GENDER AND IMMUNIZATION DEMAND
CHECKLIST

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The Vaccine Alliance

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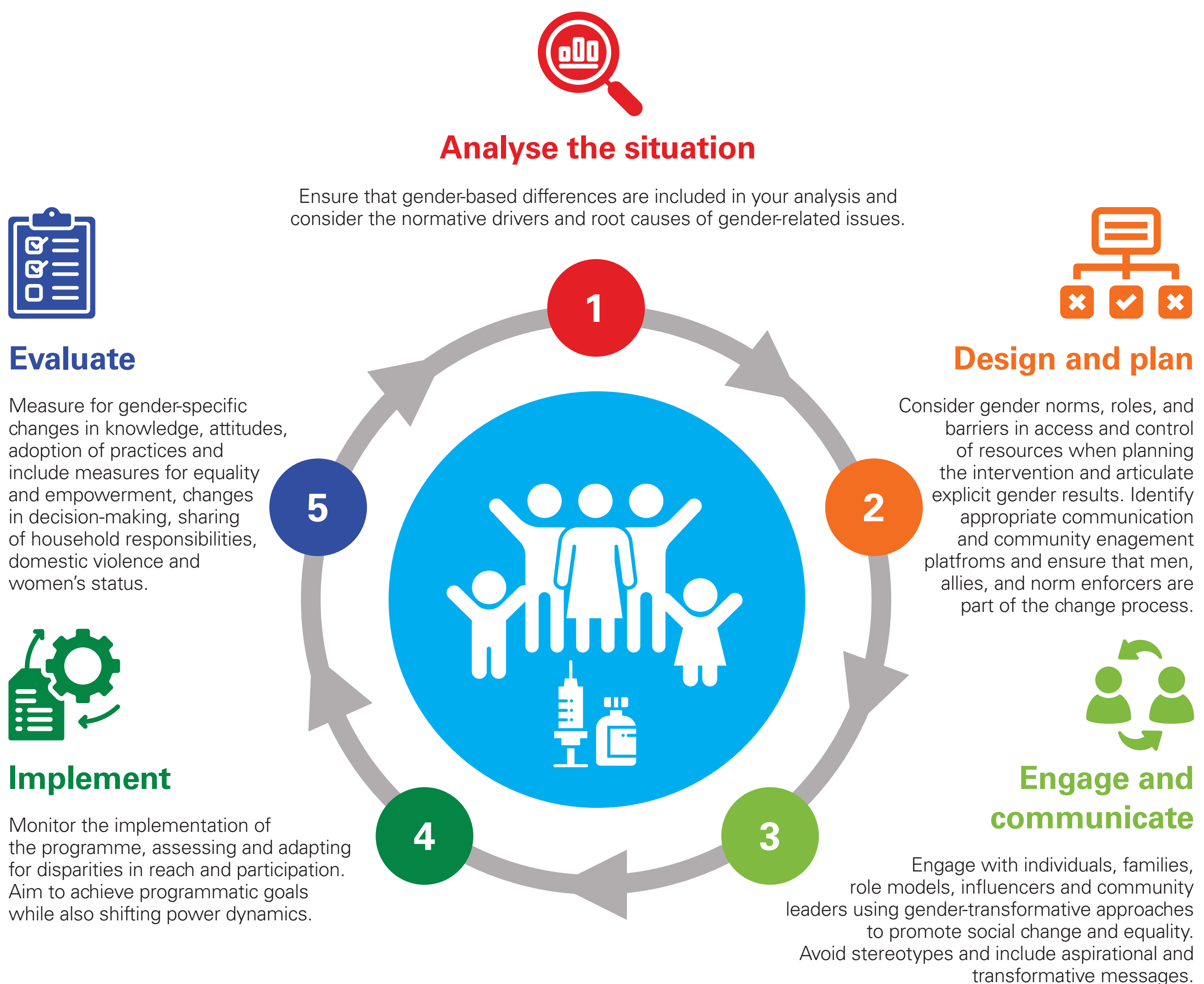
Overview

This checklist aims to guide country offices on key gender considerations as they plan, implement, monitor and evaluate gender responsive or transformative demand interventions for immunization. It provides a broad list of considerations so planners can select those actions that are relevant or feasible in their contexts. The checklist draws on the five steps of the programme planning cycle and includes an understanding of gender barriers as well as opportunities for transformative change at every step (See **Figure 1**). These are suggested actions and it is not expected that every immunization demand intervention will incorporate all the dimensions listed below. It should be noted that several points may need to be carried out across all steps e.g., participatory approaches or gender analysis should inform the entire programme cycle.

Figure 1. Steps for integrating gender in social behaviour change programming



Source: Adapted from Sengupta and Singhal, 2021

Step 1

Analyse the situation

- [ ] Analyse gender barriers before, during and after immunization to understand challenges at all points of the immunization journey (e.g., being treated disrespectfully by health workers or being blamed by the family if the child develops fever after vaccination)
- [ ] Include women, girls, men, boys and gender diverse people in the formative research and consultations to inform the programme design and ensure all perspectives, especially of vulnerable or low coverage population groups are considered (e.g., consultations with LGBTQ groups or young mothers to understand their needs)
- [ ] Identify groups and sub-groups of women and children who are missing vaccines or who may face additional barriers in accessing vaccines (e.g., children of single mothers or child marriages, minorities, migrant families, children with no birth certificate, people with disabilities, refugees or displaced people)
- [ ] Assess the specific needs and access issues for different groups of girls, boys, women, men and gender diverse people (e.g., out of school girls may be teen mothers with child care responsibilities that prevent them from attending schools or community events or limited control over family resources may hamper women's ability to purchase airtime or data on their phones for information and feedback)
- [ ] Use mixed methods for formative research that is wide and deep in order to look at immunization barriers (e.g., national surveys will show overall trends but regional studies can highlight localized challenges and concerns)
- [ ] Analyse gender roles and responsibilities related to child care within the household (e.g., in situations where mothers are working the grandmother may take on child care responsibilities, mothers with many children may have trouble finding someone to watch over the children who are home)
- [ ] Assess the power dynamics and decision making around health within households (e.g., fathers or the elders in the house may be making vaccine related decisions)
- [ ] Identify issues related to access to/control of resources, mobility and freedom of movement that might affect immunization (e.g., mothers may not have the money to pay for transportation or may not be allowed to travel long distances alone)
- [ ] Examine the accessibility of immunization services for different population groups (e.g., the vaccine facility may be far and people living with disabilities may be additionally challenged to reach facilities)
- [ ] Identify any service-related barriers (e.g., trust in government health system, timing may not be convenient for working parents, preference for female vaccinators, or location of facilities or any security risks)
- [ ] Listen to concerns, fears and perception towards vaccination and aim to understand the psychological as well as social factors that may be preventing uptake (e.g., this could include attitudes towards government-led health programmes or the willingness to try a new vaccine, or how others in a social network behave or feel about vaccines)
- [ ] Identify any specific groups that may have fears or concerns about specific vaccines (e.g., pregnant women fearing the safety of the COVID-19 vaccine or adolescent girls for HPV)
- [ ] Map social networks and influencers to identify who can motivate change for specific groups (e.g., trusted messengers such as a local health worker, elder money lender or religious leader as vaccine advocates)
- [ ] Identify role models and positive social norms around vaccines (e.g., female health workers who are vaccinated or fathers who accompany their wives and children to the vaccine centre)

Step 2

Design and plan

- ☐ Articulate gender results in the theory of change and detail which gender-specific changes are expected (e.g., an outcome may be to increase male engagement in child health care or increase health-related decision making among women)
- ☐ Include social and gender norm change objectives where possible and relevant (e.g., mothers, fathers and family members value the health of girls and boys equally or fathers believe it is acceptable for men to take children for immunization)
- ☐ Identify gender-specific demand indicators that can be tracked from the start of the programme (e.g., number of demand generation activities for fathers)
- ☐ Identify and prioritize the behavioural drivers that can facilitate or hamper vaccine uptake (e.g., conducting vaccine drives at frequently visited community spaces or using rewards or non-monetary incentives)
- ☐ Utilize behavioural nudges to influence vaccine uptake (e.g., such as prompts, reminders, commitment initiatives or pledges and role modeling)
- ☐ Utilize transformative approaches that promote active demand for vaccines and contribute to gender equality (e.g., engaging female influencers and vaccine champions, recognizing model fathers)
- ☐ Identify approaches and multimedia platforms that target different segments of women, girls, men, boys and gender diverse people (e.g., social media for urban population and educated younger women and radio for older women and men with lower literacy living in rural areas)
- ☐ Identify and mobilize community allies who can support vaccine uptake and gender norm change (e.g., grandmothers and traditional leaders, local womens' groups)
- ☐ Plan additional activities for hard-to-reach groups who may face barriers in accessing activities or information (e.g., mobile screenings of promotional videos)
- ☐ Include participatory activities for community engagement as well as feedback/listening (e.g., community discussions can be forums for awareness raising, sharing vaccine related concerns as well understanding fears and barriers)
- ☐ Advocate to adapt immunization services to meet the needs of different groups men, women, hard to reach groups, gender diverse people (e.g., flexible timings, delivery modality, indirect costs, etc.)
- ☐ Advocate for recruitment of female health workers and social mobilizers and consider the barriers they may face in carrying out their responsibilities (e.g., difficulties traveling alone, safety issues or lack of toilets or prayer spaces)
- ☐ Establish planning and coordination mechanisms that ensure women, girls, men, boys and gender diverse people's needs and experiences during and after vaccination experiences are considered (e.g., feedback mechanisms such as exit interviews should be used to plan improvements for different population groups)
- ☐ Ensure gender balance and equal representation of women and men in planning and implementation (e.g., task forces, committees, implementing partners should have equal representation)

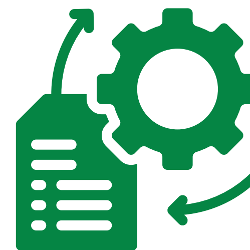
Step 3

Engage and communicate

- [ ] Consider the preferred communication approaches, including interpersonal outreach and community engagement platforms for different groups (e.g., urban male youth may prefer social media while women in remote areas may prefer community meetings)
- [ ] Engage gender matched mobilizers to promote dialogue around vaccination (e.g., women caregivers may want to speak only to female mobilizers or vaccinators; men may prefer reinforcement from peers or male community leaders)
- [ ] Engage trusted messengers who have access to groups who may be left out of other activities/ approaches (e.g., female health workers or volunteers from marginalized communities will have access to the locals and contextualized knowledge)
- [ ] Ensure gender balance in selecting champions, vaccine advocates, mobilizers and volunteers where possible (e.g., select male and female volunteers for outreach efforts and a team of male and female mobilizers to facilitate community dialogue sessions)
- [ ] Engage with men and boys to promote more equitable gender roles in carrying out household duties including child care (e.g., integrated programmes that promote male engagement in early childhood development can also positively impact vaccine uptake)
- [ ] Utilize messages that are aspirational and promote gender equality and equitable engagement for child health (e.g., a campaign tagline such as "healthy girls and boys will lead to a more prosperous nation")
- [ ] Review messages, images and tone of communication products and programmes to ensure they do not reinforce negative stereotypes (e.g., visuals showing rural women in caregiving roles could promote the idea that only women are responsible for child care or that rural women are poorly informed; showing both boys and girls in seeking immunization)
- [ ] Promote messages and visuals that challenge gender norms (e.g., using female sports celebrities or female military officers as champions)
- [ ] Tailor messages and interpersonal communication for different groups of women, girls, men, boys and gender diverse people (e.g., simplified messages for younger women or those with lower education, regional adaptations for linguistic groups)
- [ ] Pre-test materials and messages with women, men, girls, boys, gender diverse people and vulnerable groups (e.g., literate women will be able to read the text and may focus less on the visuals while women with lower literacy may rely on the visuals and ethnic or racial minorities may not feel represented in the images or visuals)

Step 4

Implement



- [ ] Incorporate feedback mechanisms to identify if the intervention is equitably reaching women, men, girls, boys and gender diverse people and responding to their specific concerns (e.g., campaigns that highlight availability of vaccines linked to national identity cards may leave out certain groups)
- [ ] Aim for gender balanced and inclusive community events (e.g., in communities where men and women cannot attend together, plan separate events)
- [ ] Partner with female and male mobilizers or advocates who can support changes in practices and norms around immunization (e.g., religious leaders and local women's groups can promote uptake as well as norm change)
- [ ] Adjust schedule of broadcasts, home visits or community sessions to fit the schedules of men and women (e.g., afternoon sessions may work better for women while men may prefer to convene in the evenings).
- [ ] Adjust timing, location and format of community engagement activities to meet the needs to diverse groups of women, men and gender diverse people (e.g., people with disabilities or the elderly may require special arrangements)
- [ ] Sensitize stakeholders such as local level health providers, community based groups, community leaders and influentials on gender equality (e.g., in some context traditional leaders reinforce unequal gender norms)
- [ ] Include training on gender and prevention of sexual abuse and exploitation as part of the induction process and capacity building for all implementing partners (e.g., power differences and social hierarchies often exist between implementing partners and community members and can be misused)

Step 5

Evaluate

- ☐ Create mechanisms for periodic monitoring of activities to enable timely programmatic corrections (e.g., specific population groups may be left out of engagement activities and adaptations may be required to reach them)
- ☐ Ensure feedback loops are available to women and girls, especially those from vulnerable groups (e.g., toll-free hotlines or community feedback tools)
- ☐ Conduct evaluations to determine if the intervention is leading to changes in both vaccine coverage and gender norms (e.g., measure for decision making and confidence in seeking services)
- ☐ Ensure the evaluation captures disaggregated data by sex, age, education, socio-economic status and place of residence (e.g., assessing perceptions of men and women, gender diverse people and being able to make comparisons based on age or education)
- ☐ Ensure the evaluation design is gender representative (e.g., some KAP surveys include mostly mothers and fail to include the knowledge levels or perceptions of fathers)
- ☐ Include gender sensitive indicators that measure gender equality and empowerment (e.g., number of women and men reached by vaccine promotion activities or proportion of adolescent girls who report making independent health decisions)
- ☐ Track male engagement around vaccines (e.g., changes in male service seeking as well as vaccine promotion)
- ☐ Assess any unintended (positive or negative) consequences related to gender norms or roles (e.g., during the initial phase of the COVID-19 vaccine rollout there was a perception that women who were mostly at home were safe and men who spent more time outside the house needed to be vaccinated)
- ☐ Evaluate the effectiveness of measures adopted in overcoming gender-related barriers to vaccination (e.g., assess the effectiveness of after-hour vaccine services or recruitment of female vaccinators and mobilizers in vaccine uptake)
- ☐ Build on evaluation findings and lessons learned to adapt and inform future programming (e.g., evaluation findings will show which approaches were effective and can be invested in or expanded or those that did not have any impact and need to be adapted or dropped)

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