https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf

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How can you embed GEDSI into your activities? How can you measure success in GEDSI programming in your work?

	Gender	Disability	Social inclusiveness	GEDSI indicators
SBCC				
Village /community malaria/health workers/volunteers				
Training				
P vivax adherence support				
"Last mile" activities				
Integration				
Rights to health				
Sustainability				

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How do you measure progress in GEDSI in your work?

	Practical (Responsive)	Strategic (transformative)
Gender		
Disability		
Other social inclusiveness		

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Example of gender matrix for *Aedes* vector control in a Pacific Nation

Activity	Practical (Responsive)	Strategic (transformative)
Training	Ensure equitable access to training including the timing and support provided at the training and duration/location of the training)	Include Gender Equity and Social Inclusiveness concepts in training programmes
Committee meetings	Ensure meetings held at times when and for a duration supporting both men and women (all ages) can attend	Ensure equity in representation at all committee meetings
IEC activities and campaigns	Ensure activities have positive gender and different abilities representation and are available to people with low literacy and with disabilities	Involve women and people living with disabilities and advocates in co-design of campaigns
Operations research	Ensure gender disaggregated data	Ensure fair and equitable access for involvement in research.
Field work/surveillance activities	Ensure both men and women are included in surveillance activities	Implement safeguarding policy to protect female workers at the workplace, during field work and surveillance activities.
IRS	Ensure all spaces including those occupied/utilised by women are sprayed. Ensure adequate time allowed for people with disabilities to move from locations to be sprayed.	
Hiring of staff/HR management	Ensure advertisements for recruitment and promotion make clear it is open to all genders	Ensure fair and equitable recruitment processes. Implement women in leadership activities to support women in leadership roles within VBD unit. Ensure fair and equitable promotion performance assessment and process.

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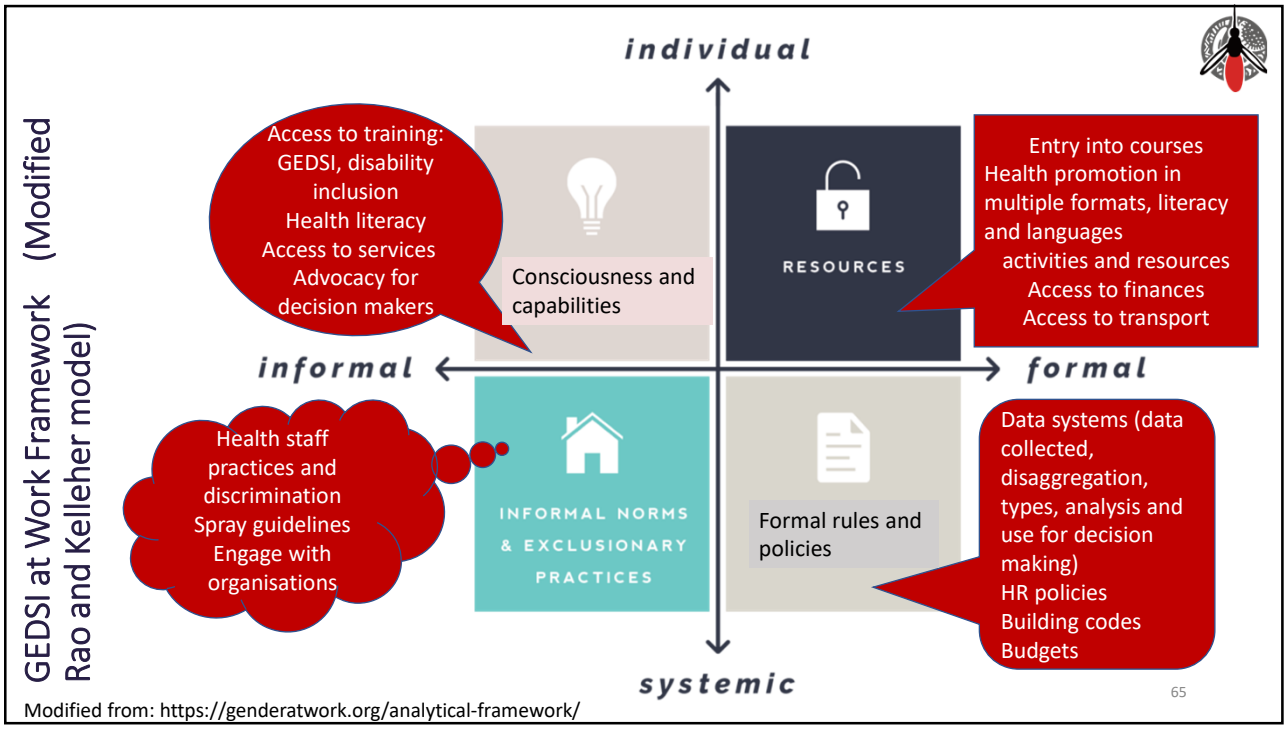

Modified from: https://genderatwork.org/analytical-framework/

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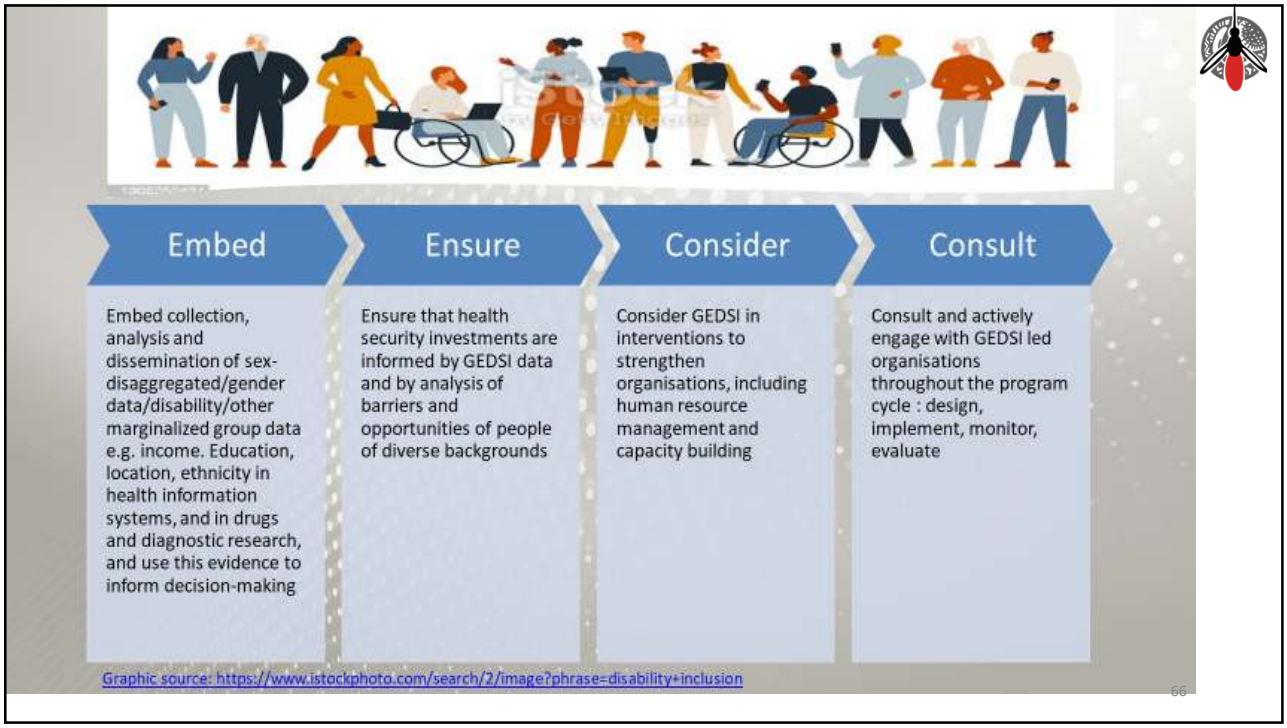

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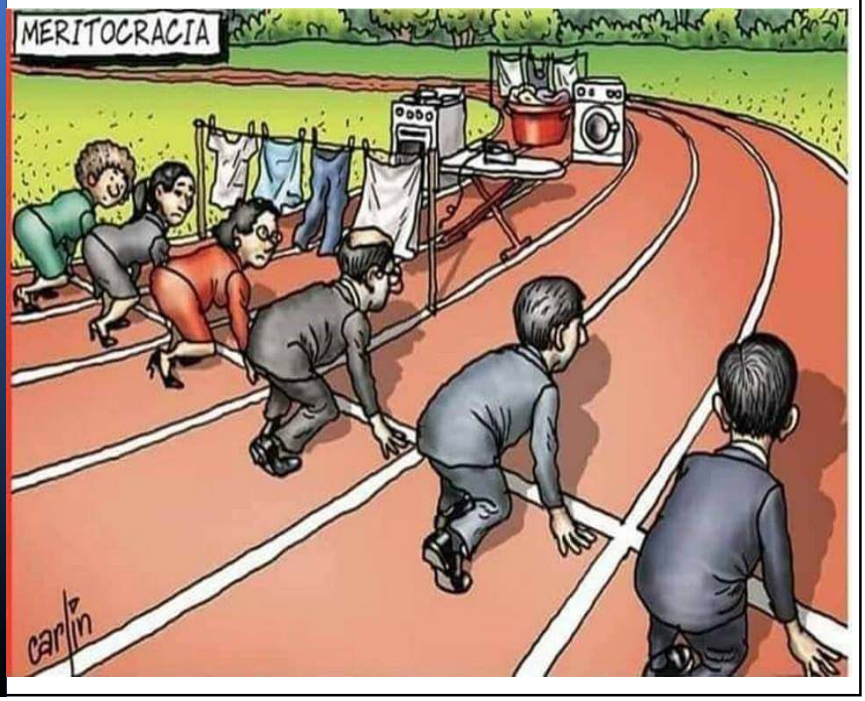
Summary



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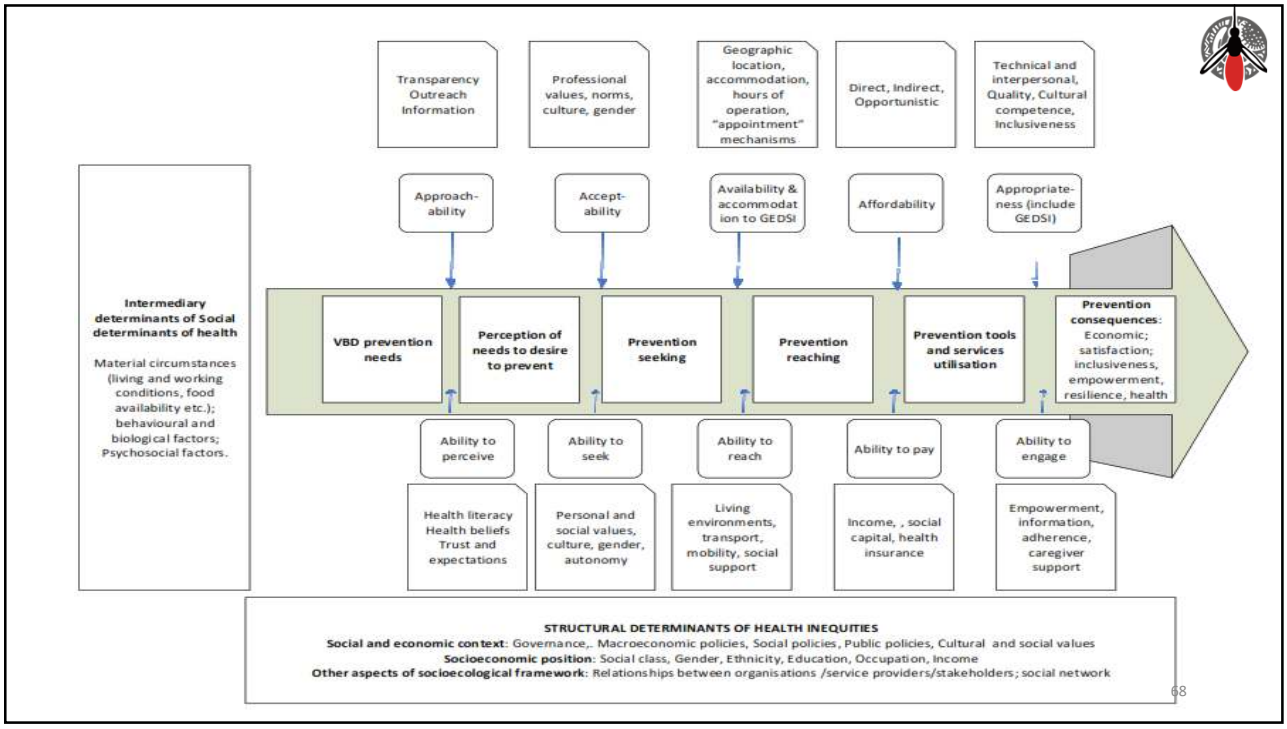

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Summary and implications

- Countries have some policy/strategies to support GEDSI
  - Application to implementation in VBD not consistent esp. for people with disability
- Access to and use of disaggregated data for decision making and M and E would assist and needs improving
- Ways to increase involvement of marginalized populations including gender, across the programme cycle need to be strengthened and strengths-based (not deficit- based) approach.
  - Ensure resourcing to implement diversity and inclusiveness
  - Explicitly and inclusively monitor and evaluate GEDSI implementation,
  - Capacity strengthening at individual staff, programme, institutional and decision-making levels required
- More countries complete survey and more in-depth enquiry and case studies would help progress GEDSI in VBD in PICTS
- Monitor and evaluate progress

Your ideas?
What can you do?
How can other programmes/ sectors help?
How can PacMOSSI and other partners help?

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References and Resources

- Presentation to the Indo Pacific Centre for Health Security Partners Forum: Disability Inclusion Session 30/9/21 Tessa Hillgrove, and Paul Deany CBM Inclusive Advisory Group. Not published
- Indo Pacific Centre for Health Security 2021 Health Security Initiative Guidance Note Supporting disability inclusion through DFAT health security investments https://indopacifichealthsecurity.dfat.gov.au/
- Indo Pacific Centre for Health Security 2021 Health Security Initiative Guidance Note Supporting gender equality through DFAT health security investments https://indopacifichealthsecurity.dfat.gov.au/
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- WHO 2022 *Inequality monitoring in HIV, tuberculosis and malaria course* Accessed through: https://openwho.org/courses/inequality-monitoring-hiv-tb-malaria

Graphic source: https://www.istockphoto.com/search/2/image?phrase=disability+inclusion

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- Disability-Inclusion in the DFAT Aid Program: Good Practice Note (2021) https://www.dfat.gov.au/sites/default/files/disability-inclusive-development-guidance-note.pdf
- Gender Equality in Investment Design Good Practice Note https://www.dfat.gov.au/about-us/publications/gender-equality-in-investment-design-good-practice-note
- Gender Equality in Monitoring and Evaluation Good Practice Note https://www.dfat.gov.au/about-us/publications/Pages/gender-equality-in-monitoring-and-evaluation-good-practice-note
- Gender Equality, Disability, and Social Inclusion Analysis Good Practice Note (2023)
- Gender Equality Investment-Level Strategy Development Good Practice Note
- Health Security Initiative Gender Guidance Note
- Health Security Initiative Disability Guidance Note
- Reaching Indigenous People in the Australian Aid Program Guidance Note

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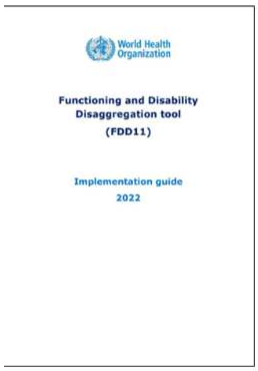
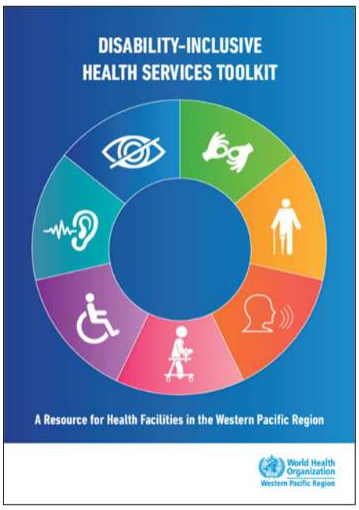
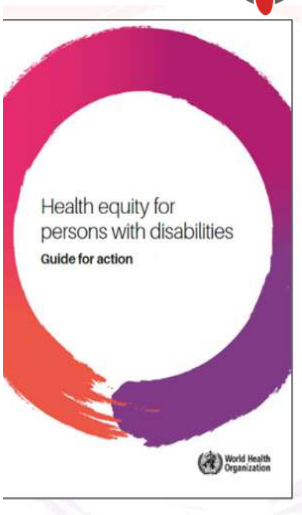
Other WHO Tools and Resources







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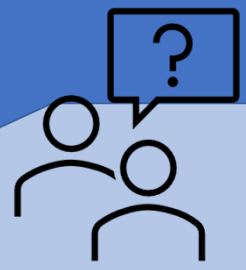
Thank you	Merci	Fakaaue
Fa'afetai	Ko rabwa	Sulang
Vinaka	Ituba	Fakafetai lahi lele
Malo	Kinisou	Si Yu'os Ma’ase
Tagio tumas	Kulo	Koɱɱool
Tenk yu tru	Kamigar	Meitaki
Tangkyu	Kalahngan	



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In case needed. Not for presentation

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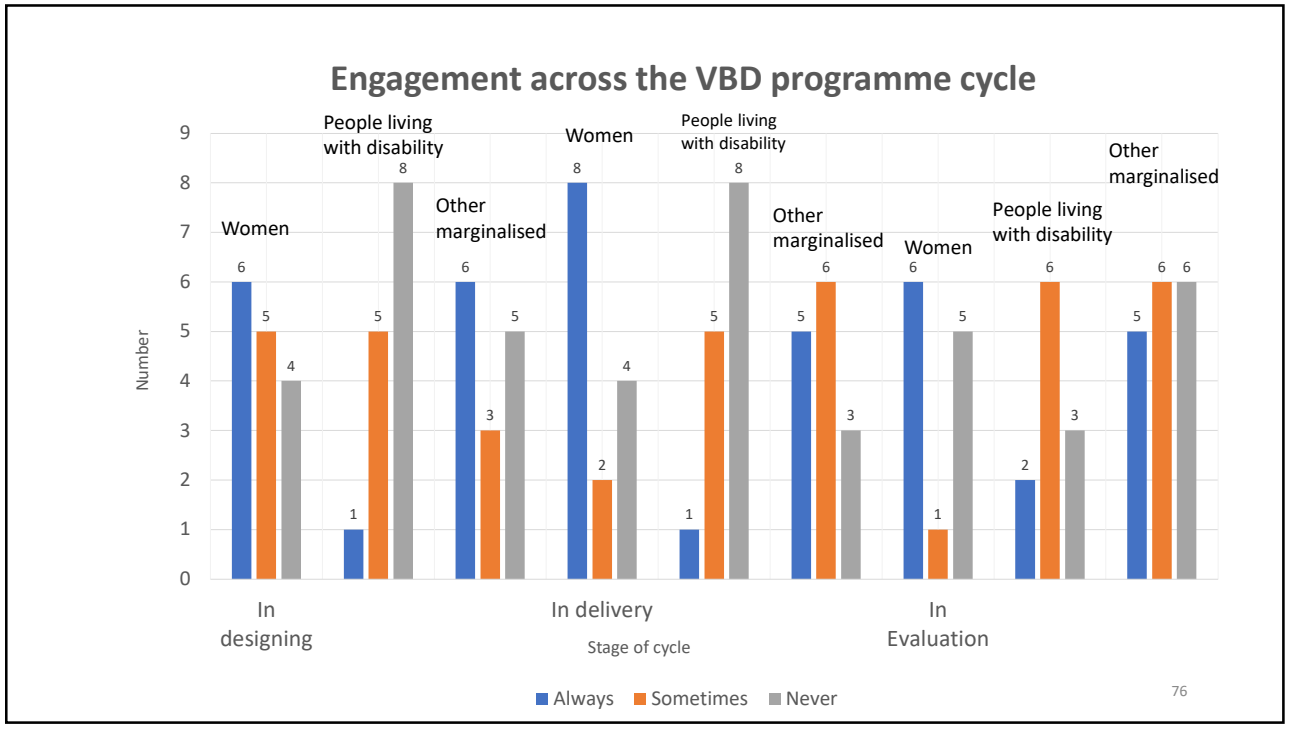

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How

- Women as volunteers
- If women are prepared and informed well" they are our eyes to the entire community, they are the voices of the people"
- Women involved only for specific tasks
- It is the policy to be inclusive but "lacks operational funding"
- Whenever these groups are involved " they are enthusiastic and active"
- Engage through "sitting and chatting with their leaders and the government agencies responsible for them"

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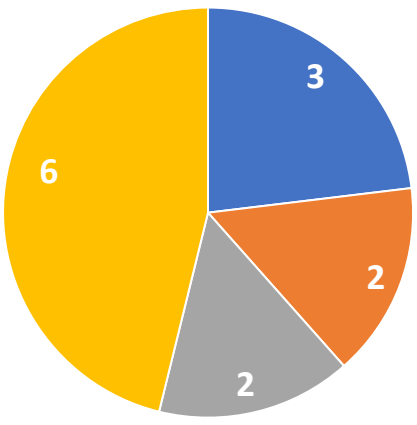
Investigate any barriers they face

- *Aim for inclusion*
- *Work with their groups and associations*
- *Protect rights*
- *Reduce discrimination*



Level of response to barriers identified	
Comprehensively	2
Somewhat	3
no	0

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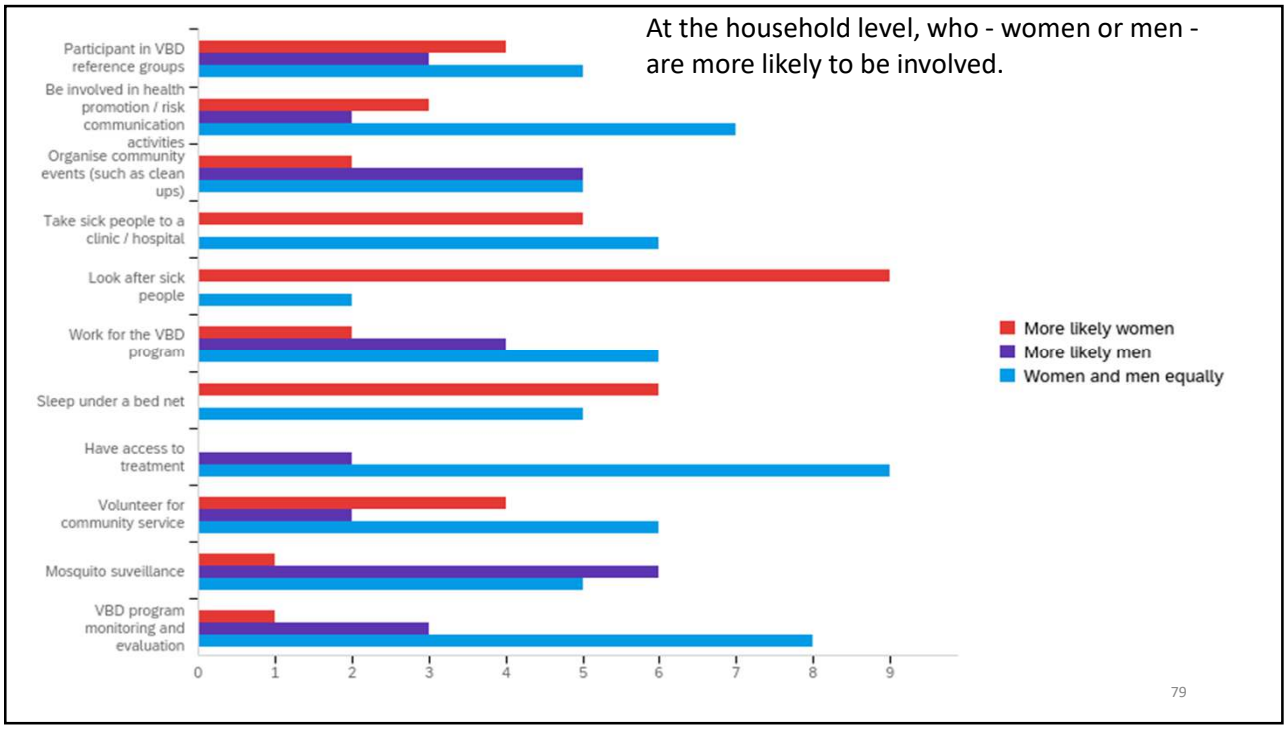
At the household level, who - women or men - are more likely to be involved.
Participant in VBD reference groups
Be involved in health promotion / risk communication activities
Organise community events (such as clean ups)
Take sick people to a clinic / hospital
Look after sick people
Work for the VBD program
Sleep under a bed net
Have access to treatment
Volunteer for community service
Mosquito suveillance
VBD program monitoring and evaluation
0 1 2 3 4 5 6 7 8 9
More likely women
More likely men
Women and men equally
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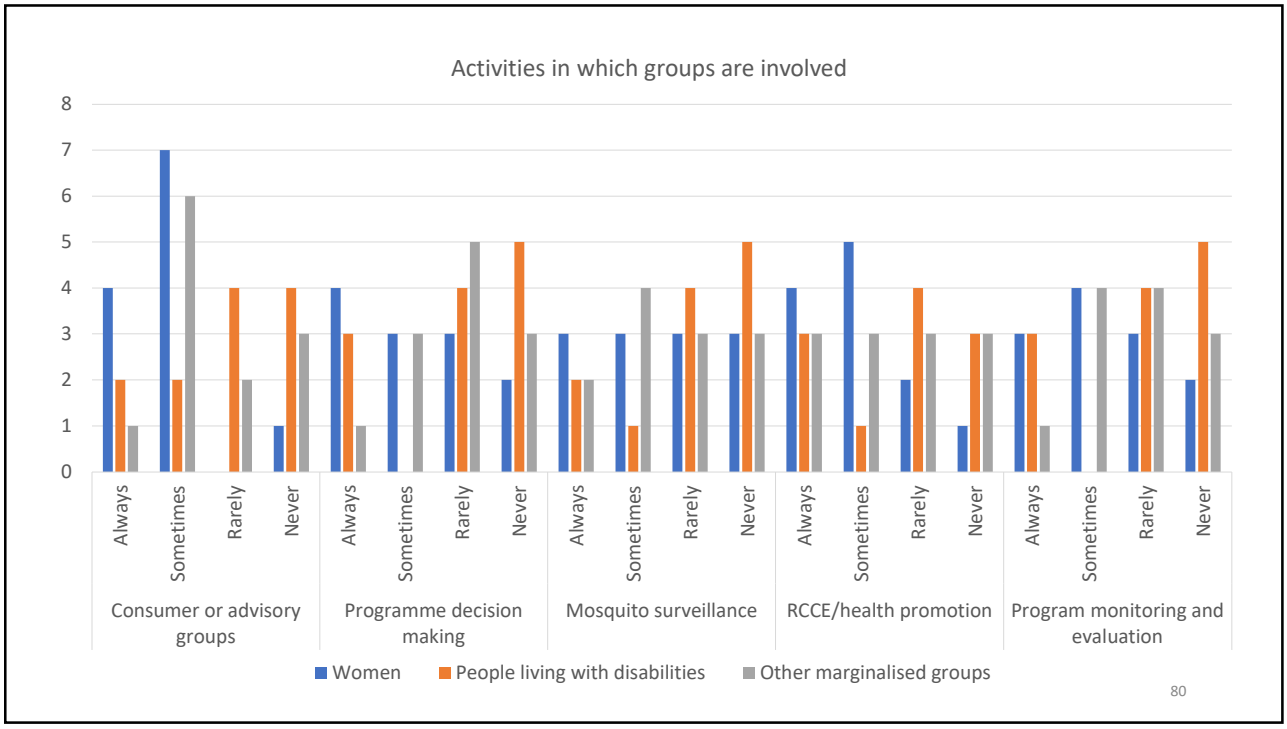
Activities in which groups are involved
8 7 6 5 4 3 2 1 0
Always Sometimes Rarely Never
Consumer or advisory groups
Programme decision making
Mosquito surveillance
RCCE/health promotion
Program monitoring and evaluation
Women
People living with disabilities
Other marginalised groups
80

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- Nets are distributed to them
- Treatment and nets for all; RCCE for all
- Try to involve women in all but for “entomology work mainly prefer men as this work is quite hard and always work in the forest as well”
- Women here in XXXX are more productive
- Everybody is susceptible to getting sick and no-one shall be left behind when trying to implement a programme and protecting human health

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Staffing of the National and Subnational vector teams

	National				Subnational			
	Total	Women	People living with a disability	Other marginalised	Total	Women	People living with a disability	Other marginalised
Range of number in team	6-14	1-11	0-6	0-11	5-30	0-30	0-20	0-15
Mean	9.2	3.6	1	2.5	23	15	3.6	5
SD	3.12	2.69	2.07	3.64	10	11	7	5
# respondents	10	10	7	8	10	10	7	9
% senior staff women	0-65%					0-65%		
Av % senior staff - women	9.8					11%		
% senior staff - People living with disability (n=2)	0-10% (n=1)					0-32%		
Av % senior staff - People living with disability	1.60%					3.20%		

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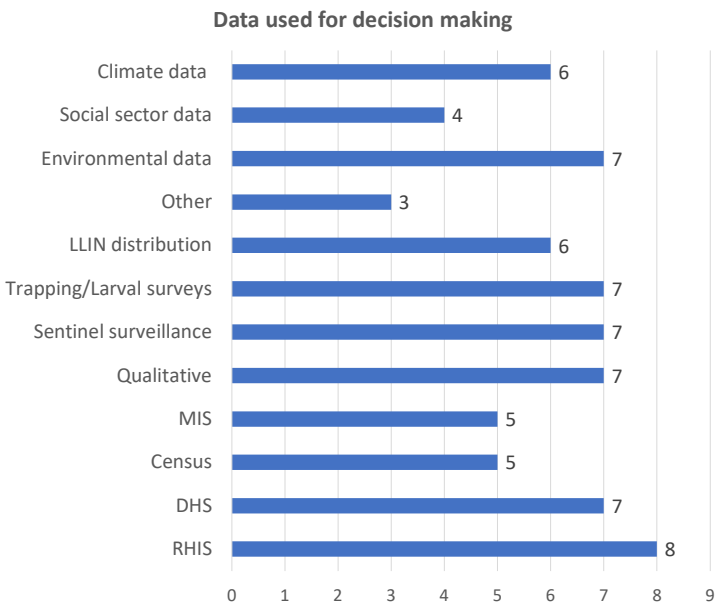

Disaggregated data available:
Gender 7
Location 9
Income 1
Education 2
Literacy 1
Disability 1

Use disaggregated data for VBD decision making
Always 4
Often 2
Sometimes 3
Never 0

Barriers to disaggregation
Don't know if such data available
Don't collect it
Not easily accessed
No digitalization
Don't access HIS

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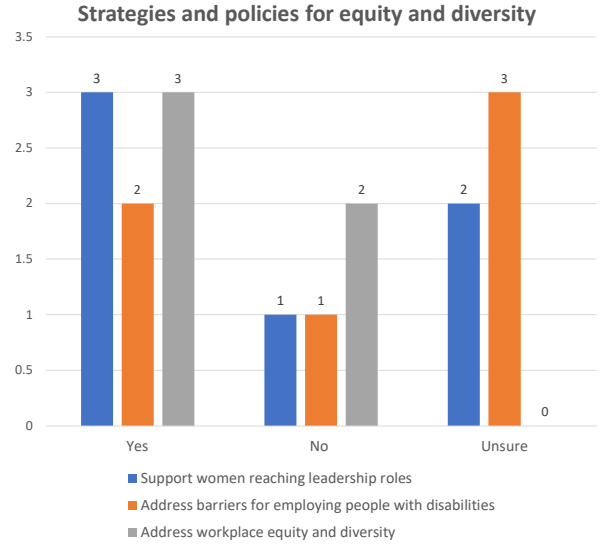
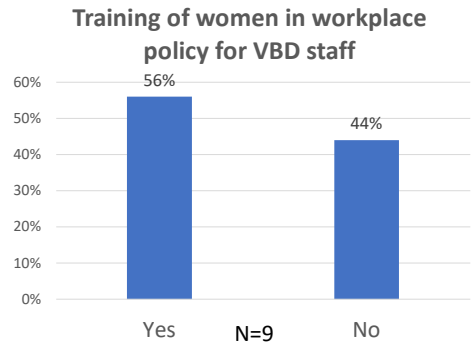


- Through the national strategic plan
- GESI policy in National health Plan
- Anyway, everyone is included in an activity that is carried out



Policies to protect women from abuse in the workplace 57% n=14
Code of conduct to promote fairness and inclusion in workplace 100% n=8
Staff trained in code 75% n=8
Complaints mechanism in place 87% n=8
Code states must take ACTION 100% (N=7)

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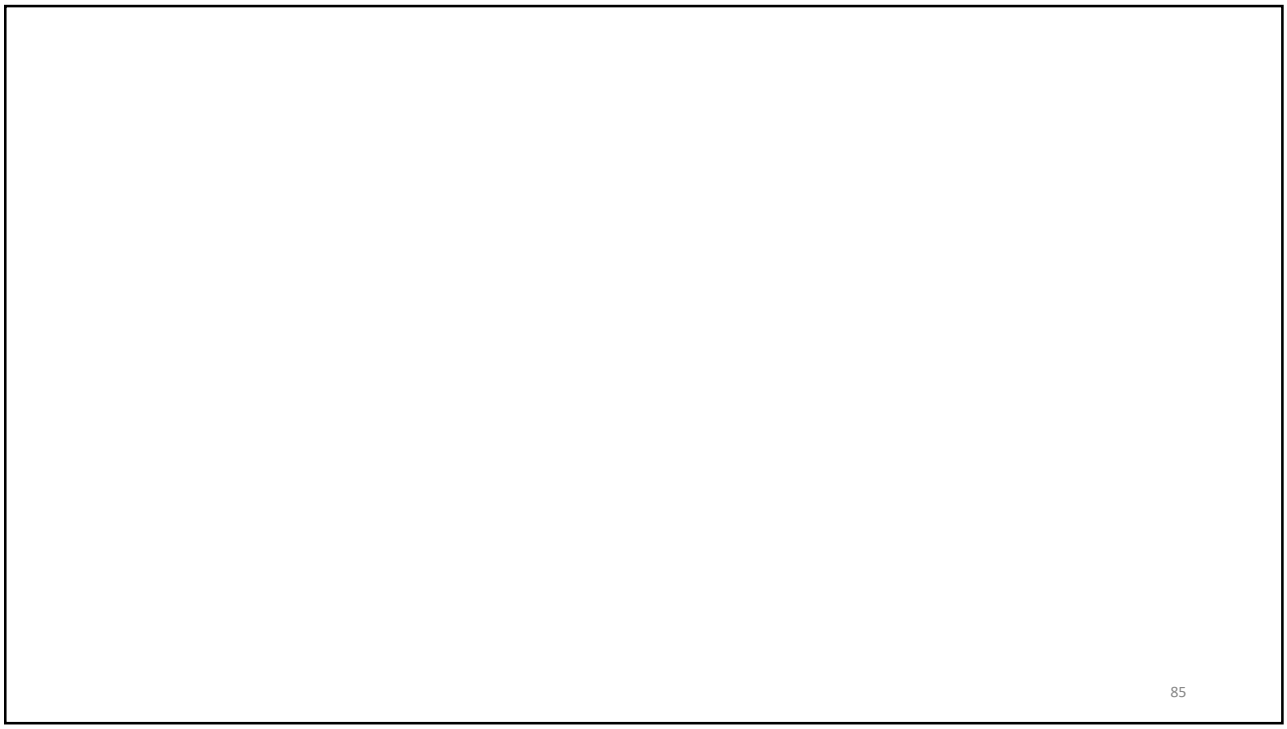

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