GAVI ALLIANCE

INFORMATION NOTE: GENDER-RELATED BARRIERS TO VACCINATION SERVICES

1. Introduction

This document is designed to provide guidance on how to include gender in HSS funding requests based on national health strategies, using the GAVI-Global Fund joint Funding Request Template. In line with the GAVI Alliance Gender Policy, GAVI works to reduce gender-related barriers to immunisation services and promote gender-sensitive health services through the Health Systems Funding Platform (HSFP).

HSS funds can be used to:

- Identify, through special studies or investigations, gender related barriers in the national health system including in the immunisation services and methods to address them.
- Remove such barriers, through capacity building of health services and community staff and special interventions.

Countries applying for support through the Request Template should:

- Provide a description of gender-related barriers to health, specific to the country context that could be relevant for GAVI programmes and how the country is moving to address them (including any sex discrepancies as shown in immunisation and health statistics).

2. GAVI Alliance Gender Policy

HSS funding for gender-related barriers supports the Board-approved GAVI Alliance Gender Policy[1], which seeks to promote increased coverage, effectiveness and efficiency of immunisation and related health services by ensuring that all girls and boys, women and men, receive equal access to these services.

The guiding principles of this policy are for the GAVI Alliance to:

1. Apply a gender perspective to all its work.
2. Complement partners' efforts to promote gender equity in health.
3. Promote country ownership and alignment with regard to gender issues.
4. Exercise strong leadership and demonstrating political will.

The Alliance has committed to pursue this policy by:

1. Generating, reporting and analysing new evidence related to gender and immunisation.
2. Ensuring gender sensitive policy and funding support.
3. Advocating for gender equality in health.

2. What new evidence related to gender and immunisation should be taken into consideration when preparing a funding request?

In 2010, the GAVI Alliance commissioned WHO to conduct a study to explore the evidence around sex disparities and gender-related barriers to children's immunisation status. The Gender and Immunisation Study[2] was carried out by the Swiss Tropical Institute and was presented to the WHO Strategic Advisory Group of Experts (SAGE) in December 2010.

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[1] For more information, please see the following link: http://www.gavialliance.org/vision/policies/gender/index.php

[2] Please see http://www.who.int/immunization/sage/1_immunization_gender_reports_without_graphics.pdf

There were two main findings of the study:

- Boys and girls have the same likelihood of being vaccinated in most countries. In other words, sex discrepancies do not seem to be a widespread problem related to vaccination globally, although some countries have reported sub-national differences (either favouring boys or girls); and
- Gender-related barriers to accessing health services were identified. In societies where women have low status and therefore lack access to immunisation and other health services, both girls and boys have lower rates of immunisation.

3. **What are gender-related barriers to vaccination services?**

Gender-related barriers to vaccination services are barriers to accessing services that are related to social and cultural norms about men and women's roles. Some of the gender-related dimensions identified in the Gender and Immunisation study[3] that may lead to reduced access to services include:

Gender-related dimensions	
Health systems	• Women have limited access to household financial resources, cannot access care • Provider attitudes and skills: Disrespect of mother's time, effort, specific circumstances, social status; poor skills • Service organisation: Unpredictability and hours of service; lack of privacy exposes women to shame/humiliation at facility;
Power and politics	• Politicisation of immunisation by local leaders manipulates women through rumours and fear; resistance to immunisation demanded by men but carried out by women • Government priorities, policies and methods pressure women through authoritarian family planning and immunisation strategies; rather than through constructive engagement • Traditional immunisation administration sees women as passive agents • Western and traditional medical system, and social norms make woman responsible for child's health status, not the husband or family
Knowledge / Health Beliefs	• Health decision-making is based on experience and knowledge; women are responsible for the consequences of their decisions as measured by child's health • Mother's behaviour (or misbehaviour) blamed for child health • Information not provided in a way that can be understood by women with alternative world view
Education, Information, Communication	• Women's lower educational level (versus men) cited as reason for non or under vaccination • "Lack of knowledge" or alternative knowledge claims dismissed and equated with illiteracy and lack of education • Health education targets women only; Men do not get information • Health messages are transferred but in an inaccessible way

[3] Hilber AM, McKenzie O, Gari S, Stucki C, Merten S. (2010). Gender and Immunisation. Summary Report, Table 2, p. 12-13. Geneva: Swiss Centre for International Health, Swiss TPH.

Agency / Decision -making	• Mother's choices depends on other family members • Limited degree of access to and control over household resources limits women's capacity to act on her own and her child's behalf
Gender /social norms	• Disempowering gender roles limit mothers' access to services • Women divide their time between maternal tasks (childbearing/rearing • responsibilities), domestic tasks, livelihoods activities, and social tasks (attending sick family members, unexpected guests, etc.) • Marital discord and domestic violence contribute to psychic overload
Poverty and Livelihoods	• In contexts where poverty leads to social exclusion, social networks may be too weak to assist mothers to take children to immunisation, both financially and by allowing them to take some time off work • Mothers don't attend health services to avoid poverty induced shame

One conclusion that can be drawn from these examples is that in many societies, women are the primary caretakers of children and are held responsible for the child's health. Equally, in some countries, women do not have the decision-making power or necessary resources to access immunisation services. GAVI's position is that health care services can improve immunisation coverage by better understanding and considering the unique challenges faced by childcare givers (e.g. accommodating women's schedules and taking into consideration other constraints women face in their multiple roles and responsibilities).

4. How could HSFP funds be used to reduce gender-related barriers to vaccination?

The above study indicates that GAVI-supported immunisation programmes should more effectively identify the constraints that women may face in accessing services – or they may inadvertently contribute to gender inequities. Below are two examples of interventions that countries may implement to reduce gender-related barriers to immunisation:

a) Immunisation programmes that reach out to men have led to greater rates of immunisation.[4] This is likely due to the fact that men are often the decision-makers even if women are the designated caregivers of children. However, men or fathers are rarely implicated in vaccination programmes, and information often does not reach them. By targeting only women, vaccination interventions may neglect the critical influence men have over women's decision-making power. Thus, GAVI encourages information /education/communication initiatives that target ***all*** decision-makers in the family and community as caretakers of children. Where men have such decision-making power, campaigns should target both men and women, using the most effective approach for the intended target audience. Vaccination services could also be provided in places that are accessible to both men and women (e.g. not only maternal and child health centres).

b) In some societies, cultural barriers prevent female caregivers from receiving services from male providers. Where cultural barriers prevent women from receiving services from men, GAVI encourages providing female service providers for women.

Technical assistance for gender-related HSS funding requests is also available for countries via WHO.

[4] Östlin P, Eckermann E, Mishra US, Nkowane M, Wallstam E (2007). Gender and Health Promotion: A Multisectoral Policy Approach, *Health Promotion International*21(S1):25-35.