

IMMUNIZATION AGENDA 2030



WHY GENDER MATTERS

Why gender matters: immunization agenda 2030

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CONTENTS

Acknowledgements	v
Acronyms	vi
Definitions	vii
Purpose and audience	ix
Chapter 1: Why does gender matter for immunization?	
What is gender mainstreaming in immunization programmes?.....	6
What is gender analysis?.....	7
Why conduct a gender analysis?.....	7
Chapter 2: IA2030 and gender	
IA2030: Core principles.....	13
Chapter 3: Understanding gender-related barriers to immunization	
Barrier 1: Poor quality services and negative health provider attitudes.....	16
Barrier 2: Low education level and health literacy.....	17
Barrier 3: Limited autonomy in decision-making and household dynamics.....	17
Barrier 4: Lack of access and control over resources and mobility.....	17
Barrier 5: High prevalence of gender-based violence (GBV) and harmful practices.....	18
Chapter 4: Gender-responsive approaches to increasing immunization coverage	
A continuum of gender-responsiveness.....	21
Approach 1: Invest in gender data and analysis.....	22
Approach 2: Make community engagement and social mobilization gender-responsive and transformative.....	25
Approach 3: Engage with men to transform gender norms.....	28
Approach 4: Empower and collaborate with civil society and change agents.....	30
Approach 5: Implement gender-responsive actions for the health workforce.....	32
Approach 6: Improve the quality, accessibility and availability of services.....	33
Approach 7: Integrate services and collaborate across sectors.....	35
Approach 8: Implement gender-responsive immunization services in emergency settings.....	37
Approach 9: Apply a gender lens to research and innovation.....	40
Chapter 5: Way forward - commitment and accountability	
Conclusion: Accelerating progress for 2030.....	44
References	45
Annexes	
Annex 1: Gender Analysis Matrix.....	50
Annex 2: Resources and tools for gender-responsive programming.....	51
Annex 3: Metrics to identify gender-related barriers to immunization.....	52

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Acronyms

BCG	bacillus Calmette–Guérin
BeSD	behavioral and social drivers of vaccination
CTC	controlled temperature chain
DTP3	three doses of diphtheria, tetanus and pertussis vaccines
GBV	gender-based violence
GPEI	Global Polio Eradication Initiative
HepB	hepatitis B
HIV	human immunodeficiency virus
HPV	human papillomavirus
IA2030	Immunization Agenda 2030
IASC	Inter-Agency Standing Committee
LGBTQI	lesbian, gay, bisexual, transgender, queer and intersex
NIS	national immunization strategy
NITAG	national immunization technical advisory group
RITAG	regional immunization technical advisory group
SARS	Severe acute respiratory syndrome
SDG	Sustainable Development Goal
SRHR	sexual and reproductive health and rights
TT	tetanus toxoid
UHC	universal health coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNICEF ROSA	UNICEF Regional Office for South Asia
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WASH	water, sanitation and hygiene
WHO	World Health Organization

Definitions

Term	Definition
Sex	Sex is typically assigned at birth and refers to the biological characteristics that define people as female, male or intersex.
Gender	Gender refers to the socially constructed roles, norms, behaviors that a given society considers appropriate for individuals based on the sex they were assigned at birth. Gender also shapes the relationships between and within groups of women and men.
Gender identity	Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth or the gender attributed to them by society.
Gender equity	Gender equity is the process of being fair to women and men. It recognizes that men and women have different needs, power and access to resources, which should be identified and addressed in a manner that rectifies the imbalance. Addressing gender equity leads to equality.
Gender equality	Gender equality is the absence of discrimination based on a person's sex or gender. It means providing the same opportunity to each person, including access to and control of social, economic and political resources, with protection under the law (such as health services, education and voting rights).
Gender norms	Gender norms refer to beliefs about women, men, boys and girls through socialization. Gender norms change over time and in different context. Gender norms lead to inequality if they reinforce mistreatment of one group or sex over the other or lead to differences in power and opportunities.
Gender relations	Gender relations refer to social relations between and among women, men, boys and girls that are based on gender norms and roles. Gender relations often create hierarchies and unequal power relations between and among groups of men and women, disadvantaging one group over another.
Gender roles	Gender roles refer to what men, women, boys and girls are expected to do (in the household, community and workplace) in a given society.
Gender analysis	Gender analysis identifies, assesses and informs appropriate responses to different needs and barriers, and asks critical questions to uncover root causes of gender-based inequities.
Gender mainstreaming	Gender mainstreaming is the process of assessing implications for women, men, girls and boys of any planned action including legislation, policies or programmes at all levels. It refers to a strategy for making women's and girls', as well as men's and boys' concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes so that women and men and girls and boys benefit equally and inequality is not perpetuated (1).
Intersectionality	Intersectionality refers to an approach to understand the complex interaction of different social markers to disadvantage and oppress different people depending on their characteristics and contexts. Gender intersects with age, race, ethnicity, class, socioeconomic status, disability, sexual orientation and gender identity, geographical location to shape social inequalities.

Term	Definition
Intersectional gender analysis	Intersectional gender analysis is an approach to identifying and addressing the interaction of different social categories and power hierarchies that result in health inequity.
Gender-sensitive	Gender-sensitive programmes show an awareness of gender roles, norms and relations while not necessarily addressing inequalities generated by them. No remedial actions are developed.
Gender-responsive	Gender-responsive programmes or policies are ones where gender norms, roles and inequalities have been considered and measures have been taken to actively address them. They go beyond gender sensitivity, and include gender-specific and gender-transformative actions.
Gender-specific	Gender-specific programmes intentionally target a specific group of women or men for a specific purpose, but don't challenge gender roles and norms.
Gender-transformative	Gender-transformative approaches are those that attempt to redefine and change existing gender roles, norms, attitudes and practices. These interventions tackle the root causes of gender inequality and reshape unequal power relations.
Gender-based violence (GBV)	Gender-based violence (GBV) is violence directed against a person because of their gender and is rooted in gender inequality. Most GBV is directed at women and girls at the hands of men; however, men can experience gender-based violence too. Transgender populations also experience unique gendered GBV. GBV includes, for example, physical, sexual, emotional and economic violence.
Caregiver	Caregiver is a person who regularly or intermittently cares for an infant or child, for example mothers, fathers, grandparents and siblings.
Empowerment	Empowerment is the expansion of people's capacity to make and act on decisions affecting all aspects of life - including decisions related to health - by proactively addressing socioeconomic and other power inequalities in a context in which this capacity or choice was previously denied. Programmatic interventions often focus specifically on empowering women because of gender inequality.
LGBTQI	LGBTQI Lesbian, gay, bisexual, transgender, queer, intersex persons and others.

Purpose and audience

Gender equality is a fundamental human right and a powerful driver for better health outcomes globally.

Immunization interventions will only succeed in expanding coverage and widening reach when gender roles, norms and relations are understood, analysed and systematically accounted for as part of immunization service planning and delivery.

This document explains the need for mainstreaming of gender across the core principles and strategic priorities of **Immunization Agenda 2030 (IA2030)**. Its purpose is twofold:

- (i) to improve awareness and understanding of how gender-related barriers can affect immunization programme performance; and
- (ii) to provide practical "how to" concepts, tools and methods, and actions that can be used to effectively integrate a gender perspective into immunization programmes.

The target audience is everyone engaged in supporting, managing or implementing immunization programmes – managers and service providers, as well as the staff of ministries of health and other sectors (e.g. ministries of education, ministries of gender, ministries of finance), civil society, international organizations and donor partners involved in realizing the IA2030 vision of a world *where everyone, at every age fully benefits from vaccines for good health and well-being*.

SUMMARY



Gender is a relational term used to describe socially determined differences between women and men, girls' and boys' roles, attitudes, behaviour and values as perceived in a given societal context. Sex is a biological difference.

Gender is NOT synonymous with just women and girls and NOT just for action or the benefit of women and girls only.



Women, men, girls and boys all must be involved to advance gender equality and societal transformation.



Not all women and girls are the same, as inequalities, needs and barriers differ across caste, ethnicities, age, location, wealth quintile, literacy levels, marital status, special needs (such as disability) and conflict conditions.



Gender mainstreaming is about addressing gender issues across all sections, sectors and levels in any planned action including legislation, policies and programmes.

Gender mainstreaming should consider the needs of all women and men, girls and boys equally.



Source: Gender toolkit: integrating gender in programming for every child in South Asia. UNICEF ROSA (2018).

CHAPTER 1

Chapter 1: Why does gender matter for immunization?



Global studies have not found major sex-based discrepancies in immunization coverage: girls and boys have the same likelihood of being vaccinated in most low- and middle-income countries. A few exceptions exist at the subnational level within socioeconomically and geographically marginalized groups – boys have been found to be more immunized in some instances, and girls in others (2). However, attention to gender-related issues in immunization programmes goes beyond focusing on coverage discrepancies between girls and boys. There are multiple ways in which gender roles, norms and relations influence who gets sick, who has access and control over resources, who's voice is heard, and who's health needs are met, including for immunization.

Gender impacts immunization both on the demand side, through people's health seeking behaviours, and the supply side provision of health services. To increase immunization coverage, and in particular to sustainably reach "zero-dose" children and missed communities, it is necessary to understand and address the many ways in which gender interacts with additional socioeconomic, geographic and cultural factors to influence access, uptake and delivery of vaccines. These factors include age, race/ethnicity, religion, marital status, education, wealth, sexual orientation and gender identity, HIV status, disability and migration status. Fig. 1 provides some examples of the most common gender-related barriers to immunization. These barriers are discussed in more depth in Chapter 3.

Immunization has been shown to be a one of the best investments a government can make. The return on investment for immunization is higher than for education and infrastructure projects combined (3). Each dollar invested is estimated to generate a 26-fold return based on savings from health-care costs and lost wages and productivity due to illness (4). Investments in women's health have also been shown to yield broader economic growth (5). Combining gender-focused initiatives with immunization sets us on a path to maximize our return on investment in vaccines.



IMPORTANT NOTE

This document is primarily about the gender inequalities that exist between men and women. Addressing the barriers to immunization faced by others who are gender diverse/non-conforming is also important. While not specifically addressed in this document, many of the principles and tools can also be adapted for these groups.

Figure 1. Common gender-related barriers to immunization



[Source: Adapted from Immunization and gender: a practical guide to integrate a gender lens. UNICEF ROSA (2019)]

Gender-related barriers and gender inequality can prevent people, both male and female, from getting vaccinated. These operate at multiple levels from the individual and household to community and health systems. These gender-related issues are underpinned by power relations, leading to different opportunities, limitations, challenges, needs and vulnerabilities, especially for women and girls. The goal of gender equality is not for women and men and girls and boys to become the same, but to ensure that **everyone** has the same chances and opportunities to access and benefit from immunization services.

By applying knowledge about gender and taking action to design gender-responsive interventions it is possible to implement more effective immunization programmes and increase coverage for all.

Another way to view the pathway to achieve this vision (which is shared by IA2030) is through the framework described in Figure 2. This framework explores gender barriers and approaches across different socio-ecological levels of household, community, health facility, and laws and policies.

Figure 2. Framework of gender-barriers and approaches to achieve IA2030 goals

Goal	Fully immunized girls and boys			
Outcomes	Household	Community	Health Facility	Laws & Policies
	<ul style="list-style-type: none"> • Women and girls freely access health & immunization services • Women gain resources and increase decision-making power • Women have stronger capacity to negotiate health care • Men's increased participation 	<ul style="list-style-type: none"> • Community prioritize needs of mothers and children • Women and girls can easily access health services • Women's participation and voices increase in decision-making bodies 	Health services are: <ul style="list-style-type: none"> • accessible for all • high quality and responsive • efficient and skilled • needs-based and trusted • non-discriminatory • promote gender equity 	<ul style="list-style-type: none"> • Gender-sensitive health policies and laws protect women's and girls' rights • Increase men's participation in fatherhood and caregiving
Inputs	<ul style="list-style-type: none"> • Promote gender equality through social and behavioural change communication • Income generating activities for women based on context • Life skills, literacy programmes • Parenting course to promote positive fatherhood 	<ul style="list-style-type: none"> • Sensitize community on the value of immunization • Increase community-based outreach services • Strengthen mother's/ fathers' care groups • Increase women's decision-making in public 	<ul style="list-style-type: none"> • Gender training and guidelines for health providers • Incentives, skills and protection (referral) for female providers • Promote gender equity in clinical governance and allocation of resources based on needs of women and men 	<ul style="list-style-type: none"> • Integrate gender and address specific barriers of women and girls into health national action plans and training • Develop gender-responsive service delivery guidelines & tools
Structural Causes	<ul style="list-style-type: none"> • Women lack decision-making power and resources to access and utilize health services • Women's low literacy level • Gender roles and norms: mothers being main caretakers – time, poverty, low value of girls • Lack of men's involvement in care 	<ul style="list-style-type: none"> • Women's lack of voice • Gender and social norms: women should stay at home and undertake care work • Women's limited mobility • Lack of supportive measures in the community to access health services 	<ul style="list-style-type: none"> • Gender-blind attitudes of health workers and service provision without needs met • Lack of female providers • Health facilities aim to reach only women and not men • Female health workers face threats in the communities 	<ul style="list-style-type: none"> • Lack of laws, policies, data and training on gender issues in health sector • Lack of accountability • Lack of guidance on engaging men in child rearing and health care

[Source: Adapted from Immunization and gender: a practical guide to integrate a gender lens. UNICEF ROSA (2019)]

Box 1 Beyond immunization: Did you know?

Achieving gender equality and women's and girls' empowerment is one of the **Sustainable Development Goals (SDGs) – Goal 5**. It is also a driving force for advancing all other goals, including SDG3 on health and well-being. Applying a gender lens to increase immunization coverage contributes to SDG5 and SDG3 in particular. More on the SDGs and gender:

■ **United Nations: Achieve gender equality and empower all women and girls**

<https://sustainabledevelopment.un.org/topics/genderequalityandwomensempowerment>

■ **UN Women, Progress on the Sustainable Development Goals: The gender snapshot 2021**

<https://www.unwomen.org/en/digital-library/publications/2021/09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2021>

■ **Equal Measures 2030, Gender Advocates Data Hub**

<https://www.equalmeasures2030.org/data-hub/>



SDG 5: Achieve gender equality and empower all

 <p>Target 5.1 End all forms of discrimination against all women and girls everywhere.</p>	 <p>Target 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.</p>	 <p>Target 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.</p>
 <p>Target 5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.</p>	 <p>Target 5.5 Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life.</p>	 <p>Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.</p>
 <p>Target 5.7 Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.</p>	 <p>Target 5.8 Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women.</p>	 <p>Target 5.9 Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.</p>

What is gender mainstreaming in immunization programmes?

Gender mainstreaming is a process and a strategy for reaching gender equality. This means assessing the implications for women and men of any planned action, including legislation, policies and programmes, in all areas and at all levels. As a strategy it involves **integrating the concerns and experiences of women, as well as men**, into the design, implementation, monitoring and evaluation of immunization policies, budgets and programmes with a view to promoting equality and not perpetuating inequality.

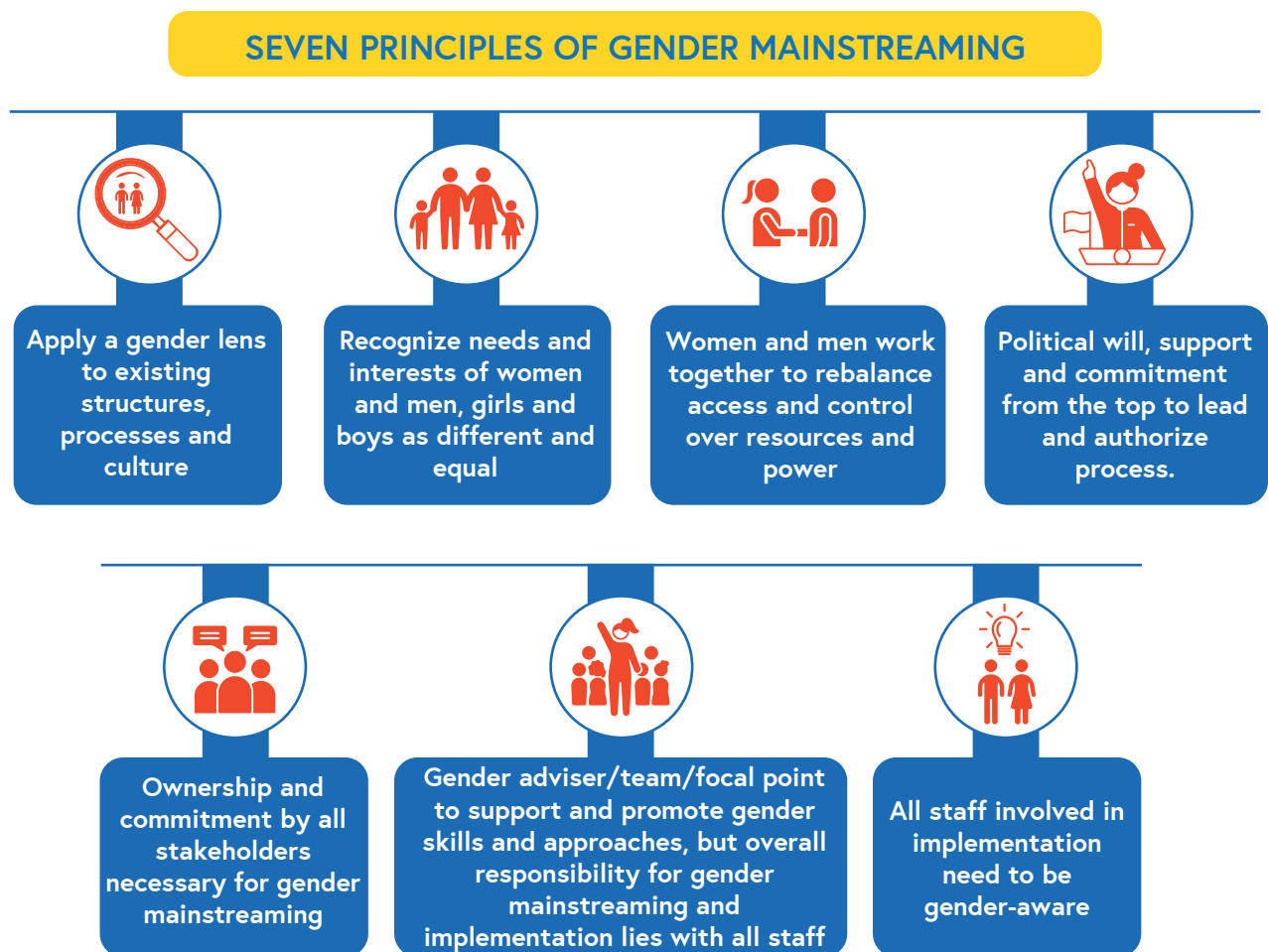
Gender mainstreaming is undertaken at three levels – (i) policy, (ii) institution/organization and (iii) programme/project – and is based on seven principles of gender mainstreaming (see box).



Gender mainstreaming is NOT the goal itself, but rather a PROCESS or a STRATEGY for achieving the goal of gender equality.

Mainstreaming gender equality is about more than just understanding different needs of diverse women, men, girls and boys. It is also about understanding the ways in which the different roles and expectations within a society dictate what it means to be male and female and consequently, how this shapes context and the situation in which programming is conducted. Gender mainstreaming is about applying knowledge of gender to implement more effective programmes and to take opportunities to promote equality between women and men, girls and boys.

Figure 3. Seven principles of gender mainstreaming



[Source: Gender toolkit: integrating gender in programming for every child in South Asia. UNICEF ROSA (2018).]

What is gender analysis?

Gender analysis is the **starting point for the process of gender mainstreaming**. It refers to the methods of collecting and analysing quantitative data (numbers, percentages, proportions, ratios) and qualitative information (preferences, beliefs, attitudes, behaviours, values, etc) through a gender lens.

It is a systematic methodology for examining the difference in roles and norms between women and men, girls and boys; the different levels of power they hold; their differing needs; constraints and opportunities; and the impact of these differences in their lives. An effective gender analysis will also consider additional factors, including age, ethnicity, race, disability, gender identity, geographic location and socioeconomic background.

An example gender analysis matrix is included in Annex I. Further information on how to do a gender analysis is provided under "Useful resources" in this chapter.

A gender analysis consists of **three basic components**:



Gender- and sex-disaggregated data and information (both quantitative and qualitative)



Analysis (what does the information mean?)



Gender perspectives (analyse the differences between women and men, girls and boys)

Remember, "analysis" can occur on many different levels. It can be an analysis that is done at a desk when planning a programme or project, or it can be an in-depth research and analysis that can be contracted out to partners and communities.

[Source: Gender toolkit: integrating gender in programming for every child in South Asia. UNICEF ROSA (2018).]

Why conduct a gender analysis?

Gender analysis is useful to reveal the nature and extent of gender inequalities and discrimination against women and girls, and men and boys. In concrete terms, gender analysis helps:

- To avoid making assumptions about the lives of women and men, boys and girls.
- To understand why gender differences exist between all groups in a population.
- To recognize how the cultural, economic and legal environment places women and girls (men and boys) at a disadvantage in terms of opportunities throughout their lives, and the linkages between inequalities at different societal levels.
- To identify how these differences may prevent women and girls as well as men and boys from participating in or benefiting from programme/projects.
- To recommend specific actions to meet the needs of women, men, girls and boys in an equitable manner.
- To monitor and evaluate the progress achieved in closing the gaps between women and men, girls and boys in their ability to access and benefit from an intervention as well as reducing gender discrimination.

Types of questions to ask for a gender analysis of immunization programming:

- How do women and men get information about essential vaccines, and what are their preferred channels/methods/platforms/trusted sources? How do these differ for women and men, and for women and men from urban/rural areas, different ages and ethnicities, and those with disabilities?
- Who makes decisions about children's immunization in the household? Which generation? What resources do women and men need to be able to ensure their child is immunized (e.g., information, money, time, transportation)? Who has access to and control over these resources?
- In specific neighbourhoods or communities, who can access households to immunize children where house-to-house campaigns take place? Are there areas where only female health workers or volunteers are permitted to enter households? How does access (or lack of it) impact planning for frontline workers, such as social mobilizers and vaccinators?
- Are women equally and meaningfully participating in immunization programme design, implementation, monitoring and evaluation at different levels? How? What could be done to further increase their participation?
- What barriers exist for women and men to access health centres to seek immunization (related to, for example, quality, safety, availability, access and space in waiting areas)? How could these barriers be addressed most effectively?
- What are the possible barriers shaped by sociocultural and gender norms as well as laws/policies that might hamper immunization coverage or, for example, the effectiveness of transit and mobile teams reaching people on the move?
- How are health workers recruited, trained and supported/supervised? What are their opportunities to progress professionally and to be equally remunerated? Are there any issues related to worker safety, workload or flexibility of working hours? Do health workers receive gender training?
- Have women and men from different backgrounds been consulted and involved in designing, monitoring and evaluating immunization services? If so, in what ways?



Useful resources

For more information on how to do a gender analysis, see:

- ***Immunization and gender: a practical guide to integrate a gender lens into immunization programmes*** (UNICEF Regional Office for South Asia [ROSA] 2019)
<https://www.gavi.org/sites/default/files/document/programmatic-policies/UNICEF-ROSA-Practical-Guidance-on-Immunization-and-Gender-2019.pdf>
- ***Gender mainstreaming for health managers: a practical approach: the WHO Gender Analysis Matrix*** [included in Annex I] (WHO 2011)
https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAnalysisMatrix.pdf
- ***Taking sex and gender into account in emerging infectious disease programmes: an analytical framework*** (WHO Western Pacific Region 2011)
https://iris.wpro.who.int/bitstream/handle/10665.1/7977/9789290615323_eng.pdf

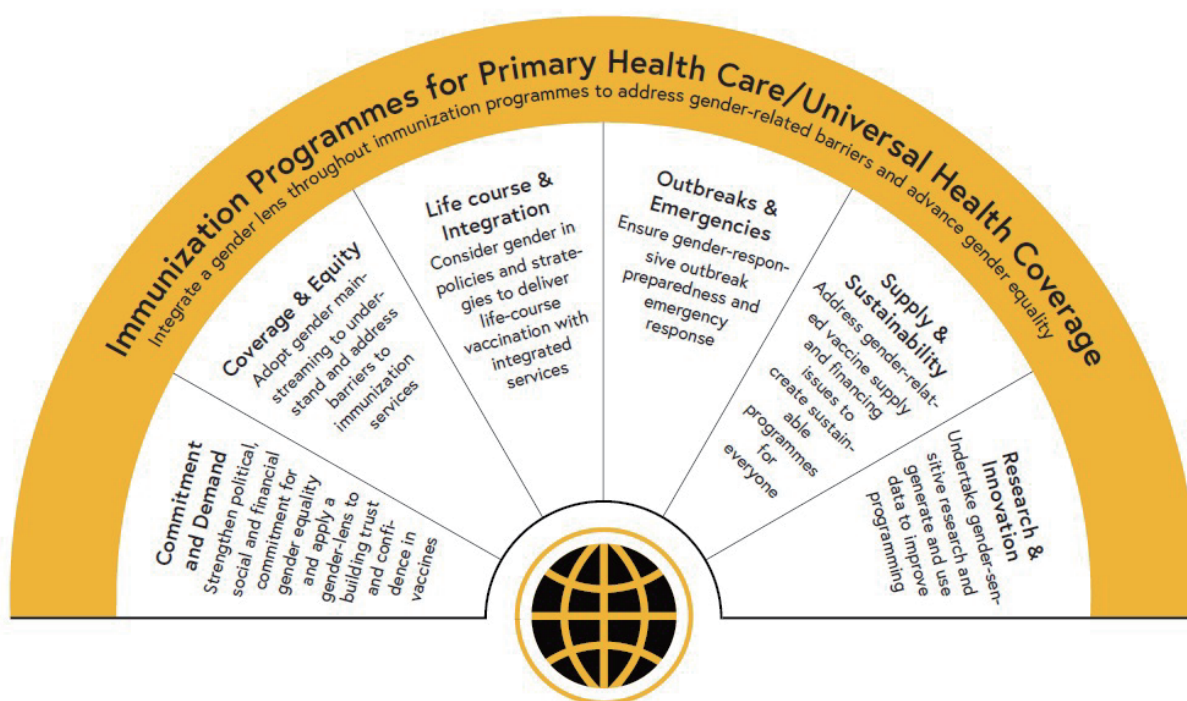
CHAPTER 2

Chapter 2: IA2030 and gender



IA2030 sets an ambitious, overarching global vision and strategy for vaccines and immunization for the decade 2021–2030. It positions immunization as a key contributor to people's fundamental right to the enjoyment of the highest attainable physical and mental health. **Immunization is a catalyst for creating a healthier, safer and more prosperous world for women, girls, boys and men everywhere.** IA2030 aims to ensure that no one is left behind, in any situation or at any stage of life.

Figure 4. Gender and IA2030 strategic priorities



IA2030 commits to **addressing gender-related barriers to immunization and advancing gender equality** in order to realize its vision for the decade: a world where everyone, everywhere, at every age, fully benefits from vaccines for good health and well-being. Gender is an important cross-cutting consideration for all seven IA2030 strategic priorities. Key examples are shown in Fig. 4.

The strategic priority "Coverage & Equity" highlights gender as a key area of focus. The overall ambition of coverage and equity is that everyone should have access to safe and effective vaccines regardless of their geographical location, age, socioeconomic status or any gender-related or other obstacle. Understanding the role of gender in accessing immunization services and implementing gender-responsive approaches has been identified as a high-impact strategy for accessing underserved populations.

Box 2 Gender and UHC

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

Addressing gender-related barriers and the specific needs of women and men in health services, advancing gender equality, and increasing women's meaningful participation in the design and delivery of health services are needed to advance the SDGs and achieve UHC. Because most of the world's poorest people are women, and because women are also consumers and providers of health services, they will be the main beneficiaries of UHC.

Addressing existing barriers and extending health coverage to women and girls everywhere will help to achieve UHC. Women constitute two-thirds of the health workforce, and thus make an essential contribution to delivering health and immunization services globally. Women are key for delivering UHC. They must be fully recognized as drivers of change and be part of decision-making at all levels in global health.

Gender and equity are a cornerstone of universal health coverage (UHC) and primary health care.

More on the SDGs and gender:

- **Primary health care on the road to universal health coverage: 2019 monitoring report. (WHO 2020)**
<https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf>
(see pages 57–84, "Chapter 3: Breaking barriers: towards more gender-responsive and equitable health systems")
- **WHO Universal Health Coverage Web page (WHO)**
https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
- **Call to Action: Universal Health Coverage. (September 23, 2019. Women in Global Health (WGH))**
<https://www.womeningh.org/uhc-gender>

IA2030 aims to understand and address all direct and indirect barriers to immunization service access shaped by gender and gender inequality (outlined in the next section on core principles), including demand-related barriers e.g., access to health information, resources, decision-making and people's experience of health services as well as supply-related barriers, such as government policies, hiring, remuneration and promotion of health workforce, quality of services, and health worker attitudes. Identifying and addressing these barriers can be done through employing gender-responsive strategies (see Chapter 4) which take into account the different needs, experiences and vulnerabilities of women, men, girls and boys – including gender-transformative actions that aim to dismantle harmful gender norms and roles, empower women and girls, and advance gender equality.

IA2030: core principles

The seven strategic priorities of IA2030 are anchored in the four core principles (see below). Viewed through a gender lens, the principles are rooted in the fundamental value of gender equality and provide guidance for translating the IA2030 strategy into practical actions.

IA 2030

People-focused

Responding to the different needs of women, men, girls and boys



The design, management and delivery of immunization services should be shaped by and responsive to the needs, experiences, preferences and vulnerabilities of women, men, girls and boys of diverse backgrounds. Programme design should be led by and inclusive of communities that programmes are targeting (e.g., marginalized or missing communities where zero-dose children are often found). Community-based approaches should be favoured over "one-size-fits-all" national or regional solutions. When programmes target women, women should lead programme design.

"Do no harm" should be a central principle in programming to avoid creating adverse impacts or reinforcing harmful gender norms and roles that contribute to marginalization, sexual harassment, exploitation and other forms of GBV.

Country-owned

Driving progress through country commitment to gender equality



Country ownership and accountability should be promoted at all levels to ensure that countries recognize the potential and importance of addressing gender-related barriers to accessing and utilizing health care, and that they are equipped with the resources they need to identify and address gender-related and other intersecting social barriers in health services.

Linkage with relevant gender equality processes and commitments, including the SDGs (particularly SDG5), at the country level is key. Engage with national committees responsible for driving results and monitoring progress towards SDGs, and other national and global gender equality commitments. Women's equal participation in national immunization bodies and advisory groups must be promoted.

Partnership-based

Aligning efforts to maximize impact for gender equality



Immunization partners, including ministries of health, should align and coordinate their actions to increase efficiency, build on complementarity and involve sectors beyond health for mutual benefit in identifying and addressing gender-related barriers to immunization and increasing women's meaningful participation at all levels of the health system.

Local communities and civil society, especially groups and organizations led by women and adolescent girls or youth, should be involved in planning, implementing and overseeing immunization interventions to strengthen accountability and sustain impact. Other critical partners include national ministries of gender/women, gender units in health ministries and global partners such as UN Women, United Nations Population Fund (UNFPA), UNICEF, United Nations Development Programme (UNDP) and other UN agencies with gender units.

Data-guided

Promoting evidence-based decision-making informed by sex-disaggregated data and gender analysis

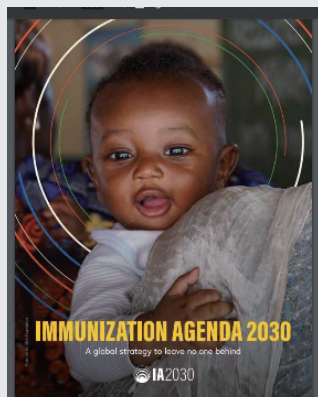


High-quality, "fit-for-purpose" gender data, disaggregated and analysed by sex and age, and additional factors such as ethnicity, disability and geographical location, should be used to track progress, identify gaps and challenges, improve programme performance, and form the basis of programming and decision-making at all levels. Particular efforts should be made to generate evidence and data via qualitative studies and behavioural science inquiry.



Useful resources

- **Immunization Agenda 2030: A Global Strategy to Leave No One Behind** (WHO 2020)
<https://www.immunizationagenda2030.org/>
- **Strategic Priority 3: Coverage and Equity** (WHO 2020)
<https://www.immunizationagenda2030.org/strategic-priorities/coverage-equity>



CHAPTER 3

Chapter 3: Understanding gender-related barriers to immunization



This section highlights different ways in which gender shapes both the demand for and provision of immunization services. To develop effective interventions for increasing immunization, it is necessary to fully understand these different barriers, how they are compounded by other barriers as a result of additional social factors (such as socioeconomic status, disability and the rural/urban divide) and the levels on which they operate.

Barrier 1: Poor quality services and negative health provider

Factors related to the **quality, acceptability** and **accessibility** of health services may deter women and men from attending immunization services for themselves and their children. This can include the following:

Poor working conditions and lack of supportive supervision: Health workers are often performing their jobs without adequate remuneration, equipment/transport, or supervision. This can create an overburdened and demoralized workforce which in turn is challenged to provide quality services. This is discussed further in Chapter 4.

Patronizing and disrespectful treatment has been reported as endemic in vaccination sites in many countries. Poor treatment by providers deters many women from returning to health centres after they have had a negative experience, resulting in a missed opportunity for vaccination. In many settings it is unusual for men to bring children for vaccination. As a result, they may be ridiculed, which discourages them from returning and possibly results in further missed vaccinations.

Absence of female health-care providers: In areas where sociocultural and/or religious norms and practices restrict women's mobility and social and physical contact between men and women, women may not seek care for themselves or even for their children unless they have access to a female provider. In Afghanistan, for instance, women refused life-saving tetanus toxoid (TT) from male vaccinators. Both men and women reported that the lack of separate waiting areas inhibited women's use of health facilities (6).

Disabilities (physical and cognitive) compound gender barriers and disadvantages. People living with disability are more than twice as likely to report finding health-care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care (7). The intersectional impact of gender and disability may result in different challenges and barriers. For example, disability in a man may be more acceptable to a community than for a woman, who may be treated as an outcast. These realities threaten to undermine UHC and can impact mothers' and fathers' access to immunization services for their children.

Discrimination in health-care settings is widespread and takes many forms, affecting both users of health services and health-care workers (e.g., pay gaps, sexual harassment, limited promotion opportunities). **LGBTQI** communities face significant social stigmatization, discrimination and marginalization, contributing to negative health outcomes (8). Although research on links with immunization outcomes is limited, research shows LGBTQI communities experience limited access to essential health-care services, lack of competent and quality care from providers, and challenges in affording services necessary to realize the right to health. In Brazil, the negative attitudes of health workers towards LGBTQI service users have been documented in primary, secondary and tertiary health care. A national survey carried out in the United States found that 28% of trans people had postponed health care due to discrimination, and 28% reported being harassed by health workers when they did seek care (9).

Other service quality barriers: Lack of adolescent-friendly services, long distances to health facilities, long waiting times, and lack of appropriate opening hours, sanitation facilities and confidentiality. These factors can have a differential impact on women and men's access to immunization services.

Barrier 2: Low education level and health

There is a strong link between maternal **education**, child health and positive immunization outcomes (10,11,12). While lower literacy levels and lack of access to health information can hamper both women's and men's knowledge of, utilization and access to immunization, women are often more disadvantaged. Although a father's level of education is also associated with a child's immunization status, a mother's lower education level is more commonly related to undervaccination (13). Women who are more literate, regardless of their education level, are more likely to vaccinate their children in both urban and rural settings (10).

Part of the strong link between mothers' education level and childhood immunization coverage is explained by socioeconomic status and context-specific factors. Mothers with a higher level of education tend to live in more affluent households and in areas with better access to health services (14,15). Children of younger women without education, especially those belonging to poor households, are more disadvantaged (2).

Barrier 3: Limited autonomy in decision-making and household

The different social roles assigned to women and men affect the degree to which women have access to and control over **decision-making** related to their health and their children's health (16). While traditional gender norms and roles generally render women the designated caregivers for children, men often are decision-makers within households due to unequal power relations and gender inequality. Yet vaccination interventions often only target women caregivers, neglecting the influence men have over decisions about immunization and other health-care issues. Health-care-related decision-making is negotiated within the household and extended family. Mothers may be limited in their bargaining power in both the gendered (with the male head) and generational (with elderly women and men) power dynamics of the household (2,17).

Women's **decision-making** and **agency** have been strongly associated with children's immunization status. For example, a study in Nigeria showed that the higher women's autonomy and decision-making capability was, the more likely they were to immunize their children. Studies throughout South Asia have shown that women's greater decision-making autonomy translates into greater use of maternal and child health services and positive health outcomes (18).

Mothers who perceive that spousal permission is required for their child's immunization are less likely to fully immunize their child. An assessment carried out in Afghanistan shows that many women cannot take independent decisions on their own health and often culturally required to be accompanied for seeking health services. Male heads of households (i.e., husband, father or brothers) generally make those decisions for women, inhibiting timely access to health-care services for women and their children (19). This delay is further exacerbated by needing to arrange for a chaperone once permission is granted.

Barrier 4: Lack of access and control over resources and mobility

Women, especially in lower-income and emergency settings, tend to have poorer access to and control over critical resources, **such as time, money, information and transportation**, that may influence health and immunization outcomes. This is especially the case for single mothers, and those in low-income households in rural areas (2). In a study conducted in Nigeria, the most commonly reported barrier to accessing immunization was the lack of financial resources for the costs of transportation or services (20).

Women's restricted access to and control over **financial resources** makes it less likely that their children are immunized. In families where women play an important role in decision-making, the proportion of financial resources devoted to children is greater than in families in which decision-making is less equal (21). A study exploring the links between women's autonomy and children's immunization coverage in Ethiopia found that women who had the power to decide about use of financial resources were more likely to have their children partially or fully immunized, compared to women who were not involved in decision-making. Importantly, women who made financial decisions jointly with their husband were even more likely to have their children vaccinated, compared with women who made financial decisions independently (21), pointing to the important role men can play in improving children's health outcomes. This finding indicates the value of immunization messaging that targets the couple, as well as men and women individually.

Although immunization services are usually free of charge, **transportation** adds a "**hidden**" **cost** in many settings. In poor areas, mothers need to raise the necessary resources or mobilize means of transport to take their children to be vaccinated. **Mobility** may also be restricted by safety and security concerns which are heightened in conflict and emergency settings. For instance, the prevalence of GBV also generally increases under these circumstances (2). In a study on women's health-care access in Afghanistan, almost one-third of women reported insecurity as a reason for not visiting the health facility when sick (23).

Time is also a resource and an opportunity cost which may create barriers for immunization, especially for women if distances or waiting times for vaccination are very long (24). Women are generally expected to take on the majority of household work and caretaking responsibilities, social tasks and other family obligations, ranging from cooking, cleaning and taking care of children and sick family members to collecting water and firewood and entertaining guests. This applies also to the mostly female health workforce who often struggle with multiple responsibilities and long "double" work days. Globally, women perform on average three times as much unpaid care and domestic work as men (25). Studies in Bangladesh, China and Gabon have pointed to time constraints that limit opportunities for health seeking and access to health services (24). Time costs due to weak infrastructure are greatest in remote areas, while workforce participation creates additional time and income constraints for women in urban areas (2).

Religious or cultural norms also affect women's **mobility** as they may influence **interactions** expected or permitted between women and men. For example, in the Nigerian Hausa tradition, unrelated men may not speak to women without permission from their husbands. In polio eradication activities, deploying women frontline workers has increased the effectiveness of immunization delivery, as in many settings only women can access households and vaccinate children inside (26). All-male vaccinator teams were found to be ineffective, posing a critical gender-related barrier to polio eradication efforts (27). A review of polio immunization in Afghanistan suggested that mothers' refusals were related to interactions with all-male vaccination teams (28).

Barrier 5: High prevalence of gender-based violence (GBV) and harmful practices

One in three women experience **GBV** in their lifetime. Moreover, conflict and displacement may exacerbate existing violence and lead to new forms of violence against women (29). While men and boys may be affected by GBV, women and girls are disproportionately affected. Apart from being a serious human rights violation rooted in gender inequality, GBV has multiple negative health effects on physical, psychological, sexual and reproductive health. Immunization services may provide critical entry points for health workers to refer survivors to receive appropriate support. Health workers themselves can be subjected to GBV through sexual harassment by co-workers/supervisors and the community.

In addition, **GBV also has a harmful effect on immunization outcomes**. GBV may decrease the likelihood of women utilizing health services for themselves or their children due to fears of disclosing violence to others outside the household. A study focusing on the impact of intimate partner violence on childhood immunization in Bangladesh confirmed a strong and significant effect on children's immunization levels (30). In Rwanda, a study on GBV care found that women abstained from seeking health care to avoid more violence and abuse and to "protect the reputation" of their husband and family (31). GBV has been shown to contribute to overall lower use of reproductive and maternal health services and adverse child health outcomes (18).

Child marriage, a form of GBV, also has a direct impact on girls' and women's access to and utilization of health services, including immunization. Currently, in the least developed countries, 40% of girls are married before the age of 18 and 12% of girls are married before age 15 (32). Adolescent girls forced into child marriage are less likely to have knowledge about health, and are more likely to suffer from GBV, unwanted pregnancies and maternal morbidity and mortality, while gender norms restrict their decision-making and agency in the family and their mobility, hindering their access to vaccination services (33). Child marriages are heavily associated with low education levels, as girls who are denied educational opportunities are more likely to marry young. Child marriages weaken girls' and women's bargaining power on health decisions. For example, in South-West Asia child marriages were found to lead to 11% fewer antenatal visits. A study looking into the effect of early marriage on women and children's health in sub-Saharan Africa found that the probability of children receiving basic vaccinations is twice as high and their neonatal mortality reduction is nearly double if their mothers married between age 15 and 17 instead of between age 10 and 14 (34).

Son preference, rooted in gender inequality, has also been found to decrease the likelihood of girls receiving vaccinations in some settings. Although globally there are no major disparities in girls' and boys' immunization coverage, the preferential treatment of boys is perpetuated in some contexts. Girls have faced greater abandonment and neglect in many areas of the world, particularly Asia (35). Indian girls, for example, were found to be less likely to receive health care, to have less money spent on them for medicine and to be taken to health-care facilities at later stages of illness (36).

CHAPTER 4

Chapter 4: Gender-responsive approaches to increasing immunization coverage



Gender-related barriers need to be effectively addressed from both the demand and service provision/supply side, at all levels ranging from individuals and communities to health services and national policies and structures. This chapter demonstrates *how* gender-responsive approaches and gender mainstreaming can be implemented in the different priority areas of IA2030.

A continuum of gender-responsiveness

Programmes, policies and interventions are considered to be "**gender-responsive**" when gender roles, norms and inequalities have been analysed and appropriate measures have been taken to actively address them. Gender-responsive programmes can be either "**gender-specific**" so that they target a specific group of women or men but do not challenge gender norms and roles, or they can be "**gender-transformative**" when they address the causes of gender inequality and attempt to transform harmful gender norms and roles.

Immunization interventions should, at a minimum, be gender-specific, and ideally and when possible, gender-transformative. Fig. 5 is adapted from WHO's Gender Responsive Assessment Scale (37) and provides an overview of each level, with illustrative examples related to immunization programming. Gender-unequal and gender-blind are harmful and contrary to the IA2030 core principle of doing no harm.

Figure 5. Gender Responsive Assessment Scale

GENDER-RESPONSIVE				
Gender-unequal	Gender-blind	Gender-sensitive	Gender-specific	Gender-transformative
<p>Perpetuates gender inequalities, reinforces stereotypes, privileges men over women (or vice versa).</p> <p><i>Examples:</i> Intentionally only disseminating vaccination leaflets to men; promoting harmful, traditional stereotypes about men's and women's roles in information, education and communication materials.</p>	<p>Ignores gender roles, norms and relations, and the differences in opportunities and resource allocation.</p> <p><i>Examples:</i> Informing the community about the next polio campaign only through posters when 80% of women and 10% of men in the village are illiterate; setting up a vaccination information point only at a marketplace where women are not allowed to visit.</p>	<p>Shows an awareness of gender roles, norms and relations while not necessarily addressing inequality generated by them; no remedial action developed.</p> <p><i>Examples:</i> Director of a national immunization programme acknowledges gender issues; programme assessment includes gender analysis which is not followed up in implementation.</p>	<p>Intentionally targets a specific group of women or men for a specific purpose; doesn't challenge gender roles and norms.</p> <p><i>Examples:</i> Organizing a mobile tetanus vaccination site in a women's handicraft studio and community kitchen; sending women vaccinators to households in areas where women cannot freely interact with men.</p>	<p>Addresses the causes of gender inequality; transforms harmful gender roles, norms and relations; promotes gender equality.</p> <p><i>Examples:</i> Community programme encouraging fathers to take an equal and active role in child health and immunization; women, men and youth equally participate in immunization delivery design and implementation at different levels.</p>

The action lists in this chapter are categorized by where they generally fall on the gender continuum – between gender-sensitive, gender-specific and gender-transformative. However, these categories are not rigid and should be used for guidance only. *How* an activity is implemented and the context in which it is implemented will affect the categorization. (see Annex II for additional resources and tools for gender-responsive programming).

Approach 1: Invest in gender data and analysis

Immunization programmes are strongly driven by the use of data. In order to mainstream gender, these data need to be systematically broken down by sex and additional factors such as age, location, socioeconomic background, disability and ethnicity. This will make it possible to identify and respond to gender inequities and to design appropriate gender-responsive immunization programmes and policies. The current global gender data gap means that health actors lack sufficient knowledge of the gender dynamics to design targeted health policies and achieve progress on the SDGs. Generating gender data is critical for action.

Fig. 6 shows how using both "sex-disaggregated" and "gender-disaggregated" data provides a gender perspective to inform the design of a programme or intervention.

Figure 6. An illustrative example of the difference between sex-disaggregated and gender-disaggregated data in a district where DTP3 (three doses of diphtheria, tetanus and pertussis vaccines) coverage is 74%. These statistics are fictitious.

Data	Possible implications
District DTP3 coverage is 74%	
Statistics disaggregated by sex	
DTP3 coverage girls: 75%; DTP3 coverage boys: 73%	This difference is not significant, and there appears to be no difference in vaccination of boys and girls.
Gender data	
For mothers with at least high school education, DTP3 coverage is 79%. For mothers with none or only primary education, coverage is 69%.	Mothers who are educated may be more health literate and understand the importance of vaccination. They may also have better access to health services, as they are likely to be less disadvantaged.
For mothers with a bank account or mobile money service provider, coverage is 81%; for those who do not, it is 65%.	These mothers may have more autonomy in decision-making in the household and a separate source of income apart from their partners. Therefore, they are more able to vaccinate their children.
For facilities where health workers are at least 50% female, DTP3 coverage is 79%; for other sites (where most health workers are male), coverage is 71%.	Many mothers feel more comfortable approaching a female health worker. Consequently, attendance may be higher in facilities with more female health workers.
For mothers reporting violence at home from a partner, coverage is 64%, compared to 77% for those not experiencing violence at home.	Mothers reporting GBV may use health services less for themselves or their children due to fears of disclosing violence to others outside the household.

DATA & ANALYSIS



Collect and analyse immunization data (qualitative and quantitative) disaggregated by sex and additional factors, including age, ethnicity, socioeconomic background and disabilities. *[Gender-sensitive]*



Make sure all immunization action plans, strategies, policies, surveys and programme updates contain sex-disaggregated data and are informed by a gender analysis. *[Gender-specific]*



Monitor gender-sensitive indicators in immunization plans and programmes (see Annex III for some suggested indicators). *[Gender-specific]*



Use participatory methods for data collection (ensuring women's and men's meaningful participation). *[Gender-specific]*



For monitoring and evaluation, include indicators that measure the anticipated changes for women and men, girls and boys. *[Gender-sensitive]*



Useful resources

- **Gender statistics manual: Integrating a gender perspective into statistics** (UN Statistical Division 2015)
<https://unstats.un.org/wiki/display/genderstatmanual/Integrating+a+Gender+Perspective+into+Statistics>

- **Equal Measures 2030's Gender Advocates Data Hub**
<https://www.equalmeasures2030.org/data-hub/>

A resource for data, visualizations and impact stories showcasing data on gender equality issues across the SDGs. Includes analysis of the state of gender equality across 129 countries (covering 95% of the world's girls and women) through a 2019 SDG Gender Index and 2020 Projections on five key gender equality issues taken from the Index.

- **Global Health 50/50: Towards Gender Equality in Global Health**
<https://globalhealth5050.org/>

Global Health 50/50 is an independent research initiative that informs, inspires and incites action and accountability for gender equality and health equity.

- **Behavioral and social drivers of vaccination (BeSD)**
<https://www.demandhub.org/besd/>

The BeSD workstream aims to support programmes and partners to boost the availability, quality, and use of data to assess and address reasons for undervaccination. This can be achieved with the use of evidence-informed and globally standardized tools, adapted locally. Data will inform the design and implementation of targeted interventions and global tracking of comparable trends.



Gender Lens

Participatory data collection

Uncovering powerful new insights about those living in hard-to-reach communities

TEGA (Technology Enabled Girl Ambassadors) is a mobile based, peer-to-peer research app used by some of the world's leading development organizations to provide safer, faster, more scalable and authentic research around the world. TEGA empowers adolescent girls aged 16–24 to conduct interview research within their own communities, including with men and boys. This unique approach unlocks the open and honest conversations that might otherwise be lost or not included when collecting data in traditional ways.

Insights collected by TEGAs help organisations better understand the reality of girls' lives, meaning better designed, more targeted development programmes that have real impact.

More: <https://www.girleffect.org/what-we-do/mobile-platforms/tega/>

Gender-sensitive indicators in polio eradication

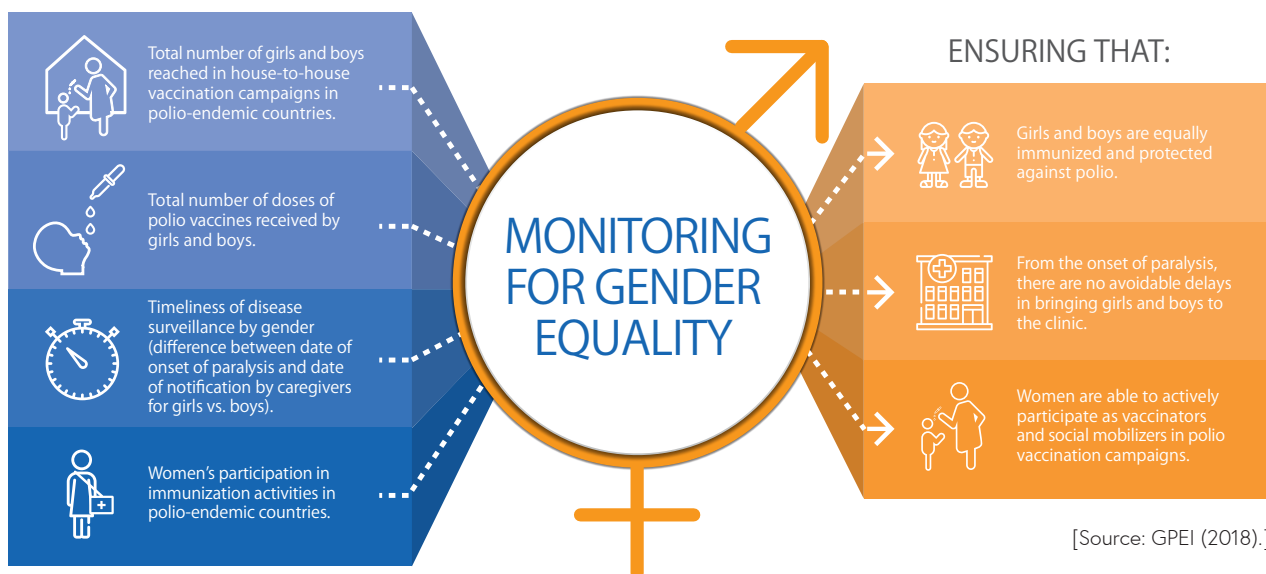
To ensure equal access to vaccinations and the engagement of women, in 2017 the GPEI developed four gender-sensitive indicators for monitoring progress (Fig. 7). The indicators measure (i) whether girls and boys are reached equally with polio vaccines; (ii) the total doses received by girls and boys; (iii) the timeliness of surveillance for girls and boys; as well as (iv) women's participation as frontline health workers.

Figure 7. GPEI gender equality monitoring



The Global Polio Eradication Initiative (GPEI) is committed to monitoring and addressing gender-related barriers in immunization, surveillance and communications activities to ensure all girls and boys are reached with life-saving polio vaccines.

THE GPEI CONTINUOUSLY TRACKS AND MONITORS:

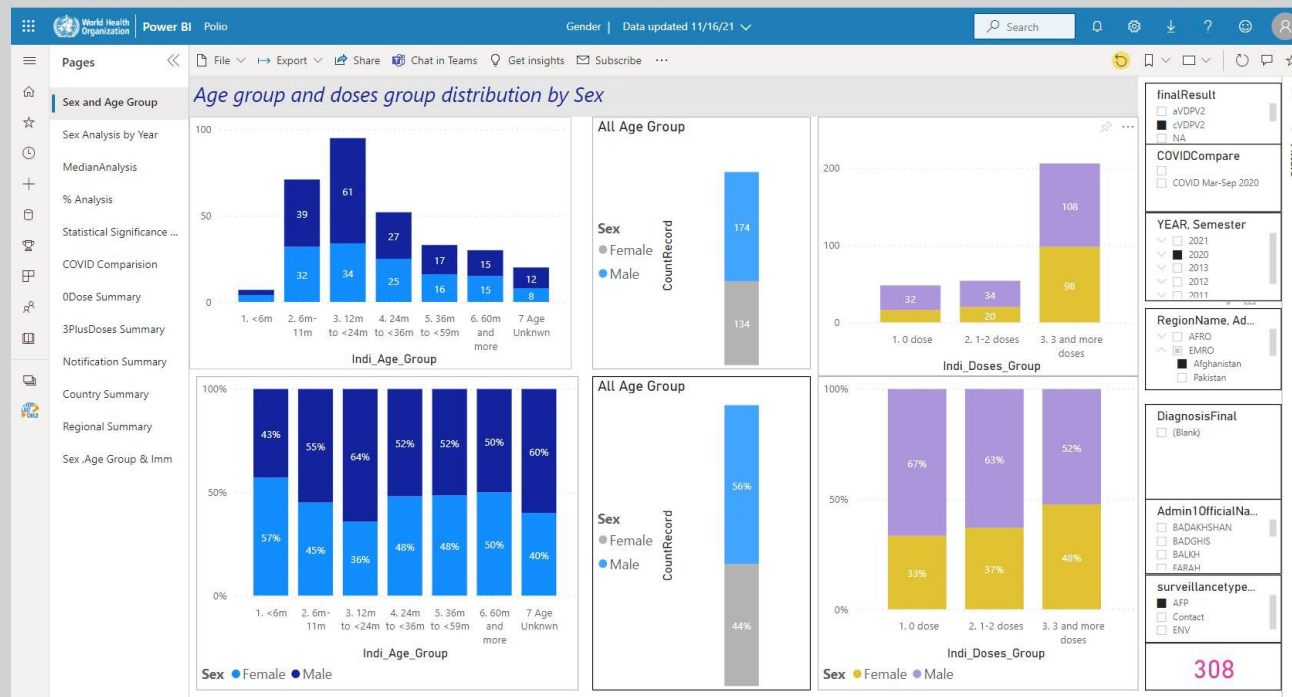


[Source: GPEI (2018).]

Box 3

Spotlight on sex-disaggregated data in polio eradication

The GPEI constantly collects and analyses sex-disaggregated data to track whether girls and boys are reached equally with vaccines and through polio surveillance and ensures that any gender discrepancies found are effectively addressed.



Approach 2: Make community engagement and social mobilization gender-responsive and transformative



Gender Lens

MIRA Channel (Women Mobile Lifeline Channel) is an integrated mobile phone channel to provide health information to rural women and connect them with public health services using mobile phones in low-resource settings in India. Each subchannel has multiple tools delivering information to women through interactive "edutainment" tools by building their knowledge and creating awareness on critical health issues, including vaccination, and ultimately connecting them to the public health services. It supports women to go for regular antenatal check-ups and timely vaccination, helping to adopt safer behaviours while reducing maternal and infant mortality.

More: <http://www.zmqdev.org/mira-channel-2/>

Community outreach and engagement, social mobilization, health promotion and community-based interventions are critical to addressing gender-related barriers to immunization and health-care access. Demand promotion, being among the IA2030 strategic priorities, is a crucial component of effective immunization delivery, particularly in reaching underserved populations and zero-dose children (38).

Understanding and addressing the different needs, preferences for communication channels and platforms, and concerns of women and men are central for successful behaviour change and community outreach. The recipients of community engagement and immunization-related messages must at a minimum be actively consulted and ideally critically involved in the design of these interventions. This is particularly important in engaging with marginalized and difficult-to-reach communities.

Effective communication, both interpersonal and through different media channels, can promote gender equality by transforming attitudes and norms that perpetuate gender-based discrimination. Communication is also closely linked to empowerment as it contributes to building confidence and skills to negotiate choices and demand equal access to and control of resources (39). Where possible, while considering the different needs and experiences of women and men, gender-responsive behaviour change interventions for immunization should aim to be transformative – that is, try to change harmful gender norms and roles, and advance gender equality.

▶▶▶ Action List ◀◀◀

COMMUNITY ENGAGEMENT & SOCIAL MOBILIZATION



Ensure a gender-responsive lens in any social mobilization situation analyses, assessments and communication plans. *[Gender-specific]*



Ensure gender-balanced social mobilization and community engagement teams, as well as other communication-related immunization groups and events (e.g., expert panels, workshops and advisory groups). *[Gender-specific]*



Consult equally with women, men, boys and girls in the design, testing and delivery of immunization communication and products. *[Gender-specific]*



Design immunization materials, messages and interventions to challenge harmful gender norms, roles and stereotypes. For example, in all immunization-related messaging and materials portray women as equal and active participants, not only as mothers and caregivers, and show men caring for children. *[Gender-transformative]*



Choose communication channels and platforms that address differences in access (related to education and literacy, mobility, workload or social practices). *[Gender-specific]*



Useful resources

- **Gender-responsive communication for development: guidance, tools and resources** (UNICEF ROSA 2018)
<https://www.unicef.org/rosa/reports/gender-responsive-communication-development-0>

Tips for gender-sensitive communication



Communication Products:

For written, visual, audio and audiovisual communication products:

- Balance the number of women and men, girls and boys featured in communication products. Show diversity - gender, age, ethnicity, dis/ability, roles, religions, rural/urban, etc.
- Include women and men, girls and boys in comparable and diverse roles. If, for example, featuring community leaders, include both a woman and a man, rather than a male leader and female housewife.
- Present the views of both women and men, girls and boys, and present them as equally important and relevant. Allow similar time for women and men, girls and boys to speak. Quote both women and men, girls and boys as sources of expertise, opinions, experiences, etc.
- Challenge oppressive stereotypes. Show women and men, girls and boys in non-stereotypical roles.
- Accurately present the situations of both women and men, girls and boys, conveying similarities and differences in their situations. Do not represent women and girls as inherently vulnerable. Show capacities, not only vulnerabilities.



Media Messages and Advocacy:

When sharing information, preparing media products and designing advocacy messages:

- Provide data - provide information disaggregated by sex and age.
- Get specific - present information about the specific situations, needs and capacities of women, men, girls and boys.
- Gender messaging - include gender equality messages.
- Repeat SDG Commitment to gender equality and women's and girls' empowerment as a means of achieving reaching children's full potential.

[Source: Gender toolkit: integrating gender in programming for every child in South Asia. UNICEF ROSA (2018).]

Approach 3: Engage with men to transform gender norms

Vaccination programmes rarely target men or fathers with information or messaging. By only targeting women, vaccination interventions neglect the critical influence men have over women's decision-making power in many settings. Targeting women only also misses out on the benefits of involving men in caregiving and decisions about immunization. Even if women have the primary daily responsibility for child health care, in some settings gender inequality and patriarchal norms allow men to control women's access to information, finances, transportation and other necessary resources to access health services (40). In many places the current health system context does not adequately recognize fathers' role in children's immunization nor does the system actively employ a gender-transformative approach to immunization (2).

Immunization programmes that reach out to men have been shown to lead to greater rates of immunization (41). Research in Uganda, for example, showed that men's involvement in child health issues was key for improving children's access to health care (42).



Gender Lens

Promundo delivers gender-transformative health programming through Program P/MenCare

Part of the MenCare Campaign, Program P is a direct and targeted response to the need for concrete strategies to engage men in active fatherhood from prenatal care through delivery, childbirth and their children's early years.

Developed in partnership with Puntos de Encuentro in Nicaragua, CulturaSalud in Chile and the Brazilian Ministry of Health, the programme has three components: offering information and tools for health-care providers, developing group activities for fathers and couples, and providing guidance for designing community campaigns. By targeting men, primarily through the health sector, Program P engages fathers and their partners at a critical moment – usually during their partner's pregnancies – when they are open to adopting new caregiving behaviours. More:

<https://promundoglobal.org/programs/program-p/#s>

▶▶▶ Action List ◀◀◀

ENGAGE WITH MEN



Target both men and women as caregivers in all immunization-related outreach and messaging. *[Gender-specific]*



Integrate themes such as gender equality, equal parenting and household decision-making, and men's equal share of childcare and other domestic responsibilities, in all health promotion messaging (including home visits) and include in education curricula. *[Gender-transformative]*



Train health personnel to positively encourage men in prenatal consultations and primary health clinics to take part in children's health and strengthen positive attitudes towards men visiting health centres with their children. *[Gender-transformative]*



Engage men's associations and groups as well as traditional/cultural/religious leaders on immunization-related communication. *[Gender-transformative]*



Use male influencers to model gender equality behaviours. *[Gender-transformative]*

Added value of engaging men and boys



Promoting human rights



Increasing entry points



Advancing development goals



Equitable partnership



Involving male leaders

Checklist: Engagement of men and boys in gender mainstreaming programming



Do programmes empower women and girls while also drawing in men and boys in gender-transformative ways?



Are men and boys drawn in as leaders and active participants and not dismissed or marginalized as potential opponents to change?



Do programmes allow men and boys to develop a greater personal stake in gender equality and to see how their lives may change in welcome ways?



Do initiatives give opportunities to men and boys to rethink issues related to masculinity?



How can behaviour change and learning environments for men and boys be created?

[Source: Gender toolkit: integrating gender in programming for every child in South Asia. UNICEF ROSA (2018).]

Approach 4: Empower and collaborate with civil society and change agents

It is important to identify and work with civil society and grassroots organizations (including women's formal and informal groups and girls and youth networks) and change agents. These organizations are powerful allies in overcoming gender barriers and increasing demand for immunization services. Civil society actors often work in the hardest-to-reach communities and can amplify the voice of the community to decision makers. Civil society actors also have the local expertise to disseminate immunization programme information to marginalized communities.

Forming and sustaining partnerships with a wide network of actors is key. Transformative change and dismantling of existing health-care barriers cannot be achieved without working together with women's groups, women leaders, women service providers, informal community networks and associations, and groups representing additional marginalized communities, such as LGBTQI, disability and refugee groups. Immunization programmes should not only involve these groups and communities in informing the design and delivery of services but also actively take steps to empower them with the necessary skills and provide them with safe platforms to voice their views.

Box 4 Change agents

Change agents are people who influence decisions about immunizing children and play a role in creating demand for immunization. Potential change agents to work with include the following:

- **Women's groups** can provide a space for building a peer support network to encourage health seeking by sharing women's burden and time for household or care work. Specifically, more marginalized groups of women, such as migrants who lack social support networks and community ties, may be at risk of not being able to attend immunization services due to resource constraints (24).
- **Elderly** women can act as social influencers.
- Women **health-care providers**, including midwives, serve as entry points for communication, trust and relationship building with other women, especially in settings where women's interaction with men is limited due to prevailing norms.
- **Men** can be important change agents as caregivers (decision-making, participating in care), clients of health and social services (especially in challenging settings such as conflict areas and camps for internally displaced people), and as influencers in the broader societal network, for example as community facilitators, cultural leaders and religious or political leaders, who can exert influence in shaping norms related to vaccine acceptance and act as allies in women's empowerment initiatives (2). Programmes with the potential to shift gender roles by empowering women through improvements in knowledge, decision-making and economic gains must consider the roles and interests of men as potential partners in these efforts.
- **Religious leaders** serve as the moral compass for the community in some settings where their opinion on health matters is strictly followed.
- **Celebrities**, especially those with a strong social media profile, can exert a public influence.

▶▶▶ Action List ◀◀◀

CIVIL SOCIETY & CHANGE AGENTS



Identify and invite change agents, including women's, men's and youth groups, and informal grassroots organizations, to participate in the planning, delivery, monitoring and evaluation of immunization services and programmes (especially in areas with low immunization coverage). *[Gender-transformative]*



Partner with initiatives that aim to build women's capacity and self-efficacy (e.g., skills building and economic empowerment) to advance gender equality, women's autonomy and empowerment. *[Gender-transformative]*



Understand the dynamics around gatekeepers in different contexts and plan special efforts to engage them. *[Gender-specific]*



Undertake gender-responsive research to understand the drivers of gatekeeping, misinformation and vaccine hesitancy. *[Gender-specific]*



Support women's equal participation in relevant structures in the development of local capacity to govern and manage immunization financing and planning, budgeting, and procuring of and delivering vaccines. *[Gender-transformative]*

Approach 5: Implement gender-responsive actions for the health workforce

Given that almost 70% of health workers are women (43), it is critical to focus on gender-related barriers within the health service. These include gender inequality in remuneration, leadership and promotions, and the prevalence of sexual harassment in the workplace, which negatively impacts the well-being of women health workers and thus the quality of health services. Women health workers often face gender **biases, discrimination and harassment** at work, and community health workers often hold a low status in the health system, where they are underrecognized, undersupported and underpaid (2). Discrimination in the health workforce is also evidenced by physical and sexual violence, wage gaps, irregular salaries, lack of formal employment, and the inability to participate in leadership and decision-making (44). Security threats and GBV limit the extent to which women health workers and caregivers can safely undertake immunization outreach missions and reach clinics, highlighting the importance of collective responsibility to safeguard staff and clients.

Although women hold the majority of the jobs in the health sector, they are underrepresented in senior and decision-making roles at the local, national and global levels. Effective health systems must ensure gender parity at all levels of decision-making to harness women's perspectives and talent (45). **The women who deliver global health, including immunization, deserve an equal say and equal pay in its design and delivery.** In 2020, over 70% of CEOs and board chairs of global health organisations were men, while just 5% of leaders were women from low- and middle-income countries (46). Women's limited opportunity to enter leadership roles in health is further compounded by the intersection of additional factors such as ethnicity, age, class, and gender identity.

▶▶▶ Action List ◀◀◀

HEALTH WORKFORCE



Provide safe and decent working conditions for health and immunization workers, at all levels, including equal pay, supportive supervision and protection from sexual harassment and violence at work. *[Gender-specific]*



Put in place safeguarding mechanisms against sexual harassment and other forms of GBV and make available a confidential feedback/complaints mechanism for immunization service providers and clients. *[Gender-specific]*



Make gender-equality training for all (male and female) health workers mandatory; ensure recruitment and training opportunities do not discriminate against women. *[Gender-transformative]*



Review and remove discriminatory human resource policies and practices to enable professional advancement of women health workers. *[Gender-specific]*



Create incentive schemes, and continued on-the-job support/mentoring and training opportunities for female health workers to advance their professional careers. Consider flexible time or childcare support. *[Gender-specific]*



Introduce measures, such as mandatory quotas, to increase women's representation at all levels of decision-making and monitoring of local, national and global health systems, including in global health organizations, advisory – e.g., national immunization technical advisory groups (NITAGs) – and expert groups. *[Gender-transformative]*

Approach 6: Improve the quality, accessibility and availability of services

The perceived quality of care, and the acceptability and accessibility of health services, influences the utilization of immunization services, especially for women. **Disrespectful, discriminatory and patronizing communication and attitudes from health-care providers** contribute to reinforcing existing gender stereotypes and traditional norms. Advancing gender equality and women's empowerment by treating adolescent girls and women with dignity, and providing them with full information, will improve the use and sustainability of immunization programmes.

Maintaining **privacy and confidentiality** in health facilities can prevent interactions being shared publicly and avoids exposing disadvantaged women to shame and stigma, for example about their children's health status (10). In Bangladesh, women were found to avoid immunization services for fear of humiliation from being "scolded" by the vaccinator for losing their child's immunization card (47). Providing a positive work environment and building capacities of health workers to respond better to the different needs of men, women, boys and girls leads to health equity improvements (19).

Immunization services are more accessible if they are brought closer to communities and to areas where women frequently visit. Even more time can be saved if immunization is bundled together with other health services (e.g., maternal health and family planning).

The availability of sufficient vaccine supplies at health centres is critical for ensuring continued demand. Low service quality, stock-outs or lack of female health workers may discourage women's attendance at immunization clinics when trade-off costs with other duties, such as household and childcare work, are high. Efforts to improve the supply chain and vaccine management and to expand the cold chain will help women receive reliable immunization services and reduce common challenges, such as long distances to travel for services (2).

▶▶▶ Action List ◀◀◀

QUALITY

- Ensure vaccinators have adequate time and support so that they can provide quality services.
- Train vaccinators and health workers to be respectful, responsive and empathetic to the needs and experiences of women, men and youth, and those who may be stigmatized and marginalized. *[Gender-specific]*
- Conduct surveys and qualitative research on client perceptions on different gendered experiences of the quality of care. *[Gender-sensitive]*
- Create a comfortable and safe environment at health centres/vaccination posts with adequate seating, lighting and sex-disaggregated toilets with a door that can be locked from the inside. *[Gender-sensitive]*
- Use a wall separator or curtains to provide confidentiality and privacy in vaccination clinics, and ensure staff are trained in patient confidentiality. *[Gender-sensitive]*
- Ensure that women, girls, men and boys are able to provide confidential feedback and have access to safe complaint and protection mechanisms. *[Gender-specific]*
- Make sure vaccination and mobile teams include both women and men. Including women health-care providers for house-to-house vaccination is essential in many settings. *[Gender-specific]*

AVAILABILITY



Schedule immunization services at more appropriate/flexible times and in convenient locations for women and their families. For example, establish a fast line and specific space for caregivers who come only for vaccination services to avoid long waiting times; open vaccination sessions earlier to accommodate women's work hours. *[Gender-specific]*



Bundle services so that caregivers can access child immunization services and sexual and reproductive health, nutrition services and/or other services at the same time and place. *[Gender-specific]*



Provide travel vouchers and related in-kind support to facilitate access to health services. *[Gender-specific]*

ACCESSIBILITY



Plan the location of service delivery to meet the needs of caregivers and ensure acceptability and accessibility of services for both women and men caregivers, including those with disabilities. *[Gender-specific]*



To reach underserved populations, consider setting up vaccination posts at transit sites (e.g., bus stops or railway stations), or high traffic sites (e.g., marketplaces or churches/mosques) or places frequented by women. *[Gender-specific]*



Ensure that the location for mobile outreach services is accessible to women and men at times that enable equal access, and that communication of immunization schedules and locations considers the most relevant channels and platforms for women and men. *[Gender-sensitive]*



Where necessary, provide security personnel to accompany frontline vaccinators and social mobilizers or ensure they operate in areas that have been blocked off by security. *[Gender-specific]*

Box 5

Zero dose approach and gender

To improve coverage and equity, IA2030 aims to extend immunization services to reach zero dose (those who have not received their first dose of DTP vaccines) and underimmunized children and communities.

Reaching these children means reaching the missed communities they are a part of. These unprotected communities are not only potential epicentres of disease outbreaks but also often deprived of other basic services and suffer from entrenched gender inequality.

Two-thirds of zero-dose children live in households surviving on less than US\$ 1.90 per day – the international poverty line. Their mothers are twice as likely to miss out on antenatal care or skilled birth attendance. The homes they live in are less likely to have access to clean water or sanitation. A lack of immunization is just one of a range of problems. Nearly 50% of zero-dose children live in three key geographic contexts: urban areas, remote communities and populations in conflict settings. Each of these settings has unique gender-related barriers to be addressed.

The zero-dose approach helps to increase the visibility of marginalized and excluded groups and communities and can provide an entry point for strengthening key services within and beyond immunization.

There is no one way of reaching these missed communities. Approaches will vary from country to country and within countries, contexts and settings. Improving coverage will require flexibility, innovation and the expertise of a range of disciplines. Gender analysis and gender-responsive strategies will have a key role to play.

For more on zero dose:

<https://www.gavi.org/vaccineswork/zero-dose-child-explained>

<http://www.immunizationagenda2030.org/strategic-priorities/coverage-equity>

<https://sites.google.com/view/erg4immunisation/products>

Approach 7: Integrate services and collaborate across sectors

Establishing **linkages with other health and non-health interventions** can improve immunization coverage throughout the life course and advance gender equality. Immunization programmes can be strong entry points to increase access to other primary health-care services and education. Joining with other services expands reach and presents opportunities to address gender-related barriers and inequities. Integration is also an essential requirement to ensure high-quality and cost-effective service delivery in the shift towards UHC.

The availability and introduction of HPV and other new vaccines beyond the traditional routine immunization schedule requires new approaches that consider the **specific needs of different ages throughout life**. In particular, adolescent boys and girls, and pregnant women benefit from integrated care. For example, HPV causes cervical cancer, the fourth most common cancer in women. Adolescent girls aged 9–14 are currently the primary target group recommended by WHO for HPV vaccines (48). Mother and daughter communications that integrate cervical cancer screening services together with announcements about the importance of HPV vaccination provide additional motivation for vaccine recipients to complete the schedule of doses. For adolescent boys, there is the possibility to offer Td vaccination or health education sessions (while girls could receive Td vaccination at the same time as HPV).

Gender analysis to understand people's different needs and vulnerabilities helps target interventions effectively. For example, with efforts focused on the elimination of maternal and neonatal tetanus, less attention has been given to tetanus incidence and mortality among men. The identification of tetanus cases following voluntary medical male circumcision in sub-Saharan Africa highlighted a gender gap in tetanus morbidity disproportionately affecting men, as women are often vaccinated during antenatal visits. Therefore, incorporating tetanus booster vaccination for boys and men into national programmes, and supporting coverage through integration with other services frequented by men, should be a priority (49).

Integrated care with a life-course approach has the potential to contribute to raising immunization coverage; decreasing maternal mortality and morbidity rates; increasing knowledge of women, men, girls and boys of reproductive health and rights; and promoting equitable access to education as well as transformation of harmful gender norms and roles. Partnerships with other health programmes such as HIV/AIDS, malaria; reproductive and sexual health; WASH (water, sanitation and hygiene) and nutrition; and with non-health sectors focusing, for instance, on education, protection (including GBV) and economic empowerment can be built into comprehensive approaches for widening immunization reach.



Gender Lens

The introduction of HPV and other new vaccines that go beyond the traditional immunization schedule requires a change of thinking beyond childhood, and alignment to a life-course perspective to delivery. Adolescence provides an opportunity to reverse prior life disadvantages and improve health outcomes in the short term and into adulthood. Just as women's TT vaccination during pregnancy has proved to be a consistent predictor of child vaccination, young girls' and women's cumulative exposure to vaccination from adolescence through childbearing age may create a virtuous cycle of acceptance, understanding of the importance of vaccination and, ultimately, utilization – leading to increased childhood immunization.

Source: A gender lens to advance gender equity in immunization. Equity Reference Group for Immunization (2018).

▶▶▶ Action List ◀◀◀

INTEGRATION



Develop partnerships beyond the health sector to integrate life-course immunization information into government educational curricula; community and state-level women's empowerment programmes; men's groups; income-generating activities; religious institutions; protection, education and nutrition interventions; the private sector and others. *[Gender-transformative]*



Integrate immunization with other health, education, social protection or other service programmes that communities/women trust and fully participate to address gender-related barriers and maximize opportunities for vaccination (e.g., combine HPV vaccinations with a tetanus booster dose; partner with HIV, malaria, WASH, nutrition programmes, sexual and reproductive health; and maternal and child health services). *[Gender-specific]*



Support GBV referral pathways and train immunization workers to refer clients to existing medical, legal and psychosocial support service for GBV survivors. *[Gender-specific]*



Support and link with birth registration/civil registration and vital statistics systems through immunization services – with HepB (hepatitis B) and BCG (bacillus Calmette–Guérin) (vaccines given at time of birth) – to ensure both boy and girl births are officially recorded. *[Gender-sensitive]*



Promote changes in legislation or in immunization policy to extend the target age range beyond early childhood, to permit catch-up vaccination for all vulnerable groups, which include boys and men in some contexts. *[Gender-specific]*



Carry out implementation and social and behavioural research for evidence on effective delivery of integrated, coordinated packages of vaccination services which respond to the different needs of women, girls, boys and men. *[Gender-specific]*

Approach 8: Implement gender-responsive immunization services in emergency settings

Emergencies, such as outbreaks, disasters and conflict, affect women, girls, boys and men differently. To be effective, **immunization services must be responsive to and address the different needs, priorities, capacities and roles of people in emergency situations.** As 40% of the world's unimmunized children live in conflict-affected countries or in fragile humanitarian settings, children in conflict settings are therefore central to tackling inequity and reaching zero-dose children.

During emergencies, children may lose access to education, with adolescent girls being disproportionately affected. As a result, they also lose access to school-based immunization programmes. The responsibility for care of children and the elderly often falls on adolescent girls and women, making distance and time constraints, in addition to insecurity, major obstacles for accessing health services. Conflict-related migration and displacement may result in a rise in single-parent households, which can intensify women's burdens and increase challenges to accessing services for themselves and their children. Emergencies are known for inducing an increase of GBV, sexual exploitation and unwanted pregnancies in settings where health-care provision is often already limited and resources diverted (50).

While critical in all contexts, community engagement and outreach are even more vital to ensuring that accurate information and timely services reach the people who need them during emergencies. Community health workers, community leaders and religious leaders can be important change agents supporting immunization.

Overlooking gender issues in emergency planning and response creates a danger for further entrenching gender norms and expectations, creating negative outcomes for women and other marginalized groups.

Immunization activities during emergencies can offer a platform to deliver additional support to the most vulnerable. Although humanitarian emergencies can compound discrimination and exacerbate existing risks, crises can also provide opportunities for addressing inequalities and promoting transformative change. For example, supporting local women and women's organizations to take an active, leading role in immunization planning and delivery carries potential for transformative change.



Gender Lens

Over 18,000 girls became pregnant during the Ebola crisis in Sierra Leone. Girls were extremely vulnerable to pregnancy, not only because of limited sexual and reproductive health information and services and widespread fears of becoming infected by health personnel but also because social protection systems collapsed and GBV increased. Girls in Sierra Leone are prohibited from attending school if they are visibly pregnant, and these girls were forced to drop out. Girls' lack of access to schools and appropriate reproductive health care, including ante- and postnatal care, also affected their access to critical health services, including immunization. More:

<https://www.unfpa.org/news/one-year-after-ebolas-en-d-sierra-leones-midwives-help-mend-health-system#>

EMERGENCY SETTINGS



Select equal numbers of men and women for outbreak/disaster assessment teams to ensure access to all people. Where feasible, include a gender and protection specialist on the team. *[Gender-specific]*



Use the Inter-Agency Standing Committee's (IASC) Gender in humanitarian action handbook (50) and the IASC Guidelines for integrating gender-based violence interventions in humanitarian action (51) for guidance on gender analysis, planning and action. *[Gender-specific]*



Provide safe access points for vaccination, with more dispersed vaccination sites allowing shorter travel distances, or provide vaccines in places where women frequently visit, such as markets. *[Gender-specific]*



Link immunization to sexual and reproductive health and rights (SRHR) and violence protection/mitigation programmes. *[Gender-specific]*



Ensure data disaggregated by sex, age and other variables are routinely collected and analysed in all emergency assessments and surveys. *[Gender-sensitive]*



Conduct real-time gender analysis of outbreaks to inform timely and future responses and interventions. *[Gender-specific]*



Involve women in the design of immunization education materials to ensure they are tailored to the local context, especially when working with marginalized people (e.g., minorities). *[Gender-transformative]*



Engage men, especially community leaders and fathers, in outreach activities on child health. *[Gender-transformative]*

In the aftermath of major outbreaks of Ebola, Zika and SARS (severe acute respiratory syndrome), it became clear that epidemics often have a disproportionate impact on women, girls and additional at-risk or vulnerable groups (e.g., LGBTQI, HIV+, disabled and refugee communities). Where gender is not considered explicitly in emergency outbreak response, specific gender needs consistently fall through the gaps. The global gender and health community advocated strongly for governments to provide a gender lens to their response to COVID-19. Nevertheless, the COVID-19 pandemic has entrenched global and societal inequities, widening the gender equality gap further. This has exacerbated gender-related barriers to immunization and health care. But, as countries begin to recover from the pandemic and focus on maintaining, strengthening and restoring their health systems and routine immunization services, health systems have an opportunity to adopt a gender-responsive, transformative approach for their immunization programmes.

For more on COVID-19 and gender:

- **Gender and COVID-19 advocacy brief (WHO 2020)**
<https://apps.who.int/iris/handle/10665/332080>
- **Five actions for gender equality in the coronavirus disease (COVID-19) response (UNICEF 2021)**
<https://www.unicef.org/documents/five-actions-gender-equality-coronavirus-disease-covid-19-response-technical-note>
- **The sex, gender and COVID-19 project (Global Health 50/50 2021)**
<https://globalhealth5050.org/the-sex-gender-and-covid-19-project/>
- **The Vaccine Alliance guidance on gender barriers in the context of COVID-19 (Gavi 2021)**
https://www.gavi.org/sites/default/files/about/Strategy/Gavi_Guidance-to-address-gender-barriers-in-MRS-immunisation_ENG.pdf
- **Gender Analysis and COVID-19 Matrix (Gender & Covid-19 Working Group 2021)**
<https://www.genderandcovid-19.org/matrix/>
- **Guidance note and checklist for tackling gender-related barriers to COVID-19 vaccine deployment (Gender & Health Hub 2021)**
<https://www.genderhealthhub.org/articles/guidance-note-and-checklist-for-tackling-gender-related-barriers-to-equitable-covid-19-vaccine-deployment/>
- **Time for Action: towards an intersectional gender approach to COVID-19 vaccine development and deployment to leave no one behind**
<https://pubmed.ncbi.nlm.nih.gov/34389628/>
- **A Systematic Review of the Sex and Gender Reporting in COVID-19 Clinical Trials**
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8622702/>

Approach 9: Apply a gender lens to research and innovation

IA2030 commits to identifying vaccine-related research and priorities for innovation according to community needs, particularly for underserved populations. Within these processes, it is critical that the voices of women and men are heard. Vaccine research and development should take into consideration sex and gender when developing and testing vaccine candidates for safety and efficacy, as well as when prioritizing products for development or roll-out. Product value must take into consideration the potential it has to address gender inequalities, for example where a disease burden is higher for one sex (e.g., hepatitis E in pregnant women) or if a vulnerable group is missed due to decisions taken in the development phase, as was the case when the early Ebola vaccine roll-out excluded pregnant women (52,53). **Gender-responsive implementation research and other forms of learning should be supported.**

Innovations in products and processes can help improve immunization delivery to underserved and marginalized populations. Examples of "needs-based" immunization innovations include CTC (controlled temperature chain) vaccines, which can reach mothers in remote areas with newborn or prenatal vaccines, or electronic birth registration technologies to help track children through the life course.

▶▶▶ Action List ◀◀◀

RESEARCH & INNOVATION



Investigate sex-based differences in immunology and vaccine response, including the importance of safety and efficacy data during pregnancy, as part of vaccine research and development (54). *[Gender-sensitive]*



Ensure that vaccine trials are designed to facilitate participation of both women and men, including specific groups such as pregnant and breastfeeding women. *[Gender-specific]*



Strengthen local capacity to conduct implementation research to identify interventions and new technologies that enhance coverage and equity and support tailored solutions to address gender-related inequities and barriers. *[Gender-specific]*



Share lessons learned on improved technologies, services and practices to address gender-related barriers. *[Gender-specific]*

CHAPTER 5

Chapter 5: Way forward: commitment and accountability



Sustained commitment to placing **gender equality at the core of immunization programmes** and ensuring equitable participation and benefits for women, men, girls and boys is essential to improve quality and performance. Leaders, groups, champions and stakeholders must be accountable to advance gender-responsiveness and support change through sustained financing at the global, national and subnational level.

Strengthening **political commitment** for gender equality and women's empowerment is key. Encouraging leaders to prioritize gender-related immunization considerations in strategic and operational planning and in policy, fiscal and legislative instruments is critical for success. To sustain progress and institutionalize efforts to address gender-related barriers, strong leadership is needed to advocate for gender equality and equity across global, regional and national policy processes and platforms. **Financing** for immunization must take into account the need to address gender-related barriers as part of budgeting processes. Budgets are often not designed to be gender-responsive, making consideration of gender issues and gender-related barriers an afterthought and therefore difficult to implement later on.

In order to secure **accountability** for results on gender-responsive immunization programming, accountability frameworks need to be developed and monitored. This could, for instance, include mandatory use of gender markers in immunization programme budget requests from donors or engaging/partnering with women's groups to facilitate social accountability, and consistent reporting on results achieved in relation to addressing gender-related barriers. Global organizations should provide regular and publicly accessible reporting against their gender equality commitments in immunization progress reports. National immunization strategies should be supported to include gender analysis and measures to address gender-related barriers in different contexts.

Health care continues to be largely led by men within countries and globally, although women are responsible for delivering it. This is also true for immunization. To move towards gender-responsive immunization delivery and address existing gender inequalities, women's participation at the top levels of health leadership must be increased, given that women make up only 5% of global health leaders in low- and middle-income countries (46). Immunization advisory groups and technical and governance bodies must take decisive steps to address the current gender imbalance at the top levels of leadership, and advocate for women's full and equal participation in decision-making related to health.

Promoting gender-responsive and transformative programming through sustained commitment and accountability will not only strengthen vaccine programmes and health systems but also contribute to advancing broader goals of gender equality and women's empowerment to achieve better health for all.



Gender Lens

A lack of data means there are critical blind spots for gender policymaking. Only 21% of the data needed to monitor the gender-related SDG targets are currently available.

Source: data2x.org.

▶▶▶ Action List ◀◀◀

COMMITMENT & ACCOUNTABILITY



Require women's equal participation at the highest levels of decision-making and planning, and strengthen women's capacity as needed to successfully administer these roles. *[Gender-transformative]*



Build commitments to gender equality with visible leadership, and develop a unified voice on gender issues through the strategic use of gender champions at the global, regional, national and subnational and community levels. *[Gender-transformative]*



Strengthen the capacity of immunization stakeholders at the country and global levels on the importance of addressing gender-related barriers; integrate learning opportunities into broader capacity-building activities on immunization whenever possible. *[Gender-specific]*



Integrate gender specific criteria in evidence reviews of regional and national immunization technical advisory groups (RITAGs and NITAGs) to ensure a gender lens is applied to the formulation of immunization policy recommendations. Include gender-balanced representation on all such advisory committees. *[Gender-transformative]*



Include gender equality in the National Immunization Strategy (NIS) and make reporting against gender equality commitments (e.g., SDG5) an obligatory part of regular immunization progress reports and updates (both at the national and global levels).



Include gender considerations in immunization programme donor applications and proposal evaluations, and include funding incentives for gender-responsive programmes. *[Gender-specific]*



Ensure that immunization financing/budgets and strategies, including the NIS, reflect gender-responsive approaches. *[Gender-sensitive]*

Conclusion: Accelerating progress for 2030

Gender equality drives better outcomes for all people everywhere. To make progress in line with IA2030, immunization policymakers and practitioners cannot ignore the importance of mainstreaming gender across the immunization programme cycle – from policy, management and design of immunization systems through to implementation, monitoring and evaluation of the services.

Adopting a gender perspective in all steps towards the goals of IA2030 must be ensured at all levels. Without truly gender-responsive action for immunization, our goals will remain elusive.

This document has outlined gender-related barriers to expanding immunization coverage throughout the life course, and it has proposed suggestions and critical actions for addressing and dismantling these barriers. The document acts as a guide for action, but successful gender mainstreaming requires changes within organizations that implement and support immunization programmes. We must "walk the talk" for gender equality and ensure that our own internal policies and systems reflect this value in practice.

Through our joint efforts we can realize the vision set in the IA2030 – a world where everyone, everywhere, at every age, fully benefits from vaccines for good health and well-being.

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ANNEXES

Annex 1:

Gender Analysis Matrix

Adapted from the *WHO Gender Analysis Matrix in Gender mainstreaming for health managers: a practical approach. Participant's notes (2011)*

https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAnalysisMatrix.pdf

Factors that influence health outcomes: health-related considerations	Factors that influence health outcomes: gender-related considerations		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health-care settings			
Health and social outcomes and consequences			

Annex 2:

Resources and tools for gender-responsive programming

- **Immunization and gender: a practical guide to integrate a gender lens into immunization programmes (UNICEF ROSA 2019)** <https://www.unicef.org/rosa/media/12346/file>
- **Gender-responsive communication for development: guidance, tools and resources (UNICEF ROSA 2018)** <https://www.unicef.org/rosa/reports/gender-responsive-communication-development-0>
- **Gender toolkit: integrating gender in programming for every child in South Asia (UNICEF ROSA 2018)** <https://www.unicef.org/rosa/sites/unicef.org/rosa/files/2018-12/Gender%20Toolkit%20Integrating%20Gender%20in%20Programming%20for%20Every%20Child%20UNICEF%20South%20Asia%202018.pdf>
- **GPEI (2019) Gender Equality Strategy 2019-2023** <https://polioeradication.org/gender-and-polio/> (polioeradication.org)
- **GPEI (2018) Technical Brief: Gender** <https://polioeradication.org/gender-and-polio/> (polioeradication.org)
- **Gender analysis toolkit for health systems (Jhpiego 2016)** <http://resources.jhpiego.org/system/files/resources/Gender-Analysis-Toolkit-for-Health-Systems.pdf>
- **WHO Gender Analysis Matrix (GAM) and Gender Analysis Questions (GAQ) in Gender mainstreaming for health managers: a practical approach. Participant's notes (WHO 2011)** https://apps.who.int/iris/bitstream/handle/10665/44516/9789241501064_eng.pdf?sequence=2
- **Gender mainstreaming for health managers: a practical approach. Facilitators' guide. (WHO 2011)** <https://apps.who.int/iris/handle/10665/44516>
- **Gender mainstreaming for health managers: a practical approach. Participant's notes (WHO 2011)** https://apps.who.int/iris/bitstream/handle/10665/44516/9789241501064_eng.pdf?sequence=2&isAllowed=y
- **Tools for assessing gender in health policies and programs (Futures Group, Health Policy Project 2014)** https://www.healthpolicyproject.com/pubs/121_ToolsforAssessingGenderinHealthPolicFINAL.pdf
- **Engendering transformational change: Save the Children gender equality program guidance & toolkit (Save the Children 2014)** https://resourcecentre.savethechildren.net/node/8503/pdf/gender_equality_program_toolkit_2014.pdf
- **Gender checklist: health (Asian Development Bank 2006)** <https://www.adb.org/sites/default/files/publication/28727/health.pdf>
- **Gender in humanitarian action handbook (IASC 2018)** https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/iasc_gender_handbook_2018.pdf
- **The Innov8 approach for reviewing national health programmes to leave no one behind – technical handbook (WHO 2016)** <https://apps.who.int/iris/handle/10665/250442>
- **Gender-inclusive language guidelines – promoting gender equality through the use of language (UN Women (n.d.))** <https://www.un.org/en/gender-inclusive-language/guidelines.shtml>
- **Gender mainstreaming made easy: a handbook for programme staff (UNDP 2013)** https://www.so.undp.org/content/somalia/en/home/library/womens_empowerment/Handbook.html
- **A gender lens to advance equity for immunization (Equity Reference Group 2018)** <https://drive.google.com/file/d/1fVPq1n-7uWimThlO7vusGkzObntM046s/view>
- **Five actions for gender equality in the coronavirus disease (COVID-19) response (UNICEF n.d.)** <https://www.unicef.org/documents/five-actions-gender-equality-coronavirus-disease-covid-19-response-technical-note>

Annex 3: Metrics to identify gender-related barriers to immunization

Measurement of gender-related barriers to immunization is often not routinely included within countries through their coverage and equity assessments. Therefore, work is under way to identify potential indicators that are both feasible and useful – at least for initial identification of gender-related barriers. These are largely "proxy" indicators representing important gender dimensions highlighted in this report (e.g., relating to household decision-making, geographic or time barriers), many of which should already be readily available, for example, from household or facility surveys. Additional work is needed to identify metrics that will be useful for monitoring programme performance with respect to reducing gender-related barriers. Further, these indicators should be seen as complementary to context-specific, in-depth (and presumably qualitative or mixed-method) assessments that are conducted at the subnational level to better understand related and underlying causes of any barriers identified, and to identify potential solutions in collaboration with local stakeholders and decision makers.

The following tables provide suggested indicators that may help identify key gender-related barriers to immunization in a chosen setting.

Table 1.1 To what extent are mothers empowered to decide on health-related matters within the family?

#	Indicator	Potential data source	Questions included in data source	Source reference
1.1.1	Who usually makes decisions about health care for yourself: you, your (husband/partner), you and your (husband/partner) jointly, or someone else?	DHS/Household surveys	Who usually makes decisions about health care for yourself: you, your (husband/partner), you and your (husband/partner) jointly, or someone else?	DHSWQ – Section 9:922
1.1.2	Women's (and girls' for those under 18) age at first marriage	DHS/Household surveys	How old were you when you first started living with your current (husband/partner)?	DHSWQ – Section 7:714–720
1.1.3	Are you (woman) or your partner currently doing something or using any method to delay or avoid getting pregnant?	DHS/Household surveys	Are you or your partner currently doing something or using any method to delay or avoid getting pregnant? Have you ever used anything or tried in any way to delay or avoid getting pregnant? The last time you had sexual intercourse, did you or your partner do something or use any method to delay or avoid getting pregnant? Who usually makes the decision on whether or not you should use contraception: you, your (husband/partner), you and your (husband/partner) jointly, or someone else?	DHSWQ – Section 3:303, 320; Section 7:725; Section 8:818

Supplemental indicators if data are available

1.1.4	% of women who report that they must have permission from their husband or another relative to take a child for vaccination	Programmatic data	NA	
1.1.5	% of fathers who report that they have accompanied the mother or themselves taken their child to a clinic for vaccination	Programmatic data, sentinel sites		
1.1.6	% of mothers who need permission to go/take child to the vaccination facility	DHS/Programmatic data	Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not a big problem: Getting permission to go to the doctor? Getting money needed for advice or treatment? The distance to the health facility? Not wanting to go alone? Who usually makes decisions about visits to your family or relatives?	DHSWQ – Section 11:1113; Section 9:924
1.1.7	% of women who report that it is hard to get vaccination services for themselves or their child because they cannot go to the vaccination clinic on their own	Programmatic data		
1.1.8	Number of demand generation initiatives targeted at men that focus on women's health issues and rights, violence against women and the importance of joint health-care responsibilities	Programmatic data/DHS man's questionnaire	In the last 12 months have you: a) Heard about family planning on the radio? b) Seen anything about family planning on the television? c) Read about family planning in a newspaper or magazine? d) Received a voice or text message about family planning on a mobile phone? e) Seen anything about family planning on social media such as Facebook, Twitter or Instagram? f) Seen anything about family planning on a poster, leaflet or brochure? g) Seen anything about family planning on an outdoor sign or billboard? h) Heard anything about family planning at community meetings or events?	DHSMQ – Section 3:302
1.1.9	Number of national immunization programme demand generation initiatives targeted at fathers and men that focus on fathers' responsibilities for children's vaccination	Programmatic data/DHS man's questionnaire		

Table 1.2 To what extent do women's multiple roles in the family (e.g. reproductive and productive work) and geographic or other access barriers influence their ability to obtain health care for themselves and their children?

#	Indicator	Potential data source	Questions included in data source	Source reference
1.2.1	% of children with up-to-date immunizations based on employment status of women/mothers	DHS/Household surveys	What is your occupation? That is, what kind of work do you mainly do? Are you paid in cash or kind for this work or are you not paid at all? Aside from your own housework, have you done any work in the last 7 days? As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business, or work on the family farm or in the family business. In the last 7 days, have you done any of these things or any other work?	DHSWQ – Section 9:909, 910, 913, 916
1.2.2	% of mothers who did not get their child vaccinated because the session time was inconvenient	SPA ANCCEI/Household		SPA-ANCCEI – Section 2:201
1.2.3	% of women employed, by occupation/have means of earning an income/cash	DHS/Household surveys	What is your occupation? That is, what kind of work do you mainly do? Are you paid in cash or kind for this work or are you not paid at all? Aside from your own housework, have you done any work in the last 7 days? As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. In the last 7 days, have you done any of these things or any other work?	DHSWQ – Section 9:909, 910, 913, 916
1.2.4	% of mothers who did not get their child vaccinated because the facility was too far	DHS/Household surveys	How long does it take in minutes to go from your home to the nearest health-care facility, which could be a hospital, a health clinic, a medical doctor or a health post? How do you travel to this health-care facility from your home? Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not a big problem: The distance to the health facility? Getting money needed for advice or treatment? Getting permission to go to the doctor? Not wanting to go alone?	DHSWQ – Section 11:1101, 1102, 1113

Supplemental indicators if data are available

1.2.5	% of all girls aged 9–13 with HPV vaccinations	Administrative data	In your current position, and as a part of your work for this facility, do you personally provide any services that are designed to be youth or adolescent friendly ? i.e. designed with the specific aim to encourage youth or adolescent utilization? Have you received any in-service training, training updates or refresher training on topics specific to youth- or adolescent-friendly services?	SPA-HWI – Section 2:202, 203
1.2.6	% of women who report that it is hard to get vaccination services because vaccinations cost too much	Programmatic data		
1.2.7	% of men who report that it is hard to get vaccination services because vaccinations cost too much	Programmatic data		

Table 1.3 To what extent does the health knowledge and literacy of women impact their understanding of vaccination, their motivation to vaccinate their children and their capacity to negotiate the health system?

#	Indicator	Potential data source	Questions included in data source	Source reference
1.3.0	% of children who did not receive DTP1 (zero dose) by mother's education	DHS/Household surveys	Have you ever attended school? What is the highest level of school you attended: primary, secondary or higher?	DHSWQ – Section 1:113, 114
1.3.1	% of children who received DTP3 by mother's education	DHS/Household surveys	Have you ever attended school? What is the highest level of school you attended: primary, secondary or higher?	DHSWQ – Section 1:113, 114
1.3.2	% of women who have weekly exposure to mass media (television, radio, etc.)	DHS/Household surveys	Do you read a newspaper or magazine at least once a week, less than once a week or not at all? Do you listen to the radio at least once a week, less than once a week or not at all? Do you watch television at least once a week, less than once a week or not at all? Do you own a mobile phone? Is your mobile phone a smartphone? During the last 1 month, how often did you use the Internet: almost every day, at least once a week, less than once a week or not at all? In the last 12 months have you: Seen anything about family planning on an outdoor sign or billboard? Read about family planning in a newspaper or magazine? Seen anything about family planning on the television? Heard about family planning on the radio? Received a voice or text message about family planning on a mobile phone? Seen anything about family planning on social media such as Facebook, Twitter or Instagram? Seen anything about family planning on a poster, leaflet or brochure? Heard anything about family planning at community meetings or events?	DHSWQ – Section 1:119–123, 129; Section 8:815
1.3.3	% of caregivers with knowledge about vaccines and the recommended schedule, by sex of caregiver	DHS/Household surveys	Do you have a card or other document where (NAME)'s vaccinations are written down?	DHSWQ – Section 5:504
1.3.4	% of children who received DTP3, by sex	DHS/Household surveys	Do you have a card or other document where (NAME)'s vaccinations are written down?	DHSWQ – Section 5:504
1.3.5	% of children who did not receive DTP1, by sex	DHS/Household surveys	Do you have a card or other document where (NAME)'s vaccinations are written down?	DHSWQ – Section 5:504

Supplemental indicators if data are available

1.3.6	% of caregivers who trust the safety and efficacy of vaccines, by sex of caregiver	Programmatic data	NA	
1.3.7	% of women who know where to go to get their child vaccinated	Programmatic data	NA	

Table 1.4 To what extent does the quality of service (encompassing providers' attitudes, inconvenient service hours or unavailability of female providers) discourage women from attending health facilities or accessing care?

#	Indicator	Potential data source	Questions included in data source	Source reference
1.4.1	% of male immunization staff, % of female immunization staff	SPA inventory questionnaire/ Administrative data (not sex-disaggregated in SPA)	Please tell me how many staff in each of the following occupational categories are currently assigned to, employed by or seconded to this facility, whether full-time or part-time.	SPA-IQ – Section 4:400
1.4.2	% of service delivery points offering integrated services (i.e., family planning, postpartum care, HIV/AIDS services, etc.)	SPA inventory questionnaire/ Administrative data	Does this facility offer any of the following client services? (see the DHS Program - SPA Questionnaires for list of interventions). In other words, is there any location in this facility where clients can receive any of the following services:	SPA-IQ – Section 1:102
1.4.3	% of caregivers satisfied with the quality of the service experience	SPA ANCCEI/Quality of Care (QoC) Assessments	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today? 1. I am very satisfied with services I received in facility 2. I am more or less satisfied 3. I am not satisfied with the services I received	SPA-ANCCEI – Section 2:202, 208, 209
1.4.4	% mothers that did not get their child vaccinated because of long wait times	SPA ANCCEI/Household surveys	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	SPA-ANCCEI – Section 2:201
Supplemental indicators if data are available				
1.4.5	# of health facilities with protocols and service delivery practices that are gender-sensitive and promote women's rights (e.g., privacy, confidentiality, sexual harassment)	SPA-HWI/ Programmatic data	Have you received any in-service training, training updates or refresher training on topics related to antenatal care or postnatal care?	SPA-HWI – Section 5:501
1.4.6	Number of facilities that implement protocols for dealing with physical and sexual GBV	Administrative data (not available in SPA)	NA	
1.4.7	Proportion of vaccinators who are female	Administrative data	NA	

1.4.8	Proportion of community health workers who are female	Administrative data	NA	
1.4.9	Proportion of health facility in-charges who are female	Administrative data	NA	
1.4.10	Proportion of district health officers who are female	Administrative data	NA	
1.4.11	% of clinics/districts that pay community health workers on time	Programmatic data	NA	
1.4.12	% of female health-care workers who report that they have experienced harassment at the workplace	Programmatic data	NA	
1.4.13	% of female health workers who feel their clinic has sufficient services (e.g., WASH facilities; shelter)	Programmatic data	NA	

Table 1.5 What role does the community play in providing a supportive environment for demand for and utilization of immunization services either through support for vaccination in the community or by coordinating with the health facility for services to be delivered through more accessible mechanisms (e.g., at appropriate times/places or alongside other routine services)?

#	Indicator	Potential data source	Questions included in data source	Source reference
1.5.1	# of sensitization sessions per year with women's groups	Programmatic data	NA	
1.5.2	# of sensitization sessions per year with men's groups	Programmatic data	NA	

Abbreviations	
DHSWQ	Demographic health survey (DHS) woman' s questionnaire
DHSMQ	DHS man's questionnaire
SPA-ANCCEI	Service provision assessment (SPA) ante natal care (ANC) client exit interview
SPA-HWI	SPA health worker interview
SPA-IQ	SPA inventory questionnaire

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