

Considerations for countries on targeting investments from Gavi's financial support

Focus area	Addressing gender-related barriers to immunisation
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Why address gender-related barriers to immunisation?

In order to increase coverage and equity, countries must address gender-related barriers to immunisation. These are **different from sex-discrepancies** in immunisation coverage, which is the difference in vaccine coverage between girls and boys.

Due to a number of socio-cultural and economic factors, mothers/ caregivers may have limited access to immunisation health services for their children. For example, when women are un/ under-educated, lack decision-making powers, economically dependent, or unable to move freely outside their homes, they are less likely to take their children to get vaccinated. These are examples of gender-related barriers. Interventions that help address such barriers are likely to yield access to under-served populations.

What are the considerations to plan interventions?¹

- Countries should conduct a detailed assessment to identify gender-related barriers that are relevant to the specific context (sub-region, community or population group).
- Review experiences of other countries/ regions in addressing similar barriers to access immunisation services.
- Develop innovative and tailored interventions to address gender-related barriers to immunisation.
- Develop and use relevant monitoring and evaluation indicators to track progress and allow for modifications, as required.
- Refine understanding of sex-disaggregated data from surveys and other existing sources, especially in countries with persisting discrepancies in coverage rates by sex. Those countries should evaluate the advantages and dis-advantages of more routine monitoring of sex-disaggregated data.

What are monitoring and evaluation considerations when implementing interventions to address gender inequities?

[Note: **Annex 1** provides a list of examples of gender related barriers, potential interventions to address them and associated monitoring indicators.]

Tracking progress against efforts undertaken to address gender inequities **does not necessarily require significant changes to a country's routine administrative system.**

- The majority of proposed outcome indicators (as listed in Annex 1) can be measured using periodic national and/or targeted surveys, including Demographic Health Surveys (DHS), Multi-Indicator Cluster Surveys (MICS) or Coverage Evaluation Surveys (CES).

¹ NOTE:

1. The JA analysis guidance includes a section on addressing gender-related barriers to immunisation as part of a larger section on improving equity.
2. Gavi's demand promotion framework can assist in developing tailored communication strategies to engage parents, caregivers, community leaders. For further information on this, please also refer to the programming guidance on 'Demand Generation'.
3. There are benefits to investing in data, including to refine understanding of disaggregated data by gender and other equity-related indicators, especially at sub-national levels. For further information on this, please also refer to the programming guidance on 'Data'.

- These indicators would likely require up-front planning so that the analysis produced for these large-scale surveys would include the necessary output tables. Countries will need to engage actively during the planning process to ensure that all analytical needs have been addressed.
- For example, if the country would like to examine the Penta3 coverage difference between the children of educated and un-educated mothers/caregivers in a targeted area, this may be obtained from a survey but will require further secondary analysis. A standard report usually does not offer this result.

Tracking intermediate results/outputs.

- Measurement of these metrics can be done through a variety of data sources such as the routine administrative system, knowledge, attitude and practice (KAP) surveys and health facility assessments (HFA).
- It will be important to review available data sources before selecting appropriate intermediate results indicators.

While proposed intermediate indicators respond directly to the range of proposed interventions, it is important to conduct **additional in-depth analyses** to improve understanding of the gaps and appropriate measures to address them. In Annex 1, we have provided some suggestions on types of additional analyses that may be considered by countries.

Annex 1. Examples of gender related barriers, potential interventions to address them and associated monitoring indicators

Barrier	Interventions for consideration ²	Monitoring indicators
Education		
<ul style="list-style-type: none"> • Low education levels among women may be associated with lower immunisation coverage of children. • Lack of mobile phone ownership/access by some caregivers makes information sharing challenging. 	<ul style="list-style-type: none"> • Characterise and/or validate context-specific gender-barriers to immunisation based on analysis of available demographic and social data. • Plan tailored immunisation awareness and advocacy interventions targeting mothers and fathers. Communication content and approach should be developed, particularly for less-educated groups: <ul style="list-style-type: none"> - Create/Improve information resource centres on vaccination for all caregivers through existing health and non-health community platforms. - Engage women/ primary caregivers and strengthen linkage between health workers and caregivers. [Countries with successful interventions: Zimbabwe] - Engage youth and deploy youth mobilisers. [Countries with successful interventions: Rwanda, Ethiopia, Malawi, Pakistan] - Use mass media and SMS messaging. [Countries with successful interventions: Nigeria, Kenya, Indonesia] - Use of wearables, eg, simple bracelets, charms to serve as vaccine reminders. [Countries with successful interventions: Afghanistan] 	<p>Outcome indicator:</p> <ul style="list-style-type: none"> • Difference in Penta3 coverage between the children of educated and un-educated mothers/caregivers. • Distribution of Penta3 coverage by education level of caregivers over time. • Drop-out rates (only targeted areas at national/ sub-national levels monitored): <ul style="list-style-type: none"> ○ Dropout DTP1/MCV1 ○ Drop-out rate between Penta1 and Penta3 <p>[Note:</p> <ul style="list-style-type: none"> ○ While it may be difficult to assess year-to-year change over time, it is hypothesised that the difference between children with caregivers of different educational levels may decrease with time. ○ By “educated,” we refer to caregivers with at least primary education. ○ Outcome indicator 2, listed above, will likely strengthen understanding of the context and changes over time of target population. ○ Outcome indicator 3 (reference: drop-out rates) may help assess the success of proposed interventions.]

² Many of these interventions can be implemented with Gavi support. Please contact your Gavi SCM to see which intervention may be implemented with Gavi funding.

Barrier	Interventions for consideration ²	Monitoring indicators
		<p>Intermediate results indicators:</p> <ul style="list-style-type: none"> • Percent of vaccinated children referred by community health workers/CSOs • Percent of caregivers of under-immunised children who express lack of information and/or motivation • Percent of defaulter children traced and referred by CHWs/CSOs • Percent of facilities that have a functioning health committee (or equivalent body) that includes community members and meets at least quarterly
Economic		
<ul style="list-style-type: none"> • Caregivers with limited access to household funds are less likely to influence household decision-making, including access to and utilisation of health services. • Working mothers who are the primary caregivers of children are likely to have limited access to immunisation services for their children as clinic timings may conflict with the work hours. 	<ul style="list-style-type: none"> • Emphasise availability of cost-free vaccinations in informational campaigns. [Countries with successful interventions: India] • Institute flexible and/or longer immunisation centre hours for working caregivers. [Countries with successful interventions: Senegal] • Offer health centre appointments at the same time for multiple children in a family. 	<p>Outcome indicator:</p> <ul style="list-style-type: none"> • Difference in Penta3 coverage between the highest and lowest wealth quintiles <p>[Note: As with “education” outcome indicators, the above indicator will require further analysis to enable meaningful monitoring. For example, examining the distribution of the population and the distribution of Penta3 coverage across wealth quintiles are important.]</p> <ul style="list-style-type: none"> • Penta3 coverage in the targeted areas of intervention • Dropout DTP1/MCV1 • Drop-out rate between Penta1 and Penta3 <p>Intermediate results indicators:</p> <ul style="list-style-type: none"> • Number of children vaccinated in targeted health facilities where opening hours are flexible/have been extended – analysis would focus on trends • Percent of caregivers of under-immunised children who express lack of information and/or motivation

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Socio-cultural factors		
<p>Religion, culture, racial or ethnic hierarchy, caste or marital status of caregivers may influence whether a child will be vaccinated, e.g. in some societies, cultural barriers may prevent female caregivers from seeking immunisation services from male health workers.</p>	<ul style="list-style-type: none"> • Employ female health workers, as well as minority groups, to enhance service acceptance and uptake. [Countries with successful interventions: Pakistan] • Ensure ethnic minority groups receive immunisation information in a language they can understand and which is communicated in accordance with their beliefs. • Engage ‘influencers’ in the community (elders, community health workers, community leaders/ political representatives, educators, religious leaders, media personalities, family physicians, traditional medicine practitioners) to build support for immunisation of children. • Engage mothers and fathers through information and communication campaigns, for e.g., use images of fathers with their children. 	<p>Outcome indicator:</p> <ul style="list-style-type: none"> • Penta3 coverage in targeted populations (e.g. specific ethnic and/or religious groups) • Dropout DTP1/MCV1 • Drop-out rate between Penta1 and Penta3 <p>Intermediate results indicator:</p> <ul style="list-style-type: none"> • Percent of health facilities with adequate immunisation staffing [Note: “adequate” includes the gender of the health care worker as an essential criterion] • Percent of caregivers of under-immunised children who express lack of information and/or motivation. [Note: an analysis of the perception of both mothers and fathers important for interventions addressing socio-cultural factors]. • Percent of districts where CSOs have conducted community awareness/ mobilisation sessions. [Note: monitoring the stakeholders targeted in the sessions important, e.g. parents, influencers, etc.]
Accessibility of health service facilities		
<ul style="list-style-type: none"> • Travelling long distances to health clinics can deter women, particularly younger mothers, from bringing their children for immunisation due to safety and mobility issues, time taken to 	<p>Offer greater community outreach in hard to reach geographic areas, to bring immunisation and health services closer to children and their caregivers by:</p> <ul style="list-style-type: none"> • Ensuring that planned sessions are held at immunisation centres with adequate vaccine stocks. • Ensuring that vaccinators are available to schedule and deliver predictable services of acceptable quality. 	<p>Outcome indicators:</p> <ul style="list-style-type: none"> • Percent of zero-dose children in target area (i.e. those who have not received any vaccine included in the country’s routine immunisation schedule) • Penta1 coverage in targeted areas and/or populations; the choice of targeted areas or populations will depend on the intervention that is being implemented

Barrier	Interventions for consideration ²	Monitoring indicators
<p>travel, loss of wages and out-of-pocket expenses incurred.</p> <ul style="list-style-type: none"> Follow-up visits to distant health centres to complete the immunisation schedule is also challenging and often results in high drop-out rates. 	<ul style="list-style-type: none"> Collaboration with community clinics, community health workers, and CSOs. Construction of health facilities, new EPI centres, deployment of mobile vaccination centres or introduction of house-to-house vaccination in areas with low immunisation rates. Provide safe and reliable transportation to health service facilities 	<ul style="list-style-type: none"> Dropout DTP1/MCV1 Drop-out rate between Penta1 and Penta3 <p>Intermediate results indicators:</p> <ul style="list-style-type: none"> Percent of population with geographically accessible health facility Percent of health facilities offering integrated outreach including immunisation Percent of immunisation sessions held per the microplan Percent of defaulter children traced and vaccinated Percent of targeted children immunised during outreach sessions Percent of children with home-based immunisation record Percentage of health facilities with adequate immunisation staffing. [Note: “adequate” includes the gender of the health care worker as an essential criterion] Proportion of health facilities providing immunisation services Percent of districts where CSOs conducted community awareness/mobilisation sessions
<u>Approaches of health service providers</u>		
<p>Attitude, respect, language or ethnicity of health service providers can either facilitate communication with caregivers or can create a distance in interactions/ discourage</p>	<ul style="list-style-type: none"> Provide gender and diversity sensitive training for vaccination workers. Train health care workers to be: (a) respectful and responsive to the diverse health beliefs, practices, and cultural and linguistic needs of women and men; (b) effective communicators, especially to address vaccine hesitancy and to 	<p>Outcome indicators:</p> <ul style="list-style-type: none"> Dropout DTP1/MCV1 Drop-out rate between Penta1 and Penta3

Barrier	Interventions for consideration ²	Monitoring indicators
return visits to complete immunisation schedule of children.	<p>respond to reports of serious adverse events following immunisation, in order to maintain trust and allay fears.</p> <ul style="list-style-type: none"> • Take measures to adequately resource understaffed and over-crowded centres that lead to large waiting times for caregivers. 	<p>Intermediate results:</p> <ul style="list-style-type: none"> • Percentage of health facilities with adequate immunisation staffing • Percent of health facilities with trained health workers

