INCLUSIVE IMMUNISATON POLICY, PLANNING AND PROGRAMMING GUIDANCE NOTE

This guidance note provides a set of practical actions to support the consideration and integration of gender equality, disability and social inclusion (GEDSI) approaches within immunisation programming. It is intended to support DFAT health programs and partners facilitate meaningful participation in planning and delivery of immunisation programs to support equitable access to vaccination and ensure no-one is left behind. Implementation of actions should be situated within and adapted to the local context and grounded in analysis. This guidance note is underpinned by available literature and relevant guidance. It is further informed by learnings from COVID-19, including research undertaken by representative organisations during the roll-out of COVID-19 vaccination.

GOOD PRACTICE CHECKLIST SUMMARY

1. Policy and planning
- ❑ Encourage equity and inclusion to be included as regular agenda items in immunisation planning, policy and programming discussions and decision-making processes.
- ❑ Encourage and facilitate gender, disability, and social inclusion stakeholders to be engaged in vaccine planning discussions and decision-making.
- ❑ Encourage the use of rapid gender, disability and social inclusion analysis and needs assessments tools to identify and address the barriers and specific needs of diverse groups who experience social disadvantage.

2. Community engagement
- ❑ Encourage the active involvement of diverse community stakeholders (including women, people with disabilities, older people, youth, Indigenous Peoples, ethnic minorities, and other groups who experience social disadvantage) in vaccine planning and programming.
- ❑ Provide mechanisms that enable sharing of information to and from diverse community members to help ensure accountability and inform adaptations of vaccination programs.

3. Vaccine communications
- ❑ Encourage barriers to vaccine information and uptake to be addressed through development of tailored messages in accessible formats that empower diverse groups with vaccine literacy.
- ❑ Encourage the use of diverse, trusted, and accessible communication channels to reach different groups.

4. Vaccine delivery
- ❑ Encourage Electronic Immunisation Registries (EIR) and vaccine certification systems to be designed to be inclusive and accessible to all.
- ❑ Encourage the design and use of differentiated vaccine delivery strategies to reach and accommodate the differing needs of diverse groups who experience social disadvantage.
- ❑ Encourage attention to human rights and the principle of ‘do no harm’ during vaccine deployment.

5. Workforce development
- ❑ Encourage gender, inclusion, and localisation to be considered during planning for and recruitment of human resources.
- ❑ Advocate for mechanisms to be put in place to protect the safety of the vaccine deployment workforce.
- ❑ Encourage gender and inclusion to be considered within in-service training and re-emphasised during workforce supervision.
- ❑ Encourage the work and time of the vaccine deployment workforce (including volunteers and social mobilisers) to be recognised and remunerated appropriately and fairly.

6. Monitoring and reporting
- ❑ Encourage the collection, reporting and use of disaggregated data, including for vaccine safety surveillance.
- ❑ Seek additional qualitative information on vaccine acceptance and vaccine access.
- ❑ Consider safety, rights and ‘do no harm’ principles in monitoring and reporting activities.

POLICY AND PLANNING

Everyone has the right to the highest attainable standard of health. This includes the right to the same opportunities to access and benefit from immunisation services. However, social norms, gender relations and social disadvantage can influence who has access and control over resources and services, including immunisation services. Supporting the realisation of the right to health and equitable access to immunisation requires more than just considering immunisation coverage but also asking which voices are being heard and whose health needs are being met. Supporting meaningful participation and dialogue from and with various stakeholders is important to ensure ongoing attention to equity and inclusion in immunisation policy, planning and programming. This is critical in supporting demand from groups who experience inequities and disadvantage while also driving attention to inclusive and equitable service delivery.

Policy and planning – Good practice checklist

1. **Encourage equity and inclusion to be included as regular agenda items in immunisation planning, policy and programming discussions and decision-making processes.**

- ❑ Consider how you can utilise your seat at the table with key stakeholders and decision-making forums to ask questions about how immunisation policy, planning and programming is being responsive to gender and social inequities.
- ❑ Encourage responsiveness to new evidence and emerging guidance on gender, disability and social inclusion, through iterative planning and program adaptation, and in consultation with key stakeholder groups.
- ❑ Use quantitative and qualitative data reported by partner Government and by key GEDSI stakeholder groups to track implementation (compared to national vaccination plans and priorities), to identify issues of equity in relation to vaccine access and to advocate for greater attention to equity and inclusion.

2. **Encourage and facilitate gender, disability and social inclusion stakeholders to be engaged in vaccine deployment and decision-making processes.**

- ❑ Advocate for gender and social inclusion experts, women's groups, ethnic minority and Indigenous organisations, organisations of people with disabilities and other community-based groups to be consulted and engaged in immunisation programming.
- ❑ Encourage the involvement of government departments that coordinate gender equality, disability services, social affairs, human rights and other relevant issues within immunisation co-ordination.

3. **Encourage the use of rapid gender analysis and needs assessments tools to understand and help address the specific needs of diverse groups who experience social disadvantage.**

- ❑ Encourage existing information and tools to be used to identify context specific barriers to vaccine access, taking into account intersectionality and safety issues. See DFAT's GEDSI Analysis Good Practice Note, CARE's Rapid Gender Analysis Toolkit and UNICEF's Immunisation and Gender Practical Guide for suggested guidance.
- ❑ Encourage the use of analyses and assessments to inform the development of action plans and program adaptations to help address barriers related to gender and social inequities.

COMMUNITY ENGAGEMENT

Engaging the community in immunisation programs and addressing exclusion positively contributes to improved vaccination coverage, equity and inclusion. Strong and inclusive engagement with community and civil society can assist in communicating vaccine messaging, building trust in immunisation programs, identifying groups at risk of being left behind and improving reach, including to hard-to-reach places. When community trust is strengthened and community engagement efforts are used to redress social norms and barriers for those who experience marginalisation and exclusion, there is less risk of backlash, improved inclusion and greater safety for the vaccine workforce and others in the community.

Community engagement – Good practice checklist

1. **Encourage the active involvement of diverse community stakeholders (including women, people with disabilities, older people, youth, Indigenous Peoples, ethnic minorities etc) in vaccine planning, deployment and decision-making processes.**

- ❑ Engage with community organisations to identify vaccine access barriers and the strategies necessary to address those barriers. This should consider factors related to gender, age, ethnicity, race, disability, language, religion, income level, HIV status, refugee/migrant status, etc.
- ❑ Encourage gender balance and diverse representation from community stakeholders and support engagement of groups who experience social disadvantage in coordination and decision-making bodies.
- ❑ Encourage consultation with diverse community stakeholders on communication messages and to test and deliver vaccine communications.
- ❑ Seek the involvement of and build ally-ship amongst community and religious leaders in social mobilisation efforts to support leadership that models and advocates for the shifting of gender norms and improved access and inclusion.
- ❑ Encourage diverse and trusted community members, including women and representatives from groups who experience social disadvantage, to be involved in deployment of vaccines and accompany outreach visits (where safe).
- ❑ Consider and encourage approaches which engage men alongside women and ensure there is community trust and support to mitigate against situations of backlash and harm.

2. **Provide mechanisms that enable sharing of information to and from diverse community members to help ensure accountability and inform adaptations of vaccination programs.**

- ❑ Encourage accessible and confidential feedback accountability mechanisms to be embedded into programming that encourage diverse community members and representative organisations to provide feedback on vaccine access, including on safety issues.
- ❑ Encourage community involvement in surveillance and monitoring activities.
- ❑ Encourage the involvement of diverse community stakeholders to provide qualitative information on vaccine acceptance, confidence and access.

Case study: Empowering women and engaging men to counter vaccine myths and improve uptake

In a community in Guinea, vaccinations were believed to make children infertile. Men were particularly opposed to vaccination, and women had little decision-making power in the community. A community champion model was introduced, engaging women alongside male leaders to counter vaccine myths and improve vaccination rates. The program had great support from the community chief and religious leaders which was key in mitigating against community backlash. Religious leaders were trained and encouraged to address myths, alongside other social mobilisation and mass media campaigns. Women from the community were trained to educate other women on the benefits of vaccination. Mothers were allowed to mark a child's finger (to indicate vaccination) to ensure the mark was discrete and mitigate against risk of backlash. Champions provided women with information about available services if there were issues at home and visited women at home following vaccination to check on the child and caregiver. The model has significantly improved vaccination coverage and has been replicated in other communities in Guinea. This example shows the benefits of engaging women alongside male leaders in the community and the need to embed an approach which does not increase the risk of harm or violence in the community.

Source: Catholic Relief Services. (2019). Civil Society Organization Platforms Contribute to National Immunization Programs

VACCINE COMMUNICATIONS

Health literacy, accessibility of information, access to trusted information, limited decision-making power and dependence on those in positions of power can negatively influence vaccine confidence and uptake amongst different groups. Disinformation related to the vaccine's impact on men and women's reproductive health (such as impotence, infertility or birth defects), myths and fear of side effects may also lead to fear or stigma associated with vaccination and lower vaccine uptake. Similarly, lack of sufficient vaccine safety information for some groups (including pregnant and lactating women, those with pre-existing health conditions and people with disabilities) may lead to reduced uptake. Vaccine communications and information needs to be accessible, inclusive and tailored to meet the needs of those who face particular barriers to accessing information.

Accessibility of vaccine communications – Good practice checklist

1. **Encourage barriers to vaccine information and uptake to be addressed through development of tailored messages in accessible formats that empower diverse groups with vaccine literacy.**

- ❑ Encourage the development of targeted communication messages which address the specific concerns of women, men and gender diverse people, youth, older people, people with disabilities and Indigenous Peoples; and which proactively address misinformation regarding efficacy and safety (including messages relating to impotence, infertility, birth defects, menstrual cycle changes and fear of side effects).
- ❑ Encourage the co-creation of messaging and testing of materials with stakeholders from the community, including women's groups, Indigenous Peoples, organisations of people with disabilities and faith-based leaders.
- ❑ Encourage the use of materials that represent the diversity of the community and which avoid reinforcing gender stereotypes, stigma or discrimination.
- ❑ Communicate evidence amongst stakeholders as it becomes available to support informed decision-making for diverse groups including pregnant and lactating women, children and youth, people with pre-existing illnesses and compromised immunity, and other sub-groups.

2. **Encourage the leveraging of diverse, trusted and accessible communication channels to reach different groups.**

- ❑ Encourage use of multiple communication channels and a range of formats (including audio, visual and written) to reach diverse populations. For example, mass media, social media, mobile apps, websites, community groups, existing health services, gender or disability specific services and other sectoral programs including education, nutrition and social protection.
- ❑ Encourage engagement of women-led groups, organisations of people with disabilities, youth-led groups, Indigenous communities and other community-led groups to support dissemination of vaccine communications and messaging.
- ❑ Consider utilising groups where families, couples and caregivers come together to promote joint and supported decision-making.
- ❑ Encourage the use of culturally-sensitive, inclusive and accessible approaches to provide vaccine information:

  a) Provide communication in Indigenous languages;
  b) Provide communication in necessary languages to reach migrant populations;
  c) Provide printed materials in large print to support those who may have vision impairment (including older people); include images and use simple language to support those with low literacy; and use braille to support blind people with access to information;
  d) Provide communication in sign language and integrate closed captioning to visual audio content to ensure the Deaf community and hard of hearing people have access to information.

VACCINE DELIVERY

Barriers related to gender and social inequalities can create critical challenges to meeting immunisation needs of diverse groups. Barriers vary depending on context and intersectional factors including gender, disability, socio-economic background, age, sexuality, ethnicity, geographical location and citizenship status. They may include: lack of information; limited autonomy and decision-making power; limited mobility; gender or attitudes of health workers; risk of violence; distrust in government services; location and available time of services; limited time to seek services because of caring responsibilities; inaccessible transportation and facilities; fear of exposure to communicable disease at administration sites; and bias in the home or community resulting in some groups being overlooked. Identifying and addressing these barriers is key to supporting equitable access.

Accessibility of vaccine delivery – Good practice checklist

1. **Encourage Electronic Immunisation Registries (EIR) and vaccine certification systems to be designed to be inclusive and accessible to all.**

- ❑ Consider how documentation requirements may exclude some people from registration or certification. For example, people of diverse sexual orientation, gender identity, gender expression and sex characteristics, stateless or undocumented migrants, nomadic groups, and people with disabilities who may have limited access to identity documentation.
- ❑ Where digital registration or vaccine certification is used, consider if different options can be considered for those who have limited access to smartphones or internet, or where apps or websites are not accessible. For example, women, people with disabilities, older people, those living remotely and those in economic hardship who may all have limited access to online options.
- ❑ Encourage community groups and social workers to be mobilised to assist with challenges associated with vaccine registration and/or vaccine certification.

2. **Encourage the design and use of differentiated vaccine delivery strategies to reach and accommodate the differing needs of diverse groups who experience social disadvantage.**

- ❑ Encourage provision of vaccination at sites within the community and closer to where people live to enable greater access for women, people with disabilities, rural populations and older people who may be unable to access urban centres.
- ❑ Mobilise trusted community members and organisations including women's groups, organisations of people with disabilities and community leaders to provide/accompany vaccination programs to build trust in vaccine programming.
- ❑ Encourage the integration of vaccine delivery into settings where the community has trust including community-based programs, youth centres or alongside faith services.
- ❑ Encourage integration of vaccinations into existing services that respond to gender or disability specific needs, such as sexual and reproductive health services and antenatal care; or community-based rehabilitation and disability services.
- ❑ Consider how vaccination sites (both fixed and mobile) could be made accessible, child-friendly and safe.
- ❑ Encourage extended and flexible vaccination hours to accommodate working hours and caregivers' responsibilities, ensuring health workers are adequately remunerated for overtime.
- ❑ Consider encouraging outreach visits and vaccination at home for those who may be unable to get to a fixed vaccination site (encouraging a 'do no harm' approach to be embedded).

3. **Encourage attention to human rights and the principle of 'do no harm' during vaccine deployment.**

- ❑ Advocate for attention to protecting the safety of health workers and community stakeholders including against backlash, violence, harassment, exploitation and abuse.
- ❑ Ensure attention to human rights including informed consent (free from coercion), privacy of information and confidentiality, and freedom from discrimination or exclusion.
- ❑ Advocate for links and referral processes between key services including childhood immunisation, gender-based violence services, sexual and reproductive health services, and disability services.

WORKFORCE DEVELOPMENT

The workforce is pivotal to the success of immunisation programs by facilitating access to information and services. The workforce can, however, also perpetuate gender norms, inequalities and barriers to vaccine access. With women accounting for majority of the formal and informal health workforce, gender inequalities may also heighten their risk of exposure to violence for the immunisation workforce, particularly during outreach or in remote locations. Integrating gender and inclusion considerations into planning, recruiting and training of the workforce engaged on immunisation programming is important to achieve improved outcomes for communities and to mitigate against perpetuation of inequalities.

Immunisation workforce development – Good practice checklist

1. **Encourage gender, inclusion and localisation to be considered during planning for and recruitment of human resources.**

- ❑ Encourage gender balance and diversity amongst the vaccine workforce (including social mobilisers) to allow for gender sensitive and culturally appropriate service provision.
- ❑ Encourage greater numbers of vaccinators and social mobilisers to be recruited to work at the community level acknowledging this may facilitate greater access for women, people with disabilities and older people who may have limited mobility to reach urban centres.

2. **Advocate for mechanisms to be put in place to protect the safety of the vaccine deployment workforce.**

- ❑ Encourage consultation with staff, community and representative organisations to identify safety issues and mitigation strategies.
- ❑ Support confidential and accessible complaints systems to be established and support made available for survivors/victims of exploitation, abuse and harassment.
- ❑ Implement a "zero tolerance" policy on discrimination, harassment, exploitation and abuse, reinforced through trainings and redress measures for perpetrators.
- ❑ Consider law enforcement travelling to and from administration sites with health workers and to accompany outreach or mobile vaccination programs if violence is a significant risk.

3. **Encourage gender and inclusion to be considered within in-service training and re-emphasised during workforce supervision.**

- ❑ Consider if trainings could integrate content on gender, inclusion and accessibility. This could include:

  a) Accessible and rights based patient communication and informed consent processes;
  b) Pre-vaccination communication on risks and benefits sensitive to the needs of diverse women, men and gender diverse people (including people with disabilities);
  c) Addressing negative attitudes and assumptions as a significant barrier;
  d) Codes of conduct for vaccinators to prevent and combat sexual exploitation, harassment and abuse;
  e) Safe referral of survivors/victims of gender-based violence to specialised services;

- ❑ Seek detail from training participants ahead of trainings to assess if any reasonable adjustments or supports are needed to ensure their full and meaningful participation.
- ❑ Seek disaggregated data on training attendance (by sex at a minimum and by disability where possible and privacy of information is able to be respected), using this data to assess if training opportunities are equitable.

4. **Encourage the work and time of the vaccine deployment workforce (including volunteers and social mobilisers) to be recognised and remunerated appropriately and fairly.**

- ❑ Encourage workplace flexibility that enables program staff to balance responsibilities outside of work (including caregiving responsibilities).
- ❑ Encourage remuneration of program staff (including volunteers) in a fair and timely manner including for overtime.

MONITORING AND REPORTING

Improving the collection and visibility of data enables greater understanding of how immunisation programs are effectively reaching groups within the population and can help to identity and explain inequities. When embedded into safety surveillance, disaggregation can also assist with tracking how different groups may be affected differently by adverse events following immunisation and can inform the evidence base on safety data to improve public confidence. Seeking qualitative information can also assist in understanding vaccine acceptance and barriers to access amongst various groups.

Monitoring and reporting on immunisation access - Good practice checklist

1. **Encourage the collection, reporting and use of disaggregated data, including for vaccine safety surveillance.**

- ❑ Encourage data on vaccination coverage, community engagement and workforce training to be disaggregated by sex, age and disability where data allow and other contextually relevant factors where possible including pregnancy status, comorbidity, ethnicity, geographic location, migrant status, cohort/occupation.
- ❑ Consider seeking additional technical support and resourcing on collection, reporting and analysis of data on gender, disability and social inequities where this is an identified gap.
- ❑ Seek information on sex, gender, age, disability, ethnicity, pregnancy status and other sociodemographic factors in any studies undertaken on vaccine hesitancy.

2. **Seek additional qualitative information on vaccine acceptance and vaccine access.**

- ❑ Encourage engagement of the community in surveillance activities and seek information from representative organisations and other programs to help to build a picture of vaccination acceptance, uptake and coverage and to identify groups that may be at risk of being left behind.
- ❑ Conduct or resource surveys, qualitative analyses, and collect case studies that can help to better understand vaccine acceptance and access, documenting lessons learned and informing adaptions of gender, equity and inclusion dimensions within immunisation policy, planning and programming.

3. **Consider safety, rights and 'do no harm' principles in monitoring and reporting activities.**

- ❑ Ensure privacy and confidentiality is respected when collecting, receiving or storing monitoring data and records.
- ❑ Seek feedback on social safeguarding risks, including safety and human rights issues. For example, discrimination, or forced exclusion, lack of informed consent or situations where privacy of information has been compromised.
- ❑ Consider how monitoring activities pay attention to not contributing to situations of harm for at-risk groups.

Case study: Using monitoring and reporting on social norms to inform program adaptations

During the Ebola epidemic in Sierra Leone in 2014, efforts to eradicate the disease and mitigate against other outbreaks faced significant obstacles. A series of Knowledge, Attitude and Practices Surveys showed immunisation coverage among women and their young children had slipped and antenatal visits were being missed; and pointed to the social norms and beliefs that were contributing including a mistrust of health centres and belief that vaccinations were linked to contracting Ebola. Women leaders, civil society and community members were mobilised to provide information about Ebola transmission and the importance of immunisation. They conducted outreach in hard-to-reach communities, followed up those who had not completed their immunisation schedule, encouraged utilisation of health facilities and provided incentives to mothers (clothing, nappies, toys and food). Data shows these efforts, alongside those of government, were effective in improving immunisation coverage. This demonstrates the impact qualitative and quantitative data can have in highlighting vaccination gaps and informing approaches to improve vaccination coverage, particularly amongst groups at risk of being left behind.
Source: Relief Services. (2019). Civil Society Organization Platforms Contribute to National Immunization Programs

RESOURCES AND REFERENCES

Gender considerations in vaccination programming

- United Nations Children's Fund (UNICEF). (2022). From coverage to empowerment: Integrating gender in immunization demand. Promising practices from six countries.
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- WHO. (2023). Why Gender Matters: Immunisation Agenda.
- SDG 3 Gender Equality Working Group, Gender and Health Hub, United Nations University. (2021). Guidance Note and Checklist for Tackling Gender-related Barriers to Equitable Covid-19 Vaccine Deployment.
- WHO. (2021). Critical Sex and Gender Considerations for Equitable Research, Development and Delivery of COVID-19 Vaccines.
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- CARE International. (2019). CARE's Rapid Gender Analysis Toolkit.

Disability, social inclusion and human rights

- WHO & UNICEF. (2021). Disability considerations for COVID-19 vaccination provides recommended actions to improve disability inclusion in vaccination programs.
- International Disability Alliance. Persons with Disabilities and Access to COVID-19 vaccination outlines the increased COVID-19 risk faced by people with disabilities and recommendations for their inclusion.
- HelpAge International. A vaccine manifesto: those most at risk must come first everywhere outlines vaccine access barriers that older people may face and recommendations to improve access.
- OHCHR. (2020). Human Rights and Access to Covid-19 Vaccines provides an overview of human rights considerations related to global COVID-19 vaccination supply and deployment.

Preventing sexual exploitation and abuse

- Gender-based Violence Area of Responsibility (AoR), Global Protection Cluster. (2021). COVID-19 vaccine rollout – What do we know from past public health emergencies about gender-based violence risks and gender related barriers to vaccine access?
- GBV AoR. Global Protection Cluster. (2021). Proposed Actions vis-à-vis Emerging GBV Risks in relation to the deployment and vaccination plan for COVID-19 vaccines.
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- IASC. (2020). Checklist to Protect from Sexual Exploitation and Abuse during COVID-19.
- ICRC. (2020). COVID-19 and Violence Against Health-Care – Safer COVID-19 Response: Checklist for Health-Care Services.

Community Engagement

- Catholic Relief Services (CRS). (2019). Civil Society Organization Platforms Contribute to National Immunization Programs provides case studies on effective engagement of community and civil society organisations in previous immunisation programs.

Monitoring and reporting on vaccine uptake, access and safety

- WHO & UNICEF. (2021). Monitoring COVID-19 Vaccination: Considerations for the collection and use of vaccination data guidance document provides information on disaggregated monitoring.
- WHO. (2020).COVID-19 Safety Surveillance Manual provides guidance on disaggregation of vaccine safety surveillance data.
- WHO. (2021). Data for action: achieving high uptake of COVID-19 vaccines provides guidance on data collection methods which may assist in understanding and improving vaccine uptake.
- Washington Group. Implementation Guidelines - The Washington Group on Disability Statistics for guidance on disability data collection tools.