



GENDER AND IMMUNIZATION DEMAND

FINAL REPORT AND RECOMMENDATIONS



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Foreword

I am very pleased to share with you this report gender and immunization demand. This document builds onto a review of literature exploring the intersections of gender, immunization and demand and draws on the research and analysis conducted for six case studies selected by UNICEF country offices on gender integration in immunization demand interventions.¹ It provides some practical recommendations to plan, design, implement and monitor and evaluate demand generation interventions that have integrated gender.

The objective of the document is to provide guidance to Social and Behaviour Change (SBC) teams, immunization and health teams, as well as national partners responsible for the planning and implementation of immunization demand efforts, on how to integrate a gender perspective into demand interventions.

We would like to acknowledge the contribution of UNICEF Country, Regional and HQ office colleagues for their contribution to the development of this document. We would also like to thank Ami Sengupta, SBC consultant for producing this document on behalf of UNICEF immunization unit/Health Section/New York Headquarters.

We hope you will find this resource to be useful and you can apply the recommendations and the checklist as you design your demand promotion/SBC interventions for immunization programmes.



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¹ The literature review and case studies are available as separate reports.

Introduction

Immunization is a global health success story and has prevented millions of deaths worldwide. Vaccines are critical for preventing communicable diseases and promoting human rights and development (WHO, 2020). More than 116 million infants, 86 per cent of all those born, are vaccinated every year (WHO, 2020). With the development of new vaccines, the benefits of immunization are expanding beyond infancy to include adolescents, adults and older people. The Immunization Agenda 2030 (IA 2030) envisions a world where everyone, everywhere, at every age, fully benefits from vaccines to improve health and well-being from 2021-2030 (WHO, 2020).

Gender is a critical determinant of health outcomes and impacts access to, demand for and uptake of immunization services (Feletto and Sharkey, 2019a; WHO, 2021a). Addressing gender related barriers to immunization will not only lead to equitable coverage but will contribute to gender equality and empower women to access and claim health services. Healthier women can contribute to the well-being and development of their families, communities and countries (Remme et al., 2020). Vaccines impact the well-being of girls and women at various stages of their life course – as infants and children, as adolescents and as women of childbearing age. Expanding coverage and achieving immunization for all requires understanding and responding to how gender norms, roles and relationships impact vaccine uptake. A deeper understanding of how gender impacts immunization behaviours and outcomes can help inform the design and implementation of more gender responsive immunization programmes. It is also important to recognize that gender includes women, men, girls and boys and the diversity within these groups as well as those who do not identify with or conform to binary notions of gender.

Purpose

Although several resources provide guidance on how to integrate gender in immunization programmes, there is limited practical guidance or robust evidence on gender responsive or transformative immunization demand interventions (GAVI, 2021; Feletto and Sharkey, 2019a; UNICEF ROSA, 2019; WHO, 2021a). This report builds on a review of literature exploring the intersections of gender, immunization and demand and draws on the research and analysis conducted for six case studies selected by UNICEF country offices on gender integration in immunization demand interventions.² These provide recommendations for the planning, design, implementation, evaluation and iterative design of future immunization demand generation initiatives.

Designed for social and behaviour change (SBC), immunization and health teams, as well as national partners responsible for the planning and implementation of immunization demand efforts, this report provides guidance on how to integrate a gender perspective with concrete recommendations. The report starts by introducing demand generation in the context of immunization and the gender responsive continuum. Then, it outlines recommendations for integrating gender into immunization demand promotion activities using the SBC programme cycle as a framework. Illustrative examples are embedded throughout in order to make this resource user-friendly and actionable.

² The literature review and case studies are available as separate reports.

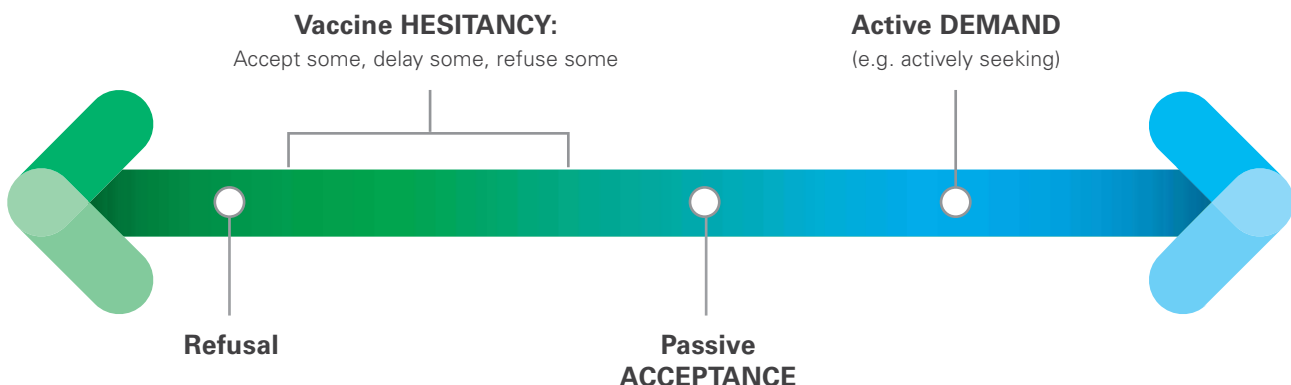
Immunization and demand

Demand in the context of immunization is defined as the actions of individuals and communities to seek, support, and/or advocate for vaccines and immunization services. Demand is dynamic and varies by context, vaccine, immunization services provided, time, and place. Demand is fostered by governments, immunization programme managers, public and private sector providers, local leadership, and civil society organizations hearing and acting on the voices of individuals and communities (Hickler, et al., 2017). Immunization demand efforts are part of social and behaviour change strategies to promote healthier, preventive and protective practices for children and their families and include a wide range of approaches such as community engagement, social and behaviour change communication, service improvements, advocating for supportive policies, fostering social movements and applying behavioural science (UNICEF, 2022a). Demand promotion is a function of the SBC sections/units under the UNICEF programming structure and is carried out in collaboration with health and immunization teams.

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In 2019, vaccine hesitancy was named one of the top 10 global health threats by the World Health Organization, underscoring the importance of minimizing barriers and amplifying facilitators to generate demand (WHO, 2021b). Demand for vaccines falls along a continuum with some individuals refusing all vaccines and others willing to receive all vaccines (WHO, 2021b). Those in the middle were considered vaccine hesitant and may refuse some vaccines, may postpone getting certain vaccines, or may be passive acceptors of vaccines (Figure 1). This continuum will vary by vaccine and context. Currently, vaccine hesitancy is understood as the intention, willingness or motivation to get vaccinated, recognizing that people may be conflicted about, or opposed to getting vaccinated (WHO, 2022).

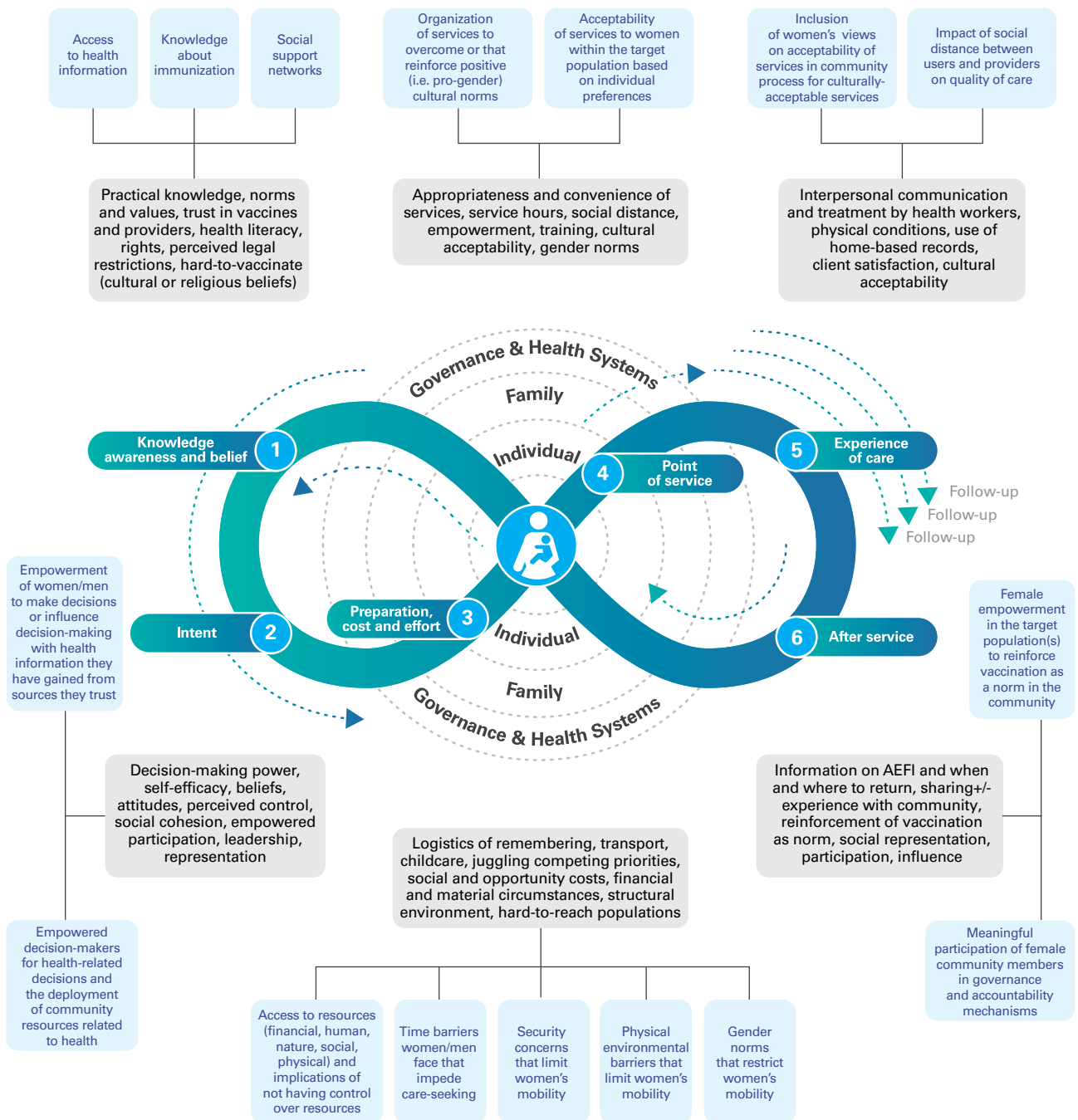
Figure 1 Vaccine demand continuum



Source: WHO, 2021b

Immunization demand and supply are closely connected and overlapping. Interactions with service providers and experiences with quality of care often determine future demand. A case in point is the lack of female vaccinators in certain countries, a service-related barrier but also one with direct implications on demand for vaccination services. Although services are needed to meet demand, services alone will not guarantee it. UNICEF has developed a Journey to Health and Immunization framework to promote a holistic understanding of the immunization process. Gender barriers impact each stage of the journey (see Figure 2). A deeper understanding of how gender impacts immunization behaviours and outcomes- before, during and after the vaccination experience- can result in more gender- responsive immunization programmes.

Figure 2: Journey to Health and Immunization

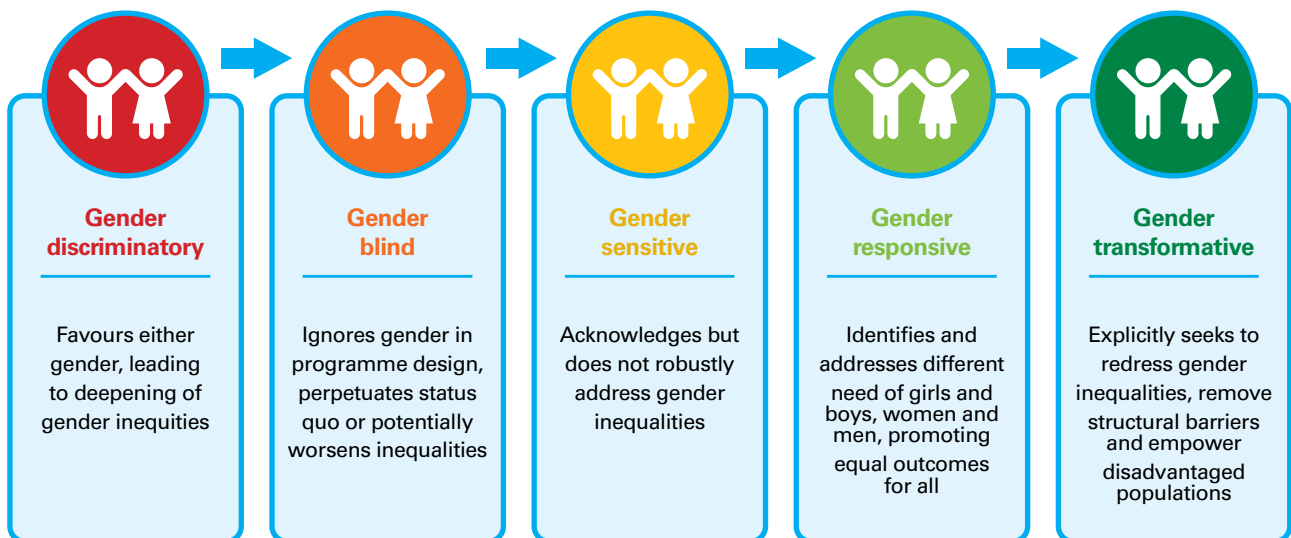


Source: UNICEF

Gender responsive continuum

Gender transformative programming aspires to tackle the root causes of gender inequality and move beyond self-improvement among girls and women to redress power dynamics and structures that serve to reinforce inequalities (UNICEF, 2020a). Gender transformative change, therefore, goes beyond awareness and behaviour change to foster shifts in the power dynamics that define gender norms and relationships. The level of gender integration in programmes can be gauged on a continuum as shown in Figure 3. At one end of the spectrum are gender discriminatory programmes that widen existing gender inequities and at the other end are gender transformative programmes that tackle inequities by rethinking stereotypes, gender norms, and power dynamics.

Figure 3: Gender Responsive Continuum

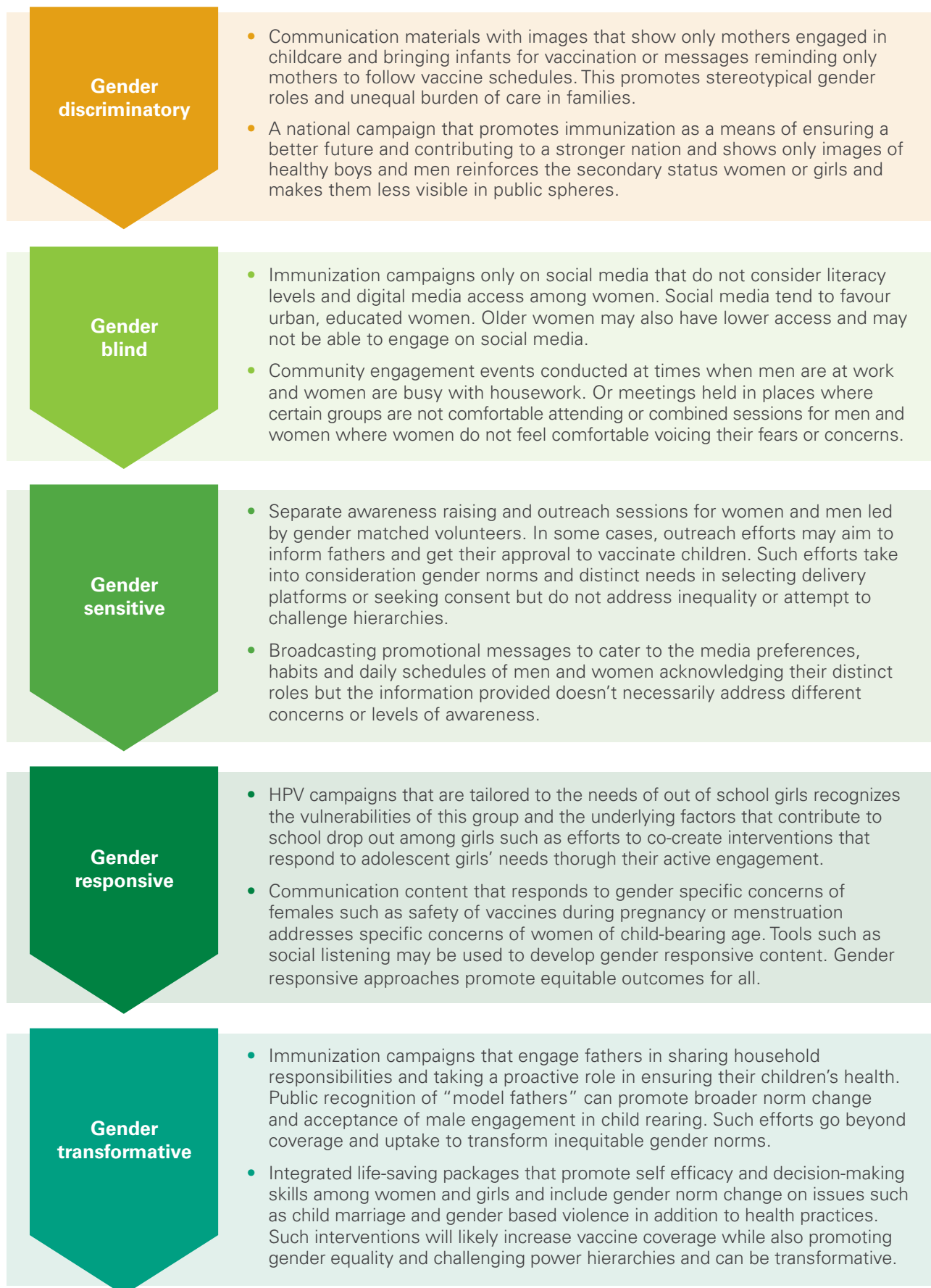


Source: Source UNICEF, 2020

The continuum can be used as both a planning and diagnostic tool to assess the level of gender integration in existing and future programmes. UNICEF programming endeavours to be gender responsive and where possible transformative. At a minimum, programmes should be gender sensitive and must not be gender blind or discriminatory. While emergency vaccine deployments may not be transformative, it is critical for gender considerations to be part of the planning to ensure efforts are responsive to the specific needs of different genders and those who identify as non-binary.

Figure 4 provides illustrative examples of immunization demand efforts along the gender continuum. Typically, an immunization campaign does not attempt to be transformative, but must consider the opportunities, roles and needs of female and male caregivers to promote equity in vaccine coverage. Longer term interventions such as mother's groups, entertainment-education programmes and community-led change efforts provide more opportunity for gender transformation and sustained commitment to transforming gender norms that can have impacts on vaccination uptake and beyond (Sengupta & Singhal, 2021).

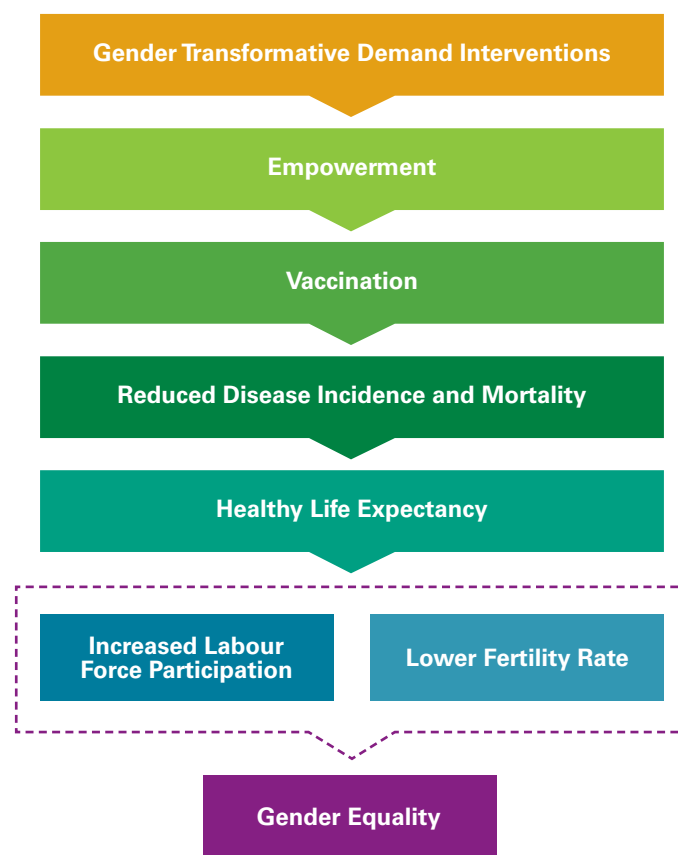
Figure 4: Illustrative examples of immunization demand efforts along the gender continuum



Integrating gender in demand generation

There is a clear association between gender equality, empowerment and vaccine uptake (see [Figure 5](#)). Empowerment and decision-making are important factors for health seeking behaviours and demand efforts that enhance women's empowerment and household decision-making and can in turn influence vaccination coverage (Gelagay et al., 2021). Children with mothers who had higher levels of social empowerment and agency were more likely to be vaccinated (Arsenault et al., 2017; Johns et al., 2022; Wendt et al., 2022.) Likewise, women who believed that wife beating is not acceptable were also more likely to have their child fully immunized than those who believed wife beating was acceptable. Additionally, vaccination among girls can improve equity indicators such as labour force participation and reduction in maternal mortality rates (Portnoy et al., 2020). These findings indicate that gender-transformative strategies can not only reduce childhood immunization inequities but contribute to gender equality and women's empowerment (Johns et al., 2022). Recognizing the linkages and planning interventions that contribute to immunization coverage as well as gender norm shifts requires robust gender analysis, strategic planning and evidence based design and adaptations.

Figure 5: Gender transformative demand interventions as a pathway to gender equality

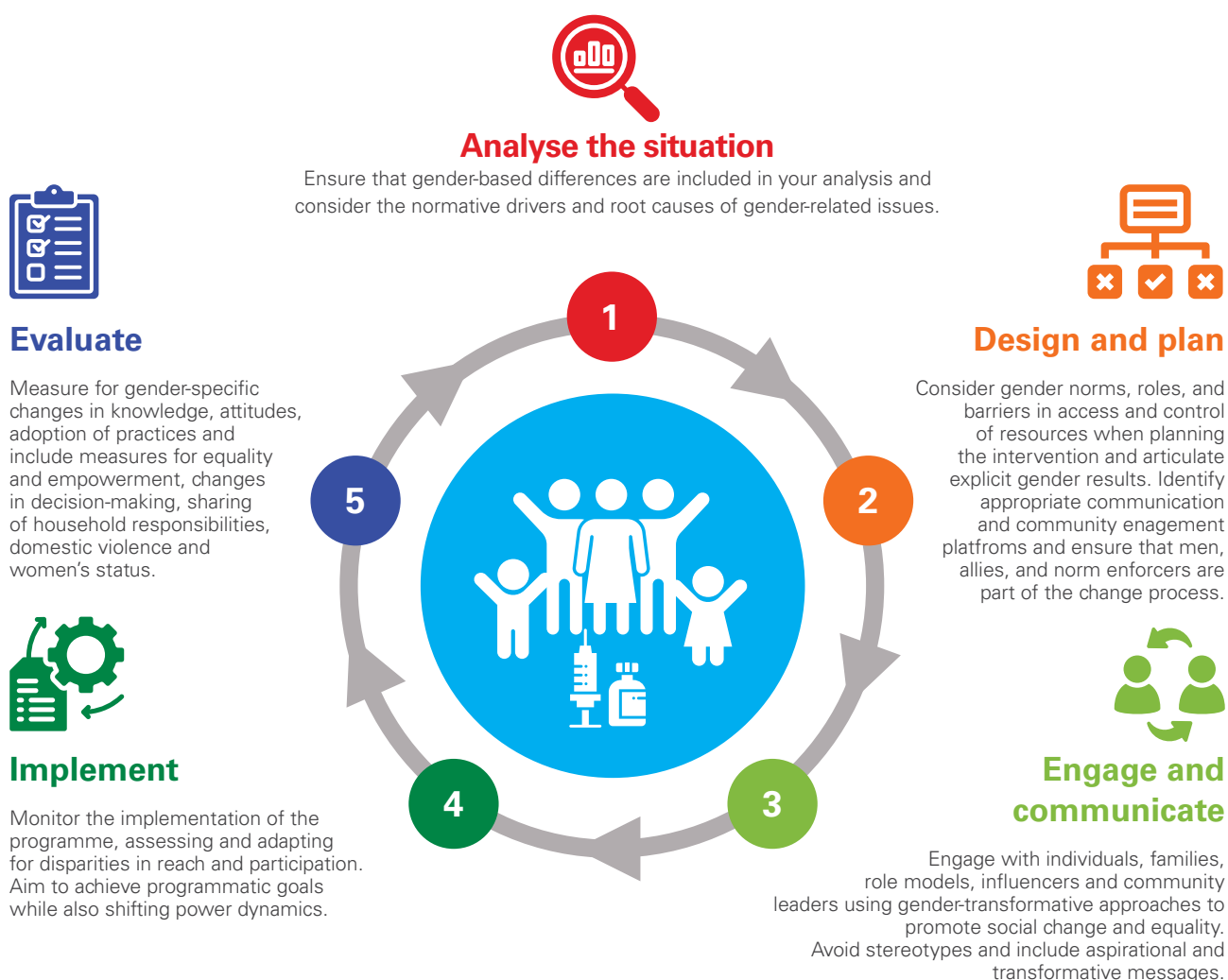


Source: Adapted from Portnoy et al., 2020

Recommendations for integrating gender in immunization demand interventions

Integrating gender perspectives in the SBC or demand promotion programme cycle requires building on a robust gender analysis that informs the design and delivery of the programme. The following section provides detailed recommendations for each step of the programme cycle. A summary of the gender specific considerations in each step are provided in Figure 6.

Figure 6: Integrating gender in SBC programming



Source: Adapted from Sengupta & Singhal, 2021

Step 1: Analyse the situation

Understanding and analysing how the socio-cultural context and prevailing gender norms impact vaccine-related decisions for women, men, girls, boys and gender diverse people is key to ensuring a robust gender perspective in all stages of the programme planning cycle. This reduces the risk of discovering gender barriers or disparities mid-way into a programme or adding gender as an afterthought. For instance, if mobility is a concern for female caregivers and cultural norms do not allow male vaccinators to interact with women and children, these factors need to be addressed from the start, as the intervention is being designed. Gender disaggregated social data should be included and used to inform the situation analysis-which should bring in women, girls, men, boys and gender diverse people's concerns, fears and perceptions towards vaccination as well as barriers to access and experience of care.

Prioritize barriers

Often the barriers to access and uptake of vaccines are known, and prioritization is required to understand which are the most important to address. Barriers can be categorized as structural, social, informational or individual. Distance to a health facility or the cost of transportation to reach a vaccination site are examples of common structural barriers, whereas pressures from others to not get vaccinated is an example of a social barrier and a lack of information about where to obtain a vaccine is an informational barrier. A resource developed by UNICEF MENA prioritized barriers based on what was most critical and feasible to address; limited mobility emerged as the key barrier preventing women from accessing immunization services and was addressed by taking vaccines to places and events frequented by women and setting up temporary vaccination sites (UNICEF, 2021). The same resource highlighted that fear of side effects – an individual-level barrier- is another key barrier and can be addressed by sharing positive vaccination stories by trusted messengers and female influencers.

Consider intersectionality

The barriers to accessing and getting vaccinated may be different for specific segments of women and more severe for those facing multiple deprivations. A woman with no education, from a poorer household, and living in a remote area is less likely to access vaccines. A case in point, most zero-dose children in India are among disadvantaged groups- households in the bottom wealth quintile, mothers in the lowest educational category, scheduled tribes, Muslims, women with incomplete antenatal care, and women giving birth outside a health facility (Johri, Rajpal & Subramanian, 2021). Zero-dose children were more likely to experience early childhood nutritional failures linked to poor growth trajectories and outcomes (Johri, Rajpal & Subramanian, 2021). Evidence from India shows that zero-dose vaccination status is an important marker of generalized vulnerability and is indicative of cumulative disadvantage over the life course. Tailored interventions that focus on groups facing these complex and intersecting disadvantages are required if the goal of leaving no one behind is to be realized. As national-level datasets may not be well-suited to providing an in-depth portrait of intersectional groups, it is important to draw on smaller, deeper analyses to better understand their lived experiences when it comes to vaccine access and uptake.



Address diversity within gender

Although gender in the context of immunization is predominantly understood as male and female, it is important to include the perspectives of LGBTQ+ population and recognize the diversity within this community. Garg et al, (2021) point out that the LGBTQ+ population has suffered from structural health inequities, which have escalated during the COVID-19 pandemic and resulted in mistrust and lack of or misinformation about the COVID-19 vaccine, contributing to vaccine hesitancy. The LGBTQ+ community faces stigma including by health workers which can hamper seeking services (WHO, 2021a). Immunization is often linked to national identity cards and transgender people may be reluctant to seek services if the gender they identify with does not match what is on their national identity card (GAVI, 2021). Broadening our understanding of gender to include the range of gender and sexual identities and tailoring programmes to reach people who do not identify within binary constructions of gender is important to prevent further stigma and exclusion.

Utilize mixed methods research

Triangulating research from large scale quantitative surveys and localized qualitative inquiry will provide a deeper understanding of the reasons behind disparities in coverage. For instance, secondary research conducted for the case studies shows that coverage of zero dose polio among boys in Rwanda is significantly lower compared to girls, and infant mortality among boys in Mozambique is higher compared to girls. Further research is required to understand the reasons for these differences and how best to respond to them.

Figure 7 provides examples of questions to include in a gender analysis to guide the design and planning of interventions.

Figure 7: Questions to include in a gender analysis for immunization programmes

Questions to include in a gender analysis for immunization programmes	
<input type="checkbox"/>	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?
<input type="checkbox"/>	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?
<input type="checkbox"/>	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?
<input type="checkbox"/>	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?
<input type="checkbox"/>	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?
<input type="checkbox"/>	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?
<input type="checkbox"/>	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?
<input type="checkbox"/>	Have women and men from different backgrounds been consulted and involved in designing, monitoring and evaluating immunization services? If so, in what ways?

Source: WHO, 2021a

Step 2: Design and plan

Designing and planning demand interventions that build on robust gender analysis will result in gender responsive programmes that are contextualized and comprehensively address gender barriers. This stage includes articulating gender specific results and identifying appropriate communication approaches and platforms.

Develop a theory of change

A theory of change that describes the gender results that are envisioned and charts a clear and logical pathway to change ensures linkages between barriers, interventions and expected results is a critical first step in designing an intervention and ensures its evaluability. A sample theory of change that builds on the vision and goal of the Immunization Agenda 2030 (IA 2030) is presented on the next page (see [Table 1](#)). The proposed outcomes, outputs and inputs are illustrative; country and field offices will need to adapt them based on the contexts, eligible or targeted population and the vaccine/s being rolled out. The expected results, barriers and proposed strategies will vary for routine, adolescent or adult immunization and again will depend on the cultural context and prevailing social and gender norms (e.g., in some places, women may already have high agency; in others, they may face higher restrictions on mobility or face exclusions based on ethnicity or religion). Humanitarian contexts or emergency vaccine interventions will require different approaches.



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Table 1: Theory of change for gender transformative immunization demand

Theory of Change for Gender Transformative Immunization Demand

If women, girls, and gender diverse people are empowered with the knowledge, motivation and skills to seek immunization services, and if men and family members (mothers-in-laws, older children or siblings) support women, girls and gender diverse people, including those from vulnerable groups to seek immunization services, and if health systems provide high-quality, gender equitable and respectful health services and if laws and policies prioritize gender responsive services, **then** women, girls and gender diverse people will have improved health outcomes and can participate as equal members of society.

Vision	A world where everyone, everywhere, at every age, fully benefits from vaccines for good health and well-being (IA 2030)				
Demand Goal:	Ensure that all people and communities value, actively support, and seek out immunization services (IA 2030)				
SEM Level	Individual	Household	Community	Health Facility	Laws and Policies
Outcomes	<ul style="list-style-type: none"> • Women, men, girls, boys and gender diverse people are empowered to seek immunization services • Men participate in their children’s healthcare and seek immunization services for children 	<ul style="list-style-type: none"> • Husbands, fathers and family members ensure immunization for women, girls and boys and gender diverse people 	<ul style="list-style-type: none"> • Female and male community leaders and influentials (religious leaders, teachers, etc.) advocate for immunization for women, girls, boys and gender diverse people in their community 	<ul style="list-style-type: none"> • Female and male service providers offer gender equitable and respectful immunization services to all in their community 	<ul style="list-style-type: none"> • Governments prioritize gender responsive immunization services including for vulnerable groups (minority, hard to reach, gender diverse population)

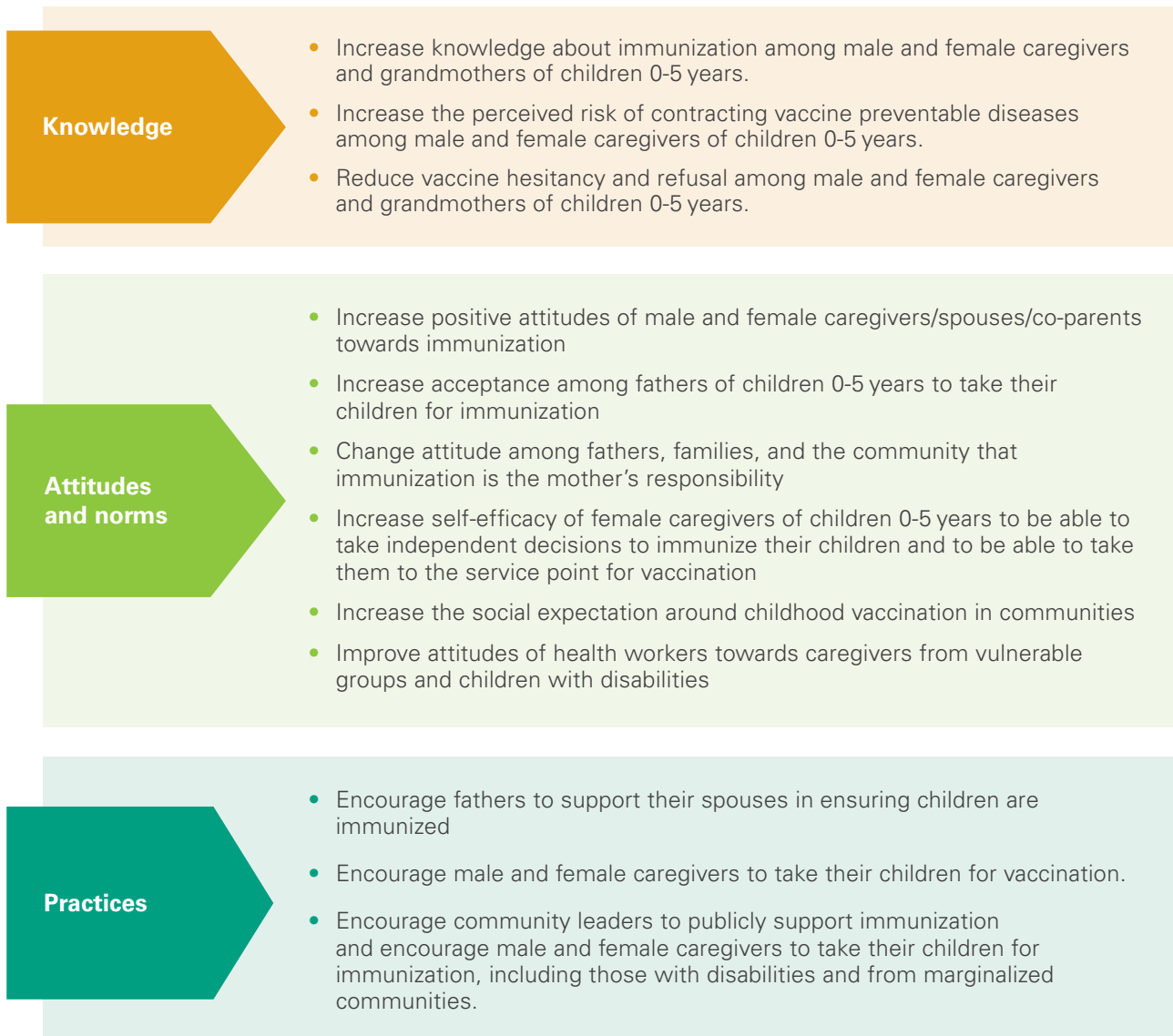
SEM Level	Individual	Household	Community	Health Facility	Laws and Policies
Outputs	<ul style="list-style-type: none"> • Women, girls and gender diverse people have knowledge/ information about vaccines (importance, schedule, location and time of services) • Women, girls and gender diverse people understand the benefits of vaccines • Women, girls and gender diverse people believe everyone in their community expects them to be immunized • Women, girls and gender diverse people are confident to seek services • Women, girls and gender diverse people feel confident to ask questions and seek clarifications from health workers • Women, girls and gender diverse people have the decision-making power to seek immunization services • Men/fathers are motivated to seek immunization services for their children • Mothers, fathers and family members value the health of girls and boys equally 	<ul style="list-style-type: none"> • Husbands/ fathers and family members have knowledge/ information about vaccines (importance, schedule, location and time of services) • Husbands/ fathers and family members understand the benefits of vaccines • Husbands/ fathers and family members value the health of girls and boys equally • Husbands/ fathers and family members believe everyone expects them to ensure the family members are vaccinated • Husbands, fathers and family members support women's decisions regarding immunization • Husbands, fathers and family members participate in children's health care and immunization as a shared responsibility 	<ul style="list-style-type: none"> • Female and male community leaders and influentials understand the benefits of vaccines • Female and male community leaders and influentials believe it is acceptable for men to take children for immunization • Female and male community leaders and influentials commit to children's health care and immunization as a collective responsibility • Female and male community leaders and influentials are engaged in immunization for women, girls and gender diverse people 	<ul style="list-style-type: none"> • Service providers have the knowledge and skills to provide gender responsive services • Service providers are motivated to promote equitable immunization services for women, girls and gender diverse people • Service providers believe respectful behaviour to all women, men, girls, boys and gender diverse people is expected of them 	<ul style="list-style-type: none"> • Governments officials and local leaders understand the benefits of equitable immunization services to all • Governments officials and local leaders are committed to support equitable immunization services to all

SEM Level	Individual	Household	Community	Health Facility	Laws and Policies
Inputs	<ul style="list-style-type: none"> • Social listening and social and behavioural data to inform programmes • Awareness raising • Engaging girls and women in planning, designing and implementing demand promotion interventions • Capacity/ Life skills development • Individual outreach • Male engagement • Media engagement 	<ul style="list-style-type: none"> • Mothers/ fathers groups • Parenting sessions for men • Outreach/ home visits • Male engagement in immunization programmes • Media engagement 	<ul style="list-style-type: none"> • Community events/dialogues/ discussions • Recognition of model fathers • Mobilize community champions • Partnering with community organizations and institutions 	<ul style="list-style-type: none"> • Gender, inclusion and interpersonal communication training • Incentives/ recognition of model health workers 	<ul style="list-style-type: none"> • Advocacy for policy makers • Public communication in support of laws and policies for immunization
Barriers	<ul style="list-style-type: none"> • Lower literacy and inadequate information • Prevailing social norms and negative peer pressure • Practical issues such as cost of transportation and loss of daily wages • Negative service and after-service experiences • Adverse events following immunization • Limited access to media • Limited participation and health seeking • Lack of confidence to interact or question health workers • Limited decision-making power and agency • Limited knowledge on immunization among fathers 	<ul style="list-style-type: none"> • Burden of household responsibility • Immunization considered a mother's responsibility • Belief that men should not be involved in childcare or immunization • Limited engagement of fathers in immunization • Poverty and economic constraints to seek out immunization services 	<ul style="list-style-type: none"> • Limited mobility • Expectation that childcare and immunization is a mother's responsibility 	<ul style="list-style-type: none"> • Limited knowledge and skills on gender equality and inclusion 	<ul style="list-style-type: none"> • Lack of gender responsive health policies • Limited availability of vaccines in remote and hard to reach areas

Set gender transformative communication objectives

Setting gender transformative communication objectives is key to ensuring gender is comprehensively addressed in demand efforts. This also makes the expected change in gender norms and relations explicit and measurable. Figure 8 provides examples of gender responsive and transformative communication objectives from the SBC Strategy for Immunization developed by UNICEF Rwanda.

Figure 8: Examples of gender responsive and transformative communication objectives



Source: Adapted from the SBC Strategy on Immunization, UNICEF Rwanda, 2021

Identify transformative approaches

A range of mutually reinforcing approaches should be used to generate demand for immunization that is gender transformative. **Behaviour change** approaches focus on equipping individuals and families with knowledge, self-efficacy and skills to seek out and receive vaccinations, often leveraging interpersonal communication as well as mass media and social media platforms. Promoting spousal communication about childhood vaccinations, for instance, may help couples start conversations about other important topics such as family planning, antenatal care, girls' education and more. **Social change** approaches work from the bottom up, mobilizing groups of individuals through participatory processes to shift restrictive gender norms related to vaccination and other health areas and transform structural inequities. If communities alleviate mobility restrictions for girls and women, then women may be more likely to seek a wider range of healthcare services for themselves and others they care for. **Social mobilization** brings together different actors to raise awareness and generate demand for immunizations and has been a key approach in immunization efforts. The engagement of key opinion leaders can help correct misinformation and shift cultural norms hindering vaccine acceptance and uptake. **Advocacy** efforts can place pressure on policymakers and leaders to ensure immunization laws and policies are gender equitable and that adequate funding is allocated to sustain gender transformative immunization efforts.

Some promising approaches for gender transformative immunization demand generation are described below.

Engage men in immunization demand

Enhancing the involvement of fathers in childcare and children's health can improve vaccination coverage, reduce the burden on women and promote more equitable roles within households. One step is to ensure interventions have messages and activities tailored specifically for fathers that not only emphasize the importance of vaccination but provide men with concrete actions they can take to ensure their children complete the full vaccination schedule (Merten et al., 2015). Men should be engaged as active participants in their child's health and well-being and vaccine promotion can be integrated with broader parenting and early childhood development initiatives.

In Ethiopia, men were found to contribute to their child's immunization by informing or reminding their wives of the immunization schedule, reinforcing the importance of following the schedule, following up with health workers and participating in community engagement activities to promote immunization (Gelagay et al., 2021). Fathers are not always part of health promotion programmes and outreach efforts for immunization. They may have limited knowledge on the importance of vaccines, the schedule and how many follow-up visits are required. Tailored information and engagement of fathers is a critical step in fostering gender transformative change. Demand efforts should develop specific behavioural objectives for fathers (e.g. accompany spouses to the health facility, remind spouses of follow-up visits or keep track of the vaccine schedule). Efforts to engage men as allies should not reinforce gender stereotypes of men being decision-makers or protectors and should not supersede the importance of women's agency and empowerment.

Identify and mobilize allies and champions

Looking beyond parents, it is important to mobilize a broader network of allies and champions who can both support caregivers to immunize children and promote immunization as a collective responsibility in their communities. In Nigeria, India, and Pakistan, social mobilization efforts to eradicate polio have engaged and trained Muslim imams to be vaccine advocates. The dissemination of key messages by these trusted leaders during Friday sermons, mosque announcements, and after prayer talks was effective in improving vaccine uptake (Nasiru et al., 2012; Obregón & Waisbord, 2010; Weiss et al., 2013)

Family members such as grandmothers or older siblings can also support immunization and shared childcare responsibilities. Human centred design research conducted by UNICEF in Mali showed that mothers-in law often look after children and take them for vaccinations. Illiteracy was a challenge faced by caregivers including grandmothers and led to failures in follow-up as they could not read the vaccine card. A co-creation session with communities suggested providing each grandmother with a jar full of stones, with each stone representing a day and reminding her to remove a stone every day and come back when the jar was empty. Such simple yet effective solutions can respond to gender-based barriers and lower literacy among women (UNICEF, 2022).

Reaching adolescents

Experiences with rolling out the HPV vaccine provide important recommendations for reaching adolescent girls and their caregivers. A study using a human-centred design methodology to capture the perspectives of out-of-school adolescent girls in India found that community-based approaches and reinforcing messages through multiple channels was recommended (Holroyd et al., 2021). Parents were perceived as the primary source of information and decision makers. Health care workers, parental figures (e.g. aunts and uncles) and trusted members of the community were identified as potential influencers. Using adolescent girls who had received the vaccine as role models and champions was another recommendation. The use of gender aligned messengers such as village leaders (Sarpanch) who are mostly male to reach fathers and influential women to reach other women were suggested (Holroyd et al., 2021).



Active engagement of adolescents can have far reaching health benefits. A positive experience with the health system can also lay the foundation for a lifetime of health-enhancing behaviours. Just as women's Tetanus Toxoid (TT) vaccination during pregnancy has shown to be a consistent predictor of child vaccination, young girls' and women's 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 increases in children's immunization (Feletto and Sharkey, 2019b).

Apply behavioural insights and nudges

Insights from social and behavioural sciences should be used to select approaches and frame messages that will generate demand for vaccination, especially over the long term (Jalloh et al., 2020). Too often immunization programmes rely on health promotion staff under ministries of health. Broadening the range of expertise can strengthen immunization demand efforts and bring in inter-disciplinary perspectives.

People often fail to follow through on their intentions to get vaccinated. Behavioural nudges can be instrumental in bridging the intention-action gap. Incentives or rewards can motivate individuals to vaccinate their children or themselves, especially when rewards are certain, immediate, and valued by recipients (Brewer et al., 2022). The Pulse Polio Initiative in India gave parents a kilogram of lentils each time they brought their child to get vaccinated and a set of plates (thalis) when a child was fully vaccinated (Busara et al., 2021). The state of North Carolina, in the United States, offered small cash rewards for adults who received the COVID-19 vaccine or drove someone to get the vaccine and consequently saw an uptick in COVID-19 vaccination rates (Brewer et al., 2022). Financial incentives should not be so large as to be coercive but may alleviate some of the financial costs associated with vaccination.

Sometimes remembering to get vaccinated or remembering when the next appointment is scheduled are the reasons why people do not get vaccinated. Nudges such as reminders via text or phone call can help individuals avoid missing their next appointment (Busara et al., 2021). Redesigning vaccination cards so that the date of the next appointment is clearly visible has also been found to improve childhood vaccination rates in Pakistan and Indonesia (Busara et al., 2021). In addition, stickers, pins, campaign paraphernalia, and other visual cues can be used to signal to others that a person has been vaccinated, creating a pro-vaccination norm in the community.



Step 3: Engage and communicate

In this step, communication approaches, materials and tools are developed and pre-tested. It is important to identify approaches and change strategies and create messages and materials that meet the distinct needs of girls, boys, women and men. Adaptations will be needed to reach specific groups such as ethnic minorities, those living in remote areas or internally displaced people and refugees. Messages and materials should avoid promoting negative gender portrayals or reinforcing inequitable gender norms. Access to media, literacy levels and media preferences and use must be considered. It is critically important that messages and materials are pre-tested prior to their use in the field. This ensures that messages, illustrations and images, songs, and other elements of the materials are understood by and resonate with participants.

Select an appropriate mix of channels

The choice of communication channels should be governed by the media landscape, as well as the media habits and preferences of the groups that programmes aim to reach, and by available financial resources. Because different groups are likely to be reached by different channels, it is important to utilize a mix. Using multiple channels will reinforce messages across different platforms, making it more likely for participants to hear pro-vaccination messages more than once. Interpersonal communication can complement mediated efforts and is key to norm change. Table 2 lists some of the advantages and disadvantages associated with different channels, as well as some gender considerations.

Table 2: Selecting Communication Channels

Communication Channels	Advantages	Disadvantages	Gender Considerations
Mass Media	<ul style="list-style-type: none"> • Reach and visibility • Credible source of information • Aspirational 	<ul style="list-style-type: none"> • Expensive • Difficult to tailor messages or target certain groups • Limited interaction with audience 	<ul style="list-style-type: none"> • Access and ownership • Literacy and language skills • Time of broadcast must be suitable
Interpersonal or Group Communication	<ul style="list-style-type: none"> • Dialogic • Creates a local buzz • Influential • Complements mass media • Promotes reflection 	<ul style="list-style-type: none"> • Resource heavy • Time consuming • Difficult to control accuracy of messages 	<ul style="list-style-type: none"> • Interest and availability given women's multiple responsibilities • Women's mobility and safety • May need to be age and gender segregated • Some topics may be sensitive to discuss
Folk or Local Media and Community Events (fairs, screenings, declarations)	<ul style="list-style-type: none"> • Locally adaptable • Popular • Participatory • Dialogic 	<ul style="list-style-type: none"> • Resource heavy (time, costs, skills to integrate messages) • Limited reach • Everyone may not participate 	<ul style="list-style-type: none"> • Women and girls may not be allowed to participate in or attend public performances • Topics may be sensitive and difficult to portray
Digital Media and Interactive Technologies	<ul style="list-style-type: none"> • Increasing in reach • Rapid dissemination and feedback 	<ul style="list-style-type: none"> • Some segments of the population maybe left out 	<ul style="list-style-type: none"> • Access and ownership • Literacy

Source: UNICEF, 2018

Print materials and one-way messaging contribute to awareness raising but are unlikely to lead to long term vaccine demand and community acceptance and ownership of immunization services (Jalloh et al., 2020). UNICEF Pakistan used a mix of complementary communication channels and platforms to address COVID-19 vaccine hesitancy and increase uptake among women (Figure 9). Tailored messaging was provided on social media and female influencers were engaged as vaccine advocates. Lady health workers included COVID-19 vaccine promotion in their outreach work.

Figure 9: Multi-layered approaches to promote COVID-19 vaccines among women in Pakistan



Source: UNICEF, Pakistan

Consider integrated entertainment-education programmes

Entertainment-education programs have been successful in shifting attitudes, promoting self-efficacy, role modelling positive norms, and engendering social change. Gender transformation is a central theme in *Itetero*, an entertainment-education programme produced by UNICEF Rwanda and broadcast since 2015. Its goal is to promote positive gender norms around parenting and early socialization and address health, nutrition, sanitation and hygiene, child protection, education, and birth registration. Through songs, stories, narrations, dramas, books and poems, the programme promotes positive parenting, including increasing the father's participation in the growth and development of a child and the mother's participation in family decision-making. The radio and TV programme includes targeted segments for different ages. Messages for adults address gender norms within households and sharing responsibilities and emphasize the responsibility of men to know about their children's health including immunization. The segment for children uses animal characters and the segment for parents is a family drama with human characters. Field assessments and feedback from community members show that the programme has contributed to positive changes in gender norms, attitudes, practices and behaviours in several aspects of early childhood development, including immunization. The experience from this intervention confirms that social and behaviour change aimed at gender transformation requires sustained engagement and reinforcement and the integration of different media platforms and interpersonal communication. Furthermore, partnerships between media, the health system, community members and local level service providers and mobilizers deliver a cohesive 360 degrees response and a single narrative for the desired change around gender norms.

Identify the specific communication needs of vulnerable groups

Specific segments of the population may have different communication needs that must be considered in the design and selection of channels, materials, and messages. Research shows that vaccine coverage in countries with greater linguistic diversity tends to be lower and less equitable (Arsenault et al., 2017). Indigenous groups, ethnic minorities, internally displaced people, refugees, and nomadic groups may speak a different language from service providers and mobilizers, and vaccine promotion messaging may not be disseminated in local languages. A rapid assessment on polio found that internally displaced people and nomadic groups in Sudan do not consider Arabic as their first language and prefer receiving information in their native language or dialect. Illiteracy was also higher among nomadic populations who tend to prefer word-of-mouth communication (UNICEF, 2020b). In addition to disseminating messages in local languages, programmes should consider audio, visual, and interpersonal communication channels to ensure messages are received by low-literacy populations. Research on promoting the HPV vaccine among out-of-school adolescents also pointed to the need to use tailored media options for low-literacy populations and ensure accessible and flexible programmes to accommodate out-of-school girls (Holroyd et al., 2021).

Adjust for gendered differences in information access

Women's limited educational opportunities and lower rates of literacy mean that their access to information about vaccines – from vaccine-related knowledge to the logistics of when and where to get a vaccine – may differ from men (Butler et al., 2022; Feletto et al., 2018). Men tend to have greater access to mass media platforms (e.g., radio, television, mobile phones, and social media), whereas women often rely more heavily on interpersonal networks for health information. Digital platforms are an increasingly popular channel for vaccination information. However, these may not be accessible to women, the elderly, the poor, and rural populations. Even if available to them, these groups may find digital technologies hard to use and may also find it hard to identify misinformation (Gender in Humanitarian Action: Asia and the Pacific, 2021). Communication preferences must also be factored into the selection of channels: In Sudan, women expressed a preference for receiving health messages at home rather than outside their home in group gatherings (UNICEF, 2020b). It is also critically important to select channels and messengers that individuals trust. Trusted messengers may not be the same for men and women or for different groups of men and women in a community.

Build trust and address concerns around vaccines

Building and maintaining trust is a critical factor for vaccine uptake (WHO, 2017). Trust becomes all the more important for new vaccines where people need to trust the sources of vaccine information such as the medical fraternity, scientists, manufacturers, and governments (Ledford et al., 2022). For example, a study in Germany highlighted that people had high trust in the health system but were concerned more about the speedy development of the vaccine and not so much about efficacy or delivery. Transparent communication to explain the process of vaccine approval in Europe and an explanation of how the standard safety procedures were carried out was necessary to mitigate fears (Fiske et al., 2022).

Trust is important for women, minorities and other marginalized groups as they may not have adequate access to information, lower intention to get vaccinated and higher levels of mistrust in

the system. Studies have noted a gender difference in the intention to get vaccinated with men reporting a higher intention than women (Zintel et al., 2022). Likewise, a study looking at the role of trust in HPV vaccine uptake among racial and ethnic minorities in the United States showed that racial groups trusted different sources of information-e.g., black women reported higher levels of trust in sources such as government health agencies, television, religious organizations, and family members compared to white women and hispanic men reported lower levels of trust in information from their doctor compared to white and black men (Harrington et al., 2021).

Integrating vaccine delivery and promotion with existing services and trusted delivery platforms such as community-based programmes, civil society organizations and health or social work forces can help build trust (GAVI,2021). Research shows that communicating in a clear, simple format with repeated and consistent messages can aid in trust building. Listening to people's concerns and responding to them is important as is the relationship with health workers, vaccine advocates and previous interactions with the health system (WHO, 2017). Providing a forum for women to express their concerns and receive reliable information from trusted sources is vital. Using community forums to provide accurate, linguistically- and culturally-appropriate information can enhance trust. Building skills and sensitizing the health work force to acknowledge mistrust and fears and encouraging them to build trusted relationships with community members, especially women and minorities can facilitate vaccine uptake (Harrington et al., 2021).

Tailor messages to the specific needs of women and men

Just as messages to engage men should consider the specific informational and individual barriers they need to overcome, so too should messaging directed towards women and girls. Research on vaccine hesitancy showed that that women are concerned about the reproductive side effects of vaccines and whether vaccines are safe for menstruating, pregnant, and lactating women. Building on insights from digital engagement, UNICEF Pakistan developed tailored messages to address vaccine hesitancy among women (see [Figure 10](#)).

Figure 10: Gender specific messages on COVID-19 Vaccines



Source: UNICEF, Pakistan

Figure 11: Understanding the needs of specific groups of women

1. Identify the profile of women you want to focus on:

**A: What is profile of unvaccinated women that have limited mobility and time?
(Check all that apply)**

urban rural areas
 old young
 high middle low income
 mothers not mothers
 pregnant not pregnant
 caring not caring for children or elders
 employed unemployed self-employed
 educated not so educated
 literate not so literate
 have access to technology don't have good access to technology

B: They are from (region, city, country):

C: Is this area conflict affected? yes no

D: Are there religious or cultural influences you should take into account for this population of women? If so, what are they?

E: Other profile information to consider

Source: UNICEF 2021

Moreover, women and girls, men and boys are not homogenous groups. For instance, schools are the most common delivery platform for HPV vaccines; although a large segment of eligible girls will be reached, those who have never attended school or dropped out are left out (Holroyd et al., 2021). An example of how to understand the needs of different groups of women is provided in Figure 11.

Some resources suggest that pro-vaccination messages may be able to leverage traditional masculinity as a way of encouraging men to get their children and spouses vaccinated. Although this kind of message framing may be effective in reaching certain groups of men, it is critically important to ensure that such messages do not reinforce patriarchal gender norms and stereotypes. Instead, messaging can work to promote positive masculinity for example: "Happy couples protect each other. Have you and your spouse gotten vaccinated?" Male engagement is not limited to fathers and should involve male leaders and role-models from the community.

In Liberia, vaccine promotion messages were created to encourage fathers to take children for vaccines. An example of a radio spot promoting male engagement for routine immunization in Liberia is provided below.

Radio Spot Script Promoting Male Engagement (in Liberian Kreyol)



Mustapha: Hawa, thank God I see you and your friends them here.
You na hear the news?

Hawa: What news Mustapha?

Mustapha: You ain't hear the Ministry of Health people coming around
to give our children polio vaccine?

Hawa: No oh Mustapha, so what time they coming give our children
this polio vaccine?

Mustapha: The Ministry of Health People say they will be giving the
vaccine to our children from (specify time).

Hawa: So who them will be taking this polio vaccine?

Mustapha: All children from the time they were born to the time before
they reach five years old will take the polio vaccine.

Hawa: But that all, Mustapha?

Mustapha: No oh Hawa. The vaccinators will go from house to house
and they will also go to the schools, churches, mosques and
market places. They will even be giving the vaccine to the
children at the different clinics or hospitals during this time.

Hawa: Thank you Mustapha for that good news. I will tell all my friend
baby-ma them to get their children ready to take the polio vaccine.

Mustapha: I myself going to tell all the men, even the pastors and imams
in the town to encourage their women and their congregation
to let the children take the vaccine.

Hawa: Mustapha, thank you for telling us yah. I going tell my husband
and my sister now about the vaccination.

Mustapha: Yes, let us tell everyone because our children da our future and
we know the vaccines will give them a healthy start in life.

This message is brought to you by the Ministry of Health and partners with support from UNICEF

Step 4: Implement

The next step involves rolling out the programme and setting up systems to monitor and document the implementation process and outcomes. Monitoring ensures the strategy is being implemented according to plan and can help identify issues that may derail or undermine vaccination efforts. Gender responsive implementation needs to be guided by the identification of the gender barriers that prevent individuals from accessing information or services, participating in activities and engaging for change.

Adjust timings to meet needs of women and men

Flexible timings are important for service delivery and community engagement. For instance evening vaccination services were provided in Bangladesh to cater to working mothers' busy schedules. In Liberia, UNICEF worked with the government to provide after-hours vaccination services to meet the needs of working parents and combined service delivery with awareness raising and door-to-door visits. Home visits were conducted when both parents were home and could be counselled together. If the father was away at work, a follow-up call was made. Female vaccinators, community volunteers and social mobilizers were also trained and recruited to promote vaccine acceptance among women. In addition to flexible timings for services, health promotion, media broadcasts and community engagement need to consider the schedules of women and men. For instance, health information was shared at facilities in Mozambique early in the morning and caregivers who did not arrive on time missed the information sessions. In Sudan, women preferred information sessions at "coffee time" in the afternoon after they have finished their domestic work (UNICEF 2020b).

Adapt for humanitarian contexts

Working in the humanitarian context requires targeted approaches to meet the unique needs of women and girls. Yemen has one of the largest internally displaced populations (IDP) globally and gender disparities have been exacerbated by years of conflict and displacement. Women have limited access to information on health and human rights. Mother-to-mother clubs have been established to provide a platform for women to learn about and share information on health practices including immunization, maternal and child health, hand washing and disease prevention. During the pandemic, mothers conducted awareness raising on COVID-19, promoting vaccines and preventive practices. In some regions, club members also learned how to sew and are making masks and clothes for sale and distribution. The integrated approach of providing a space for women to engage and adding a livelihood component fosters self-reliance and income generation, enabling women to financially support their families. Home visits, often in crowded camps, allow for information to spread to family members such as spouses, in-laws and older children, for questions to be answered, rumours and misinformation dispelled and reminders and behavioural nudges given. Receiving information from trusted messengers who people consider to be one of them and who face similar situations (homophily) increased acceptance and uptake of recommended practices.

Utilize social listening and digital engagement

Social listening, which includes tracking, monitoring, and understanding public conversations on immunization, can help identify reasons for hesitancy and refusal and counter rumours and misinformation (Obregon et al., 2020). For instance, real-time monitoring and feedback loops allowed for tailored and gender-responsive communication efforts in Sudan to promote the COVID-19 vaccine among women and address fears around fertility and vaccine safety during pregnancy and lactation. Social listening using the Talkwalker application allowed for ongoing analysis and data on gender-related barriers and enabled a sound understanding of the needs of both women and men in information and demand creation and service delivery. The social media posts were designed based on insights from social listening and hesitancy or rumours were addressed instantly. Social listening therefore became a valuable tool to learn, adapt and improve programming to overcome gender disparities in information dissemination, feedback and monitoring. Social listening also informed advocacy efforts to make vaccination centres more gender friendly and to deploy female vaccinators. The rapid feedback and adaptation were particularly important for a pandemic response.

Social listening includes online as well as offline feedback mechanisms. Both digital as well as traditional media can be utilized. In countries with low internet penetration or for specific population segments with limited media coverage, tracking community conversations, embedding feedback loops in community engagement activities and collecting social data through rapid surveys is key for relevant and targeted programming. Data from various sources should then be triangulated. Findings can inform immunization demand promotion strategies to address the needs of people with tailored and gender responsive solutions.

Mobilize community-led action

One example of engaging men comes from the Model Family initiative in Mozambique which promotes an integrated package of practices across health, nutrition and sanitation, with an emphasis on male engagement and sharing of household responsibilities. The initiative seeks to address gender inequalities at the household and community levels, while encouraging spousal communication and shared decision-making. Community health committees use pre-established criteria to verify if families are adopting the recommended practices and those who meet at least 80 per cent of the criteria as Model Families. Establishing criteria for “Model Fathers” with clear behavioural outcomes and publicly recognizing role model fathers would be a way to further the gender transformative potential of such interventions.

Step 5: Evaluate

Evaluation allows planners and managers to know what has worked well and led to the desired results, and what has not worked or demonstrated positive impact. Evaluation also serves to inform, improve and adapt future programmes. Applying a gender lens in this step provides an understanding of how the intervention affected different groups of girls, boys, women and men and gender diverse people and can inform the design and delivery of gender responsive or transformative programmes in the future.

Invest in evaluation and knowledge generation

Evaluation should demonstrate whether an intervention has i) resulted in an increase in immunization coverage and vaccine equity; and ii) resulted in any changes in gender norms and contributed to gender equality. The review of literature and the interventions featured in the case studies show the need to conduct systematic assessments on the impact of gender responsive demand efforts on vaccine uptake as well as changes in gender norms, roles and relationships. Both intended and unintended consequences must be considered. It is also important to think of evaluation and how change will be measured right from the planning and design stage. Where possible, baselines are required for pre and post intervention comparisons. Effort must be made to ensure data is disaggregated by sex, age, wealth, education, place of residence, ethnicity or caste etc.

For example, an evaluation of the Girl Effect branded Zathu mini magazine to promote uptake of the HPV vaccine among 9 year old girls in Malawi showed that using girl-centred communication resulted in girls being more informed and motivated to receive the HPV vaccine and in girls talking to their caregivers about the HPV vaccine (Jones & Kawesa-Newell, 2022). The study found positive correlations between exposure to the mini magazine and awareness of cervical cancer, and positive attitudes towards the HPV vaccine among girls and parents in treatment group compared to the control group. The Zathu mini magazine also encouraged household discussions about the HPV vaccine. Consumption of the mini magazine was also positively correlated with uptake of the HPV vaccine among girls (Jones & Kawesa-Newell, 2022). Evaluation findings should be used to improve and strengthen future efforts.

Include gender sensitive indicators

There is a need to include gender sensitive indicators to better understand how gender related changes are occurring over time. These include shifts in power dynamics and women's agency or control in different aspects of their lives. Measuring contributions to gender equality should also include indicators for changes in social norms and attitudes towards gender roles and responsibilities. For example the Global Polio Eradication Initiative included gender sensitive indicators to 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 (WHO, 2021a).

Evaluations should include measures for process and behavioural outcomes and draw on a both quantitative and qualitative methods. Participatory tools like most significant change stories, photovoice and community or social network mapping can reveal rich insights and privilege diverse perspectives. Table 3 provides some examples of gender-sensitive indicators at various levels of the results chain.

Table 3: Gender sensitive indicators

Types/Levels of Indicators	Sample Indicators
<p>Process – assess if activities are on track and going as planned</p>	<ul style="list-style-type: none"> • No. health education sessions conducted for fathers • No. of mothers’ clubs sessions held • No. of adolescent girls engaged in community level immunization activities • No of female community health volunteers recruited/trained
<p>Output – assesses if the activity or intervention is resulting in the intended change. This level of results is also referred to as intermediate outcomes.</p>	<ul style="list-style-type: none"> • % of female and male caregivers who can explain the benefits of vaccines • % of fathers who are motivated to seek immunization services for their children • % of female and male caregivers who value the health of girls and boys equally • % of women who can make decisions to immunize their children
<p>Outcome – assesses if the activity or intervention is leading to longer term behaviour changes</p>	<ul style="list-style-type: none"> • % of women and girls who seek immunization services • % of husbands who accompany their spouse to the health facility
<p>Impact – assesses if the programme has contributed to the overall goal</p>	<ul style="list-style-type: none"> • % of women and girls vaccinated

Efforts to measure gender inequalities and barriers to childhood immunization have focused mostly on coverage differentials between boys and girls and differences in the level of maternal education. A set of indicators was identified and developed to comprehensively assess the multiple barriers and challenges faced by women and men in accessing vaccines (Feletto et al., 2018). Table 4 presents some indicators that can be used to assess gender dimensions surrounding vaccine uptake.

Table 4: Indicators to assess gender barriers to vaccination

<p>To what extent are mothers empowered to decide on health-related matters within the family?</p> <ul style="list-style-type: none"> • % of women who need permission from their husband or another relative to take a child for vaccination • % of mothers who need permission to go/take child to the vaccination facility • % 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
<p>To what extent do women's multiple roles in the family and other access barriers influence their ability to obtain health care for themselves and their children?</p> <ul style="list-style-type: none"> • % of women who reported a problem in accessing services • % of mothers who did not get their child vaccinated because the facility was too far • % of mothers who did not get their child vaccinated because she was busy with other things • % of mothers who did not get their child vaccinated because the session time was inconvenient • % of mothers who report that it is hard to get vaccination services because vaccinations cost too much
<p>To what extent does the health knowledge and literacy of female and male caregivers impact their understanding of vaccination and their motivation to vaccinate their children?</p> <ul style="list-style-type: none"> • % of caregivers with knowledge about vaccines and the recommended schedule • % of caregivers that can name at least one benefit of immunization for their children • % of caregivers who know where to go to get their child vaccinated • % of caregivers of children <1 who can identify the nearest immunization centre • % of caregivers who trust the safety and efficacy of vaccines • % of children whose caregivers intend to vaccinate their child
<p>To what extent are social norms around roles and responsibility of childhood vaccination changing?</p> <ul style="list-style-type: none"> • % of caregivers who report that it is a social norm in their community to vaccinate children • % of males that strongly agree that immunization of their child is their responsibility • Number of EPI demand generation initiatives targeted at fathers and men that focus on fathers' responsibilities for children's vaccination • % of male parents participating in immunization activities • % of functioning health committee (or similar) that includes (male and female) community members

Assess male engagement

There is also a need to assess if male engagement in maternal and child health is increasing. Behaviours to track male engagement could include the proportion of men accompanying their spouses for antenatal or post-natal care visits, fathers bringing children for vaccines or wellness visits, helping with household chores and children’s school work (see [Figure 12](#)).

Figure 12: Indicators for male engagement

Examples of indicators to measure male engagement	
%	of fathers who bring their children
%	of fathers who accompanying their wives for vaccination visits
%	of fathers who remind their wives to follow the vaccine schedule
%	of fathers who promote immunization in their communities
%	of fathers who have taken their child to the health centre for routine vaccines or health visits in the past month/6 months/year
%	of fathers who can explain the importance of childhood immunization
%	of fathers who can list the immunization schedule
%	of fathers who believe it is acceptable for men to take a child for vaccination
%	of fathers who help their children with homework
%	of fathers who share household chores (e.g., caring for sick children, preparing food, washing clothes, fetching water)

Conclusion

Integrating a gender lens in all stages of the planning, design, implementation and evaluation of demand efforts will lead to gender responsive programmes. Figure 13 summarizes the key elements in ensuring gender is included in the programme cycle.

Figure 13: Integrating Gender in SBC



Source: UNICEF, 2018

Conclusion

Gender inequality exists at structural, community and household levels and needs to be addressed holistically. Ensuring immunization demand strategies are gender responsive requires an explicit integration of gender considerations at the individual, family, community, institutional and societal levels. Ultimately gender transformative immunization demand interventions will contribute towards empowering women and girls, a change that requires and must be facilitated by supportive families and engaged communities and is dependent on the availability of gender responsive health services and policies (Figure 14).

Transformative efforts need to go beyond equity in coverage and address the deeper causes of gender inequity and discrimination. This document draws on evidence to propose practical recommendations on the way forward. Although its focus is on the demand aspect of immunization, demand and supply are interlinked. Immunization demand must go hand in hand with reducing gender barriers in accessing services. Focusing on demand generation and awareness raising without recognizing and addressing the gender barriers to services will stall immunization gains and hamper the achievement of the IA2030 goals.

Figure 14: Facilitating factors for gender transformation



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