Gender & Polio Introductory Training

FACILITATION GUIDE

Stanford | Global Center for Gender Equality

Table of Contents

Acknowledgements

This training package was developed by Natasha Brownlee, Associate Gender Integration Specialist at the Global Center *for* Gender Equality (GC*f*GE), with support from Franz Wong, GC*f*GE Senior Gender Integration Consultant. The original materials from which this package was adapted, including the case study and fact sheet, were developed by Sini Ramo, independent consultant for the GC*f*GE, and Franz Wong, who also provided overall technical leadership and guidance, with support from Loida Erhard, independent consultant. Technical review and direction were provided by Lucero Quiroga, GC*f*GE Director of Gender Integration, and Angela Hartley, GC*f*GE Deputy Director of Gender Integration. Kathy Schienle provided copyediting for the materials. Design for all materials was provided by RRD Design. Financial support for the training development, delivery, and repackaging was provided by the Bill & Melinda Gates Foundation.

Acronyms

AFENET: African Field Epidemiology Network

AFP: Acute flaccid paralysis

CBO: Community-based organization

CHW: Community health workers

FLW: Front-line workers

GPEI: Global Polio Eradication Initiative

SAGE: Strategic Advisory Group of Experts

Introduction

The Gender & Polio Introductory workshop described in this facilitation guide was originally developed and delivered in 2021 by the Global Center *for* Gender Equality at Stanford University for the African Field Epidemiology Network (AFENET), a grantee of the Polio Program Strategy Team at the Bill & Melinda Gates Foundation. The training was designed to lay the foundation for future additional gender integration work at AFENET, including raising awareness, generating interest, and building capacity of key staff from AFENET and community-based organization (CBO) partners for gender integration. This facilitation guide and acompanying slide deck and resources were adapted from that original training for potential use with a wider external audience in the polio field.

Developed during the global COVID-19 pandemic, this training was designed to be delivered virtually to a multi-country audience. Activities are interactive and incorporate adult learning pedagogy within the constraints of a virtual format. Sessions incorporate a combination of plenary and small group activities as group size and virtual platforms allow. Users are welcome to adapt these resources to an in-person format if the setting allows.

The training package includes this facilitation guide and an accompanying slide deck. There are also suggested pre-read and further resources from external sources that can be found online. This training package is intended for use with polio eradication and surveillance project implementation teams that have an interest in applying a gender lens to their work. It is an introductory training for participants to begin to explore the interaction of gender with health outcomes and polio eradication and surveillance efforts; it is not intended to train staff on how to design gender-intentional programs design, nor is it intended to replace the need for local gender expertise in polio-related programming and interventions. To ensure a safe and effective training, skilled facilitators with strong gender and health expertise are required for the delivery of these materials.

Training Overview

Training Objectives

- Increase the knowledge and skills of polio project implementation staff on gender and key related concepts
- Introduce polio project implementation staff to practical methods and tools to support gender-intentional programming in polio eradication and AFP surveillance
- Enhance the ability of polio project implementation staff to identify gender gaps and barriers in polio eradication and AFP surveillance

Training Outline

	Session 1	Session 2
Objective	Understand gender and other social dimensions as determinants of health and why gender equality matters for health outcomes	Describe the links between gender and polio eradication and identify key gender gaps and barriers related to polio eradication and AFP surveillance
Time	2 hours	2.5 hours
Activities	Welcome & Introductions Health & Power Walk Key Concepts in Gender & Health Wrap-Up	Welcome & Re-Cap Introduction to Gender & Polio Case Study: AFP Surveillance in Sunlandia Gender Analysis in Polio Programming Wrap-Up

Session 1: Introduction to Gender & Health

Session Objective	Understand gender and other social dimensions as determinants of health and why gender equality matters for health outcomes
Time	2 hours
Pre-Reads	• Hawkes, S. and Buse, K. (2013). Gender and global health: evidence, policy, and inconvenient truths. *Lancet* 2013; 381: 1783–87. https://www.thelancet.com/article/S0140-6736(13)60253-6/pdf
Before You Begin	• Send out pre-read documents to all participants • Assign a character from the **Health & Power Walk facilitation sheet** to each participant and inform them of their assignment
Resources Needed	• Slide deck • Facilitation Sheet: Health & Power Walk

Session Outline

Time	Activity	Aim
15 mins	**Welcome & Introductions**	• To introduce the workshop facilitators and participants to each other • To provide an overview of the training objectives and agenda
40 mins	**Health & Power Walk**	• To understand how power, privilege, and gender interact and influence health outcomes • To explore the concept of intersectionality in a practical way
5 mins	**Break**	
50 mins	**Key Concepts in Gender & Health**	• To clarify the key concepts of gender and sex, and related concepts of equity, equality, and intersectionality • To examine the links between gender, sex, and health
10 mins	**Wrap-Up**	• To reinforce learning and key takeaways from Session 1 • To ensure participants understand pre-reads and requirements for Session 2

Activities

Welcome & Introductions

Time	Resources needed
15 mins	• Slides #1-6 **Aim** • To introduce the workshop facilitators and participants to each other • To provide an overview of the training objectives and agenda

Steps

1. **Welcome** participants to the training (include welcome by leadership, if applicable).
2. **Introduce** yourselves (facilitators) and ask participants to introduce themselves, including name, position, and one thing they hope to learn or do in this workshop.
3. Read out the overall **training objectives**.
4. Read out the **session objective** for today.
5. Introduce today's **agenda**.
6. Ask if anyone has any **questions** about the objectives or agenda.

Health & Power Walk

Time	Resources needed
40 mins	• Slides #7-10 • Facilitation Sheet: Health & Power Walk **Aim** • To understand how power, privilege, and gender interact and influence health outcomes • To explore the concept of intersectionality in a practical way

Key messages

- Gender interacts with other social markers of difference, such as age, ethnicity, sexual orientation, ability, place of residence, etc., to produce inequities that influence health

NOTE: The Power Walk is an activity that asks participants to put themselves "in the shoes" of a character to think about the intersectional nature of power and privilege based on a variety of statements their character might identify with. It is called a "walk" because, as an in-person activity, participants would take steps forward and backward to "walk" in their characters' shoes. This version has been adapted for a virtual format and therefore points are used to replace the steps.

Steps

1. **IN PLENARY:** Explain that for this first exercise, they will be participating in an interactive "Power Walk" activity.
2. Read out the description and **instructions** for the exercise. Explain that, for this activity, each participant has been assigned a character. They will listen to a series of statements and, after each is read, imagine themselves as their assigned character and how that person would answer. If the statement is likely to be true for their character, they will give themselves 1 point. If the statement is likely to be false for their character, they will subtract 1 point. If they are unsure, they should not add or subtract any points. At the end, they will each reveal their character's identity and total number of points at the completion of the activity.
3. Ensure that everyone is aware of the character they have been assigned (explain that these have been sent out in advance).
4. Read out each **statement** and give time for participants to consider their answer before moving on to the next statement.
5. Once all statements have been read, ask participants to share their character and their **total number of points** in the chat function of the virtual meeting platform.
6. **Ask** participants to take a moment to read each other's results.
7. **Debrief** the exercise with participants. Ask:
    a. What do you observe as you look at how many points the characters ended with? Who finished with the highest? Who finished with the lowest?
    b. **For those with the highest, what character do you represent? Why do you think you ended up with such high numbers?** How does it make you feel to be in front of everybody else? What do you have power and influence over in this role, and who do you have power over? What elements of your identity enabled you to move forward? What privileges or vulnerabilities does this role give you?
    c. For those with the lowest, what character do you represent? Why do you think you ended up with such low numbers? Were there any times when you felt you did have power?
    d. **What patterns do you observe?** What are the common characteristics of people with high numbers? With low numbers? Was this related to issues of gender, ethnicity, race, religion, age, etc.?
    e. What does this tell us about what our societies value? Who is given the most power?
8. Share how this exercise helps us understand **gender and power** in the context of **health**.
9. Wrap up and introduce the **break** – ask everyone to return in 5 minutes.

Break

Time

5 mins

Key Concepts in Gender & Health

Time	Resources needed
50 mins	• Slides #12-35 **Aim** • To clarify the key concepts of gender and sex, and related concepts of equity, equality, and intersectionality • To examine the links between gender, sex, and health

Key messages

- Gender is a social concept related to, but different from, biological sex, both of which impact health outcomes
- Gender, along with other intersecting identities, is an important determinant of health status and outcomes, including exposure, vulnerability and risk, knowledge and beliefs, access, decision-making power, and experience of care
- Gender roles and norms, along with gender inequality, affect health on various levels

Steps

1. **IN PLENARY:** Explain that we are now going to go through some key concepts related to gender and health.
2. Read out the definitions of **sex** and **gender**.
3. Explain that sex and gender are commonly conflated, which contributes to widespread erroneous beliefs that cultural practices, roles, and norms around gender are biologically determined and therefore cannot be changed.
4. Facilitate a **pop quiz**: One at a time, read out statements and ask participants to vote whether they think the statement refers to "sex" or to "gender." Reveal the correct answer for each statement and invite comments and reflections from participants.
5. Ensure that everyone is clear on the difference between sex and gender and understands that both sex and gender influence health outcomes.
6. Read out the definitions of **gender norms** and **gender roles**. Ask participants for examples from the Power Walk activity or from real life.
7. Explain that **gender expectations** impact everyone's attitudes and behaviors throughout the lifecycle. Roles assigned to males are seen as more valuable than those assigned to females. This leads to increased rewards and opportunities for boys and men compared to girls and women. Women and men learn that society expects them to behave differently and to fulfill certain gender roles. Make the point that people are judged by how well they adhere to the gender roles attributed to their sex, because these are not only roles, they are actually norms: rules about how people should behave and common understanding of what may happen if one does not. Explain that we have all learned to take on these roles and have had our behavior impacted by these norms, and so it is often useful in gaining gender awareness to look back at our own experiences of gender socialization.

8. Read out the definition of **intersectionality**, acknowledging the work of Professor Kimberlé Crenshaw, activist and law professor at UCLA, who coined this term in the 1980s.
9. Refer to the **Health & Power Walk activity** and how we could see intersectionality at play there. For example, the male Minister of Health ended up near the front, compared to the visually impaired young man from an ethnic minority group – both of whom are men – or the girl married as a child to a man three times her age. Gender, (dis)ability, class and income, and ethnicity were all factors at play here. If time, ask for other examples from the Power Walk from the participants.
10. Note that intersectionality is not only about understanding how identities interact, but also about understanding compounded forms of inequality and disempowerment.
11. Ask for participants to name some other factors that might interact with gender to produce inequalities in health outcomes, specifically.
12. Read through the **Gender and Health** slide, emphasizing that both sex and gender – along with other intersecting identities – influence disease patterns and health outcomes.
13. Share that you are now going to walk through several examples of how gender and health interact. Choose 2-3 of the examples below to present:
    a. **Exposure** to infectious diseases can be different based on the gendered division of labor. For example, with regard to malaria, women are typically responsible for collecting water, where they are likely to be in proximity to mosquitoes. They also have greater exposure due to the timing of tasks, such as cooking, at dusk and dawn. Men are more exposed in migrant labor and farm settings.[1]
    b. Health-related **risks and vulnerabilities** can vary between genders. For example, globally, many more men smoke than women.[2] Smoking affects vulnerability to infectious respiratory diseases such as influenza and tuberculosis.[3] Young men are more likely to die or get injured in road traffic accidents.[4] Many of these risks and vulnerabilities are due to harmful gender norms.
    c. Gender differences in **literacy levels, health knowledge, and beliefs** can affect health behaviors and outcomes. For example, gender differences have been observed in COVID vaccine hesitancy.[5] There may also be gender disparities in perceptions of susceptibility and severity of illness impacting protective behaviors in a pandemic.[6]

---

1 Bill & Melinda Gates Foundation Gender and Malaria Evidence Review.
2 Global Patterns and Determinants of Sex Differences in Smoking. Pampel, F.C. *Int J Comp Sociol*. 2006;47(6):466-487. doi:10.1177/0020715206070267
3 Jiang, C., Chen, Q., Xie, M. Smoking increases the risk of infectious diseases: A narrative review. *Tob Induc Dis*. 2020;18:60. Published 2020 Jul 14. doi:10.18332/tid/123845
4 https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries
5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8645216/
6 https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1348/135910710X485826

d. Women often **fail to seek or delay care** due to both gender roles and gender norms, such as lack of control over resource allocation in the household, greater constraints on women's time from household and other work, restrictions in mobility outside the home, or stigma attached to illness or specific diagnoses. For example, women's roles as caregivers mean they are not able to leave young children or ill family members. And the opportunity costs of foregoing paid labor may be considered too steep for a household to prioritize women's accessing healthcare over income-generating activities.
e. Women and girls face greater risks of GBV, malnutrition, and sexually transmitted infections, including HIV, due to **unequal power relations**. Women often lack the autonomy to make decisions that impact their health, including exposure risks. For example, "The recent outbreaks of the Ebola and Zika viruses have disproportionately affected women. Women are often responsible for providing healthcare in formal and informal roles. The social expectation that women will care for the sick limited women's options and the ability to control their risk of infection during the Ebola outbreaks in West Africa (Diggins & Mills, 2015). Lawmakers responded to the Zika outbreak by discouraging women from becoming pregnant (Dyer, 2015) without taking into account inequitable gender norms that inhibit women's ability to negotiate contraceptive use or engage in family planning. Though Zika affects women more harshly than men biologically, the institutional response increased women's vulnerability, by failing to focus on the couple unit and underlying gender relations."[7]
f. **Discriminatory attitudes** of communities and healthcare providers and lack of training and awareness amongst healthcare providers and health systems of the specific health needs and challenges of women and girls can affect their experience of healthcare, limit **quality of care**, and discourage women and girls from interacting with the healthcare system.

14. Add that rigid gender norms also negatively affect **people with diverse or non-conforming gender identities**, who often face violence, stigma, and discrimination as a result, including in healthcare settings. This can lead to higher risk of diseases such as HIV and mental health illnesses, including depression and suicide.[8]
15. If time, **ask** if anyone has any other examples they'd like to share or explore.
16. Read out the definition of **gender equality**. Emphasize that gender equality is not about making men and women the same, giving anyone special treatment, or making the incidence, prevalence, or morbidity of a disease the same for men and women. Rather, it is about people being free to develop their personal abilities and make choices without the limitations set by stereotypes, gender norms, or prejudices.

---

[7] https://www.measureevaluation.org/resources/publications/fs-17-205a/at_download/document
[8] Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. White Hughto, J.M., Reisner, S.L., Pachankis, J.E. *Soc Sci Med*. 2015;147:222-231. doi:10.1016/j.socscimed.2015.11.010

17. Read out the definition of **gender equity**. Emphasize that gender equity might mean that different treatment is needed to ensure equality of outcome. For example, women and men might formally have an equal opportunity to attend a polio-specific training. However, just having the equal chance to join the training may not result in women taking advantage of this opportunity, due to multiple challenges, such as in some contexts women might need permission from a male household member to attend, or someone to accompany her; women might not have access to household income, transportation, or other resources that hinder their participation; or women might need childcare if the training is happening after hours or in a different location. It is not enough to give women and men equal access to resources and opportunities; they must also be provided the means and tools to be able to fully benefit from these.

Wrap-Up

Time	**Resources needed**
10 mins	• Slides #36-40 **Aim** • To reinforce learning and key messages from Session 1 • To introduce pre-reads and requirements for Session 2

Steps

1. **IN PLENARY:** Read out the **key takeaways** for the day.
2. Share the **objective** for Session 2.
3. Explain that there will be **pre-reads** for Session 2, read out what they are, and describe how participants should expect to receive them.
4. **Thank** everyone for their active participation today.

Fact Sheet: Gender and Polio

- Worldwide, **there are no significant differences in the immunization status of girls and boys**. A SAGE report on 67 countries found no significant difference between immunization coverage of girls and boys.[i] Subsequent studies have confirmed the lack of gender disparity in immunization coverage.
- Nevertheless, there are **notable variations**, where immunization coverage is higher for girls in some countries and higher for boys in others. For instance, girls have lower immunization coverage in South Central Asia.[ii]
- **Gender-related factors influencing vaccination uptake and surveillance** activities in different contexts include education and access to information; accessibility, acceptability, and quality of health services; access to, and control over, key resources; child preference; decision-making dynamics at the household and community level; and women's autonomy and mobility.

Polio Risk Factors and Vulnerability

- The **most at-risk population** for contracting poliomyelitis is children aged under 5 years, with more than 80% of cases occurring in children aged under 2 years.
- **Sex is a risk factor** for polio, with a slight predominance found in males, who are more at risk for developing paralytic polio.[iii] [iv] Adult females are also at risk if they are pregnant.[v]
- Other **risk factors** for polio, including immune deficiency and malnutrition, are also influenced by sex. Male infants and children have weaker immune systems.[vi] Genetic, hormonal, and physiological differences help explain females' stronger innate and adaptive immune responses.
- Some risk factors for polio are associated with **gender**. Physical activity, which is heavily regulated by gender roles and norms, is a risk factor associated with the severity of paralysis.
- In communities where boys are **valued more** than girls, boys are more likely to receive better nutrition, timely medical attention, and other opportunities to advance their health and well-being.

Gender-Related Barriers to Immunization: Demand Side

- Although paternal education is also associated with a child's immunization status, lower **educational levels** of maternal caregivers are more commonly related to undervaccination of children.[vii] Maternal education has been significantly associated with polio immunity of children in the Democratic Republic of the Congo and total doses received in Nigeria.[viii] [ix] Maternal education was the only significant factor associated with accepting the injectable inactivated polio vaccine (IPV) for children in Nigeria.[x]
- In sub-Saharan Africa, a mother's **access to mass media** was significantly associated with the likelihood of vaccinating her children against polio.[xi]

- **Access to, and control over, household resources** is an important dimension of autonomy, particularly for financial **decision-making**. In Ethiopia, children of women who made joint decisions with their husbands on financial earnings were eight times more likely to be fully immunized.[xii] Inability to access the household's financial resources negatively impacts a mother's capacity to accomplish other tasks, like travel to a health facility.
- Where **gender norms** preclude mothers from **traveling alone**, mothers face the additional burden of arranging a guardian or suitable companion to travel with them. In a study in Nigeria, the most commonly reported barrier to accessing immunization was **lack of financial resources** for the costs of transportation or services.[xiii] The second-most commonly reported barrier was **distance** from the nearest health facility.
- In Ethiopia and Eritrea, greater maternal **freedom of movement** (measured via decisions to visit family and friends) was associated with children receiving full immunization.[xiv]
- A woman's **autonomy** affects her ability to access health services for herself and her children. Women's agency and decision-making have been significantly associated with children's immunization status.[xv] The higher the mother's agency, the more likely she will immunize her children.
- Where women lack autonomy, they may require **spousal permission** to immunize their children. Mothers who perceive that spousal permission is required for their child's immunization are less likely to fully immunize their child.[xvi]
- **Spousal disapproval** was also commonly reported by Nigerian mothers as the reason for non-immunization.[xvii]

Gender-Related Barriers to Immunization: Supply Side

- Health facilities **emphasize attendance by mothers** and are typically not very favorable to fathers or other male family members[xviii], which can impede men from involvement in children's health and thus overburden women. This can be exacerbated when governmental **gender-unintentional policies** pressure only women in their roles as mothers, such as through authoritarian immunization strategies.[xix]
- Due to **gender norms**, in some settings **only female vaccinators** can access households to interact with mothers and deliver vaccines to children.[xx]
- Female providers and vaccinators can face **gender and job discrimination**, **gender-based violence**, and **threats** in their work, leading to high turnover and limited provision of health services[xxi] [xxii], which can be compounded by geographic barriers. They also face low status and pay and often receive less pay than their male counterparts for the same work.[xxiii]
- **Low quality of service** (e.g., healthcare providers' attitudes, inconvenient service hours, or lack of female providers) may discourage women from attending healthcare facilities for themselves or their children.[xxiv]

[i] Martin Hilber, A et al. Gender and immunisation: Summary report for SAGE. Geneva: s.n., 2010.

[ii] World Health Organization. Addressing sex and gender in epidemic-prone infectious diseases. Geneva: World Health Organization, 2007.

[iii] Poliomyelitis in the United States, 1969–1981. Moore, M et al. 4, 1982, *Journal of Infectious Diseases*, vol. 146, pp. 558–563.

[iv] Vaccine-Associated Paralytic Poliomyelitis: United States: 1973 through 1984. Nkowane, BM et al. 10, 1987, *JAMA*, vol. 257, pp. 1335–1340.

[v] Paralytic poliomyelitis during the pre-, peri-and post-suspension periods of a polio immunization campaign. Lamina, S and Hanif, S. 3, 2008, *Tropical Doctor*, vol. 38, pp. 173–175.

[vi] World Health Organization. Addressing sex and gender in epidemic-prone infectious diseases. Geneva: World Health Organization, 2007.

[vii] Reasons related to non-vaccination and undervaccination of children in low and middle income countries: findings from a systematic review of the published literature, 1999–2009. Rainey, JJ et al. 46, 2011, *Vaccine*, vol. 29, pp. 8215–8221.

[viii] Polio immunity and the impact of mass immunization campaigns in the Democratic Republic of the Congo. Voorman, A et al. 42, 2017, *Vaccine*, vol. 35, pp. 5693-5699.

[ix] Poliovirus seroprevalence before and after interruption of poliovirus transmission in Kano State, Nigeria. Iliyasu, Z et al. 42, 2016, *Vaccine*, vol. 34, pp. 5125–5131.

[x] Parental acceptance of inactivated polio vaccine in Southeast Nigeria: a qualitative cross-sectional interventional study. Tagbo, BN, Ughasoro, MD, and Esangbedo, DO. 46, 2014, *Vaccine*, vol. 32, pp. 6157–6162.

[xi] Effect of media use on mothers' vaccination of their children in sub-Saharan Africa. Jung, M, Lin, L, and Viswanath, K. 22, 2015, *Vaccine*, vol. 33, pp. 2551–2557.

[xii] "Girl Power!": The Relationship between Women's Autonomy and Children's Immunization Coverage in Ethiopia. Ebot, JO. 1, 2015, *Journal of Health, Population and Nutrition*, vol. 33, p. 18.

[xiii] Variations in the Uptake of Routine Immunization in Nigeria: Examining Determinants of Inequitable Access. Olorunsaiye, CZ and Degge, H. 1, 2016, *Global Health Communication*, vol. 2, pp. 19–29.

[xiv] Woldemicael, G. Do women with higher autonomy seek more maternal and child health-care? Evidence from Ethiopia and Eritrea. Stockholm University. Stockholm: Stockholm Research Reports in Demography, 2007.

[xv] Maternal autonomy and attitudes towards gender norms: associations with childhood immunization in Nigeria. Singh, K, Haney, E, and Olorunsaiye, C. 5, 2013, *Maternal and Child Health Journal*, vol. 17, pp. 837–841.

[xvi] Socio Cultural and Geographical Determinants of Child Immunisation in Borno State, Nigeria. Monguno, AK. 1, 2013, *Journal of Public Health in Africa*, vol. 4, p. e10.

[xvii] Maternal reasons for non-immunisation and partial immunisation in northern Nigeria. Babalola, S. 5, 2011, *Journal of Paediatrics* and *Child Health*, vol. 47, pp. 276–281.

[xviii] UNICEF (2019) *Immunization and Gender: A Practical Guide to Integrate Gender into Immunization Programmes*, p. 7.

[xix] Ibid.

[xx] Ibid.

[xxi] Ibid.

[xxii] Hay, K et al. Gender Equality, Norms, and Health Steering Committee. Disrupting gender norms in health systems: making the case for change. *Lancet*. 2019 Jun 22;393(10190):2535-2549. doi: 10.1016/S0140-6736(19)30648-8. Epub 2019 May 30. PMID: 31155270; PMCID: PMC7233290.

[xxiii] Ibid.

[xxiv] UNICEF (2019).

Session 1. Facilitation Sheet: Health & Power Walk

Assign one of the characters below to each of the participants for the Health & Power Walk activity and call out each statement as participants "take" a virtual step backwards or forwards depending on whether they agree or disagree with the statement from the perspective of their assigned characer.

Health & Power Walk Characters

NOTE: If you have more than 10 participants, you can assign multiple participants to each character below or create additional characters. If you decide to create new characters, ensure that they have multiple social markers of identity (gender, age, race, ethnicity, class, ability, marital status, etc.).

1	21-year-old single woman, illiterate migrant laborer, with a young baby
2	Primary school teacher, man, living in the capital, 30 years old
3	Community health worker in a rural area, woman, 39 years old, married with two children
4	UN international staff, woman, single, 33 years old
5	Woman living with a serious mental health illness, unemployed, 22 years old
6	15-year-old girl married to someone three times her age
7	Visually impaired young man from an ethnic minority group
8	Minister of Health, man, 45 years old, married with six children
9	Literate domestic worker, married woman with no children, 35 years old
10	AFP community surveillance officer, single woman, rural area, 22 years old

Health & Power Walk Statements

1. "I know where to find the nearest health facility."
2. "I can easily access information about the next vaccination campaign organized in my area."
3. "I am not in danger of being sexually harassed or abused."
4. "I feel respected by local healthcare workers."
5. "I have a say in the way health services are organized and delivered in my community."
6. "I am able to access information online about AFP symptoms."
7. "I have access to family resources if I need to pay for healthcare."
8. "If I have/had children, I would be able to decide if they are vaccinated or not."
9. "I can easily access transportation (pay for public transport or have my own car) to visit the health center."
10. "I can pay for treatment in a private hospital if necessary."

Session 2:
Introduction to Gender & Polio

Session Objective	Describe the links between gender and polio eradication and identify key gender gaps and barriers related to polio eradication and AFP surveillance
Time	2 hours 30 minutes
Pre-Reads	• Handout: Gender and Polio Fact Sheet • Handout: AFP Surveillance in Sunlandia Case Study
Before You Begin	• Send out pre-read documents to all participants
Resources Needed	• Slide deck • Video: Global Polio Eradication Initiative – Gender and Polio Eradication https://www.youtube.com/watch?v=4zQjnaDFOrQ&t=15s • Facilitation Sheet: True or False Statements • Handout: AFP Surveillance in Sunlandia Case Study • Facilitation Sheet: AFP Surveillance in Sunlandia Case Study

NOTE: With extra time, an interactive breakout activity can be incorporated into this session or added as a separate third session. After the Gender Lens in Polio Programming activity, participants can split into breakout groups to apply the sample gender analysis questions to their own project or program, coming back together in plenary to share and debrief. It can also be helpful to share current country- or regional-specific sex-disaggregated data during this session, if available, and have participants discuss what they think the data means and why any gender discrepancies might exist, based on their experience in the field. For this additional exercise to be successful, a facilitator(s) with gender expertise is essential.

Session Outline

Time	Activity	Aim
10 mins	**Welcome & Re-Cap**	• To review key concepts from Session 1 • To provide an overview of the agenda and objectives of Session 2
40 mins	**Introduction to Gender & Polio**	• To introduce participants to the main links between gender and polio
5 mins	**Break**	
50 mins	**Case Study: AFP Surveillance in Sunlandia**	• To further familiarize participants about the links between gender and polio eradication, particularly related to community surveillance
5 mins	**Break**	
25 mins	**Applying a Gender Lens in Polio Programming**	• To understand the importance of applying a gender lens to polio eradication and surveillance
15 mins	**Wrap-Up**	• To review key points from the training • To share additional gender and polio resources and inspire participants to explore further • To share any relevant next steps

Activities

Welcome & Re-Cap

Time
10 mins

Resources needed
- Slides #43-51

Aim
- To review key concepts from Session 1
- To provide an overview of the agenda and objectives of Session 2

Steps

1. **IN PLENARY: Welcome** participants to Session 2.
2. Read out the **session objective** for today.
3. Introduce today's **agenda**.
4. Ask if anyone has any **questions** about the objectives or agenda.
5. Facilitate a **pop quiz**: One at a time, read out questions related to Session 1 and ask participants to vote. Share the correct answer before moving to the next question.

Introduction to Gender & Polio	
Time 40 mins	**Resources needed** • Slides #52-68 • Video: Global Polio Eradication Initiative – Gender and Polio Eradication https://www.youtube.com/watch?v=4zQjnaDFOrQ&t=15s • Facilitation Sheet: True or False Statements **Aim** • To introduce participants to the main links between gender and polio
Key messages • Sex and gender influence polio risk factors and vulnerabilities; health literacy and education; access to, and decision-making related to, vaccination and care; and experience in healthcare settings	

Steps

1. **IN PLENARY:** Explain that the main topic of this session will be exploring the links between gender and polio.
2. Show the **video** from the World Health Organization's (WHO) Global Polio Eradication Initiative (GPEI): Gender and Polio Eradication.
3. **Debrief** the video. Ask:
   a. What gender-related barriers or challenges related to polio eradication were mentioned in the video? Ensure that the following are mentioned:
      i. In some societies, boys are valued more than girls, and get better access to food and health services, including vaccinations
      ii. In some places, false rumors about the polio vaccine mean that boys are not vaccinated, as families are more worried about their well-being, and give vaccines only to girls
      iii. In some places, it is not easy for women to access healthcare with children because they lack resources such as money, transportation, or time, or are not allowed to leave home
      iv. In many countries, literacy rates are lower among women than among men, which also impacts access to health information and services

v. The power to make decisions, such as whether or not to vaccinate children, is also influenced by gender roles and norms
vi. In more conservative areas, men frontline workers are not allowed to interact with women alone

4. Introduce the **links between gender and polio**. Explain that, worldwide, a child's gender does not have a significant influence on overall immunization status. However, there are regional/sub-regional variations.
5. Share that a SAGE report[9] on 67 countries found no significant difference between immunization coverage of girls and boys. Subsequent studies have confirmed the lack of gender disparity in immunization coverage. Nevertheless, there are notable variations, where immunization coverage is higher for girls in some countries and higher for boys in others. For instance, females receive lower immunization coverage in South Central Asia.
6. Remind participants that, as we learned in the last session, **gender influences health outcomes** – and polio and immunization programming is no different. This influence operates in more subtle ways beyond sex discrepancies in immunization coverage; the key is examining, understanding, and addressing gender norms and roles in a specific context.
7. Explain that most of the links between gender and polio eradication are about **gender as a social concept**, and are not driven by biology (sex).
8. Present how sex and gender link to **risk factors** and **vulnerability**.
9. Present how gender links to **mobility** and **decision-making**.
10. Present how gender links to **health literacy** and **education**.
11. Present how gender links to experience in healthcare settings.
12. Ask if participants have any comments or questions.
13. Facilitate a **pop quiz**: One at a time, read out statements related to gender and polio and ask participants to vote whether they think the statement is true or false.
14. Invite comments and reflections from participants, then use the **True or False Statements facilitation sheet** to reveal the correct answer for each statement. Use the further information in the sheet to provide an explanation as necessary to support participants' learning. Invite further reflection, asking for participants to consider their own experience in polio eradication efforts.
15. Wrap up and introduce the **break** – ask everyone to return in 5 minutes.

Break

Time

5 mins

[9] Martin Hilber, A. et al. Gender and immunisation: Summary report for SAGE. Geneva: s.n., 2010.

Case Study: AFP Surveillance in Sunlandia

Time

50 mins

Resources needed

- Slides #70-72
- Handout: AFP Surveillance in Sunlandia Case Study
- Facilitation Sheet: AFP Surveillance in Sunlandia Case Study

Aim

- To further familiarize participants about the links between gender and polio eradication, particularly related to community surveillance

Key messages

- Sex and gender influence polio risk factors and vulnerabilities; health literacy and education; access to, and decision-making related to, vaccination and care; and experience in healthcare settings
- Gender also influences the challenges and risks faced by community health workers

Steps

1. **IN PLENARY:** Explain that for this next exercise they will be discussing a **case study** on AFP surveillance in the imaginary country of Sunlandia.
2. Divide participants into breakout groups (with 1 facilitator per breakout group) and explain that they will have 30 minutes to read and discuss the case study before returning to the plenary.
3. **IN BREAKOUT GROUPS:** Take some time to **read the case study** individually or read out as a group, taking turns with a new person reading each paragraph.
4. Facilitate a **group discussion** on the questions in the handout. Discuss each question in terms of gender norms, roles, and relations; access to, and control over, resources such as information, money, time, and transportation; and interaction and experience with health system/health providers. Ask the group to list as many examples as they can think of for each.
5. **Wrap up** the breakout session by asking if anyone has anything else they want to share or ask related to gender barriers and other factors that may affect AFP surveillance.
6. **IN PLENARY:** Welcome everyone back to plenary and ask a representative from each breakout group to **present the main points** and answers from their discussion.
7. Using the **AFP Surveillance in Sunlandia Case Study facilitation sheet** to guide the discussion, invite comments, feedback, and reactions from other participants, encouraging further discussion on questions included in the case study exercise.

Break

Time

5 mins

Applying a Gender Lens in Polio Programming

Time	Resources needed
25 mins	• Slides #73-85 **Aim** • To understand the importance of applying a gender lens to polio eradication and surveillance

Key messages

- Gender analysis highlights differences among men, women, boys, girls, and gender non-conforming individuals regarding, for example, risk factors and vulnerability, health-seeking behavior, access to health information, resources and services, decision-making processes, experience of care, health outcomes, and more
- Context-specific gender analysis is a critical first step toward identifying and addressing gender barriers and inequities and is crucial to designing interventions that reach all people

Steps

1. **IN PLENARY:** Tell participants that they will now learn about how gender analysis can be a helpful tool to ensure gender equality in polio eradication and surveillance.
2. Begin by introducing the definition of **gender gaps**. Explain that gender gaps reflect the unequal distribution of opportunities, resources, or outcomes.
3. Then, explain how gender gaps are revealed through **data analysis**.
4. Note that both gender gaps and gender barriers should be analyzed with attention to **intersectionality** (how gender interacts with other social markers to shape outcomes).
5. Read out the definition of **gender analysis**. Explain that gender analysis can help identify gender gaps, and sources and consequences of inequality, and that applying a gender lens can result in better program design and greater impact.
6. Explain that **gender analysis in health** helps to bring forth and clarify differences between and among women, men, and gender non-conforming individuals, their relationships and different life circumstances (social, economic, and political) – and to identify how these conditions affect their health status and their access to – and interaction with – the healthcare system.
7. Explain that **gender analysis in polio eradication** can be used to understand what influences polio eradication outcomes and what barriers and challenges exist in a specific project or program context. Some of the aspects a gender analysis may consider are: Risk factors and vulnerability; Roles, norms, and responsibilities; Needs and challenges; Access to, and control over, resources; Access, use, and experience of health services.
8. Walk through the slides on each aspect. Explain that the questions in the slides are just **illustrative** of the types of questions a gender analysis might ask – they are not comprehensive. Gender analyses are context-specific and should be developed with the support of a gender expert.

9. **Wrap up** by asking if anyone has anything else they want to share or ask related to gender barriers and other factors that may affect AFP surveillance.

Wrap-Up	
Time 15 mins	**Resources needed** • Slides #87-105 **Aim** • To review key takeaways from the training • To share additional gender and polio resources and inspire participants to explore further • To share any relevant next steps

Steps

1. **IN PLENARY:** Facilitate a **pop quiz**: One at a time, read out questions and ask participants to vote. Share the correct answer before moving to the next question.
2. Read out the **key takeaways** for the day.
3. Remind participants of the **training objectives** and ask for any reflections, key takeaways, or feedback from the participants, if time.
4. Present the list of **further resources** on gender and polio, for those who are interested in diving deeper.
5. **Thank** everyone for their active participation in the workshop (can include a thank-you from leadership, as applicable).
6. Share any **next steps** that are specific to the audience of your workshop.

Case Study: AFP Surveillance in Sunlandia

Background

Sunlandia, a country that has suffered from widespread conflict for more than seven years, including massive internal displacement and population movements, is currently experiencing circulation of wild poliovirus (WPV). The country has managed to maintain an acute flaccid paralysis (AFP) surveillance system operating at the community and health facility levels, as well as environmental surveillance.

Vaccinators and social mobilizers in Sunlandia are mainly men; women make up only 10% of all frontline workers, which drops to 3% in rural areas. Women rarely work outside the household because of increasing insurgency and heightened insecurity in many areas. Moreover, Sunlandia is a society where women are expected to stay home to take care of household chores, children, and the elderly, and women working outside the home is unusual.

The literacy rate for women is 20%, compared to 60% for men; these figures are higher in the capital area. The highest-risk areas for polio transmission and circulation are camps where internally displaced persons live and among nomadic populations that regularly travel in high-risk border areas where WPV is circulating. Throughout the country, men are generally considered as the "heads" of households and make decisions about healthcare and other household expenditures. Men, especially in the minority areas in the south of the country, mainly trust local healers and prefer traditional medicine practitioners rather than visiting health centers.

As women rarely leave the household area, the radio is their main source of information and news, along with community health workers (CHWs), who are their most trusted source of information on health issues. Men mainly trust their local religious leaders and get information related to health from religious leaders, community leaders, and TV. Only 5% of women have access to a mobile phone or internet, and the majority of those are in the capital area. Men in Sunlandia are well connected to the internet, with 70% having smartphones.

Scenario

Joseph and Sara live in a small rural community in the southern part of Sunlandia, near the border regions where WPV is circulating. Joseph and Sara have four children, and one of them, four-year-old Rose, starts to develop AFP symptoms, with floppiness in her left leg.

Joseph is away working in the capital and Sara is home alone with the four children. Sara is scared about what is happening with her daughter but does not know what to do. She doesn't drive a car and has no money to pay for local transportation.

The nearest health facility is 10 kilometers away, and she remembers always receiving rude treatment from the only two doctors that work there (both are male, and there are no women healthcare providers in the facility). Sara is also worried what will happen to Rose if she remains paralyzed with the floppy leg and how this will impact her opportunities in society.

Sara remembers that a community health worker visited the household last month and was asking about such symptoms and if their children were vaccinated in the last polio campaign. Rose was not vaccinated, but Sara was scared to say this when the team visited.

Sara's husband makes decisions about the children's vaccinations and heard from the religious leader in the village that vaccines contain ingredients that are harmful for girl children and make them infertile. The CHW left a folded brochure with some relevant information and instructions for what to do. Unfortunately, Sara never finished primary school and cannot read.

Questions for discussion

1. **What gender-related barriers and factors negatively affecting polio eradication can you identify in this scenario, considering the situation of Sara and Joseph and the overall situation in Sunlandia?**

2. **What gender-related barriers and factors should be addressed when approaching communities in Sunlandia in relation to community outreach and information-sharing related to AFP and polio?**

3. **What barriers exist for community health workers conducting active case surveillance in communities in Sunlandia? Can you describe how these barriers might be different for women and men?**

Session 2. Facilitation Sheet: True or False Statements

Use the sample answers below to help guide the breakout group discussions on the True of False statements activity.

"We vaccinate all girls and boys equally; therefore, gender plays no role in the immunization program."

Answer: False. While globally, there are no significant differences in the immunization status of girls and boys, there are notable variations, where immunization coverage is higher for girls in some countries and higher for boys in others. For instance, girls have lower immunization coverage in South Central Asia. Moreover, in order to reach every child with repeated vaccination, increasing the role of women at different levels of the polio eradication program is critical,[10] which requires overcoming gender barriers for women to effectively participate in all aspects of polio eradication efforts.[11]

"There are no differences in terms of girls' and boys' vulnerability to contracting polio or getting help when displaying AFP symptoms."

Answer: False. Sex is a risk factor for polio, with a slight predominance found in males, who are more at risk for developing paralytic polio.[12] [13] Male infants and children have weaker immune systems.[14] Genetic, hormonal, and physiological differences help explain females' stronger innate and adaptive immune responses. Adult females are also at risk if they are pregnant.[15] In addition to biological factors, social factors and power dynamics around gender that shape girls' and boys' opportunities and vulnerabilities are also crucial. Immune deficiency and malnutrition, risk factors for polio, are influenced by gender. Physical activity, which is heavily regulated by gender roles and norms, is a risk factor associated with the severity of paralysis. For example, in societies where boys are more valued than girls, boys are more likely to receive better nutrition, timely medical attention, vaccines, and other opportunities to advance their health and well-being.[16]

There are also gender differences in receiving help when displaying AFP symptoms for a number of reasons, including gender differences in parents' literacy and education levels, access to awareness-raising campaigns and knowledge of polio and AFP, as well as gender differences in parents' health-seeking behaviors, access to and control over resources, mobility and decision-making. In particular, evidence shows that when mothers are constrained due to dominant gender norms, there can be gender differences in vaccination, which is the greatest gender risk factor associated with polio, particularly in contexts where there is a preferential treatment for sons.[17]

---

10 GPEI (n.d.) FAQ: Gender and Polio Eradication. https://polioeradication.org/wp-content/uploads/2018/07/polio-vaccination-gender-FAQ-Frequently-Asked-Questions-GPEI_Gender-and-Polio_20180710.pdf

11 WHO (2019). GPEI Gender Equality Strategy 2019–2023. https://polioeradication.org/wp-content/uploads/2020/07/Gender_Strategy_EN.pdf

12 Poliomyelitis in the United States, 1969–1981. Moore, M. et al. 4, 1982, *Journal of Infectious Diseases*, vol. 146, pp. 558–563.

13 Vaccine-Associated Paralytic Poliomyelitis: United States: 1973 through 1984. Nkowane, B.M. et al. 10, 1987, *JAMA*, vol. 257, pp. 1335–1340.

14 World Health Organization. Addressing sex and gender in epidemic-prone infectious diseases. Geneva: World Health Organization, 2007.

15 Paralytic poliomyelitis during the pre-, peri-and post-suspension periods of a polio immunization campaign. Lamina, S. Hanif, S. 3, 2008, *Tropical Doctor*, vol. 38, pp. 173–175.

16 WHO (2019). GPEI Gender Equality Strategy. 2019–2023. https://polioeradication.org/wp-content/uploads/2020/07/Gender_Strategy_EN.pdf

17 WHO (2018) Global Polio Eradication Initiative technical brief: gender. Geneva: World Health Organization; 2018 (WHO/Polio/18.05). https://polioeradication.org/wp-content/uploads/2018/07/GPEI-Gender-Technical-Brief-2018.pdf

"Men and women can equally access health information and make decisions about their own and their children's healthcare in the areas we work in."

Answer: False. Parents face differential access to health information and decision-making due to their gender, combined with other contextual factors such as socio-economic status, ethnicity, religion, age, and place of residence. Gender barriers that impact differential access to and control over information include gender gaps in education and communication; knowledge, attitudes, and perceptions; and health-seeking behaviors.[18] Moreover, health systems themselves are gendered, which also affects men's and women's access to health information. These include gender barriers in the design and management of health services (such as immunization hours that do not take into account other demands on women's time and the challenge of transportation, especially for remote communities[19]) and gender gaps and barriers in human resources in healthcare (where, for example, gender norms for acceptable male-female interactions shape and determine the delivery of immunization[20]).

"The sex of the community health worker conducting active case search or conducting outreach on polio eradication rarely matters. What matters is how good and skilled they are in their job."

Answer: False. While adequate capacity and skills are critical for all community health workers, regardless of sex, how they are able to access women, particularly mothers, in households is dependent on their sex in some contexts. For GPEI, for example, "female front-line workers (FLWs) have increased the effectiveness of health service delivery, and in many settings only women can access households and vaccinate infant children inside the household. Female social mobilizers have improved attitudes toward polio vaccination and the perceptions of risks associated with the disease. All-male vaccinator teams, on the other hand, were found to be ineffective, posing a critical gender-related barrier to polio eradication efforts."[21] However, female providers and vaccinators can face gender and job discrimination, gender-based violence, and threats in their work, leading to high turnover and limited provision of health services,[22] [23] which can be compounded by geographic barriers. They also face low status and pay and often receive less pay than their male counterparts for the same work.[24]

---

[18] WHO (2018). Global Polio Eradication Initiative technical brief: gender. Geneva: World Health Organization; 2018 (WHO/Polio/18.05). https://polioeradication.org/wp-content/uploads/2018/07/GPEI-Gender-Technical-Brief-2018.pdf

[19] GC*f*GE (2021). Gender and Polio Profile.

[20] WHO (2018). Global Polio Eradication Initiative technical brief: gender. Geneva: World Health Organization; 2018 (WHO/Polio/18.05). https://polioeradication.org/wp-content/uploads/2018/07/GPEI-Gender-Technical-Brief-2018.pdf

[21] WHO (2018). Global Polio Eradication Initiative technical brief: gender. Geneva: World Health Organization; 2018 (WHO/Polio/18.05). https://polioeradication.org/wp-content/uploads/2018/07/GPEI-Gender-Technical-Brief-2018.pdf

[22] UNICEF (2019). Immunization and Gender: A Practical Guide to Integrate Gender into Immunization Programmes, p. 7.

[23] Hay, K. et al. Gender Equality, Norms, and Health Steering Committee. Disrupting gender norms in health systems: making the case for change. *Lancet*. 2019 Jun 22;393(10190):2535-2549. doi: 10.1016/S0140-6736(19)30648-8. Epub 2019 May 30. PMID: 31155270; PMCID: PMC7233290.

[24] Hay, K. et al. Gender Equality, Norms, and Health Steering Committee. Disrupting gender norms in health systems: making the case for change. *Lancet*. 2019 Jun 22;393(10190):2535-2549. doi: 10.1016/S0140-6736(19)30648-8. Epub 2019 May 30. PMID: 31155270; PMCID: PMC7233290.

Session 2. Facilitation Sheet: AFP Surveillance in Sunlandia Case Study

Use the sample answers below to help guide the breakout group discussions on the Sunlandia case study. Participants may identify additional examples from the case study and/or their own experiences. The examples on this sheet are illustrative and supportive, but not exhaustive.

What gender-related barriers and factors negatively affecting polio eradication can you identify in this scenario, considering the situation of Sara and Joseph and the overall situation in Sunlandia?

Sample Answer:

Sara experiences several **gender barriers to access to resources** that are common among women in many contexts due to harmful gender norms and restrictive gender roles, including:

- Lack of **literacy skills** to understand information being provided, due to lower gender norms that undervalue education for girls and women
- Lack of access to **viable transportation options**, due to gender norms that restrict women's mobility, which makes accessing the nearest health facility even more difficult
- Lack of access to **communications and media**, such as mobile phones and internet, due to lack of control over financial resources
- Lack of access to respectful healthcare services and female healthcare service providers

Sara experiences several **gender barriers to control over resources** that women experience in many contexts, due to harmful gender norms and restrictive gender roles, including:

- Lack of **decision-making power** about healthcare and other household financial resources, due to gender norms that value men over women
- Lack of **agency** to speak up about her children's vaccination status, due to gender norms about women's knowledge and control over family health decisions

Joseph experiences several **gender barriers to involvement in his children's healthcare** that are common to men in many contexts, due to harmful gender norms and restrictive gender roles, including:

- Lack of **interaction with community healthcare workers** and **clinic providers**, due to men working outside of, and away from, the home
- Lack of access to **viable healthcare information sources** due to gender norms that influence men to value religious and community leaders over healthcare professionals
- Lack of **awareness of the gender barriers faced by women** in accessing resources for themselves and their families, due to gender norms that value men over women

What gender-related barriers and factors should be addressed when approaching communities in Sunlandia in relation to community outreach and information-sharing related to AFP and polio?

Sample Answer:

Programs can address women's lack of access to effective community outreach and information on AFP and men's experience of gender barriers that prevent awareness of gender barriers faced by women by:

- **Using gender-intentional communication media(s) strategies** that would allow both women and men to access information about polio and its prevention. For example, targeting women with radio and face-to-face interaction with female community health workers (CHWs) and targeting men (as fathers, as traditional medicine practitioners, and as religious/community leaders) with television and internet communications through messages tailored for each audience.
- **Using participatory communication approaches with women and/or men** to allow for clarity of polio-related messaging for building confidence and agency about appropriate healthcare decisions, as well as fostering communication and dialogue among household members by explicitly discussing and addressing harmful gender norms that affect household-level decision-making. Such approaches can help translate information about polio into knowledge about its prevention and eradication and support women to have more involvement and agency over family healthcare decisions.
- **Using participatory communication approaches with religious leaders, community leaders, and traditional medicine practitioners** to raise awareness about the importance of accurate health information, as well as the importance for all members of households to have access to, and knowledge of, relevant healthcare issues, including why it is important for both women and men to be informed and to be equally involved in decision-making.
- **Hiring and building capacity of women CHWs and providing gender-intentional training for all CHWs**, as well as reviewing and revising working terms and conditions of CHWs to be gender-intentional (for example, by addressing gender barriers that CHWs face in doing their work, such as gender-based violence, discrimination, equal pay, etc.).
- Hiring and building capacity of women doctors or para-health practitioners at clinics and providing gender-intentional training for all staff, as well as reviewing and revising clinic working terms and conditions to be gender intentional.

What barriers exist for community health workers conducting active case surveillance in communities in Sunlandia? Can you describe how these barriers might be different for women and men?

Sample Answer:

Barriers for community health workers may include:

- **Lack of access to certain populations**, depending on gender of CHW and family/community member
    - **Women CHWs** may have more/better access to female family members than men CHWs, due to gender norms
- **Lack of access to religious leaders** (as the main source of information for men), or access to those who may have incorrect knowledge of vaccines
    - **Men family members** may be more affected by this gender barrier, as they are most likely to receive and trust health information coming from religious leaders, while **women family members** may lack the agency to speak up or challenge incorrect information
    - **Women CHWs** may experience barriers to accessing and educating religious leaders if gender norms prevent them from interacting with, or being respected by, male leaders
- **Lack of access to remote communities**, some of which are in conflict-stricken areas where insecurity is heightened
    - **Women CHWs** may experience additional access barriers due to gender norms around mobility in those regions, as well as gender-based violence and threats to their safety

References

A rapid review of evidence on the determinants of and strategies for COVID-19 vaccine acceptance in low- and middle-income countries. Moola, S., Gudi, N., Nambiar, D. et al. (2021). *J Glob Health*. 2021;11:05027. Published 2021 Nov 20. doi:10.7189/jogh.11.05027

Demographic and attitudinal determinants of protective behaviours during a pandemic: a review. Bish, A., Michie, S. (2010). *British Journal of Health Psychology*, 15: 797–824. https://doi.org/10.1348/135910710X485826

Effect of media use on mothers' vaccination of their children in sub-Saharan Africa. Jung, M., Lin, L., Viswanath, K. (2015). *Vaccine*, 22, vol. 33, pp. 2551–2557.

ERG Discussion Paper (2018): Gender Lens to Advance Equity in Immunization.

Gender and global health: evidence, policy, and inconvenient truths. Hawkes, S., Buse, K. (2013). *Lancet*; 381: 1783–87. https://www.thelancet.com/article/S0140-6736(13)60253-6/pdf

Gender dimensions to the Ebola outbreak in Nigeria. Fawole, O.I., Bamiselu, O.F., Adewuyi, P.A., Nguku, P.M. (2016). *Ann Afr Med*. 2016;15(1):7–13. doi:10.4103/1596-3519.172554

Gender Equality, Norms, and Health Steering Committee. Disrupting gender norms in health systems: making the case for change. Hay, K. et al. (2019). *Lancet*. Jun 22;393(10190):2535–2549. doi: 10.1016/S0140-6736(19)30648-8. Epub 2019 May 30. PMID: 31155270; PMCID: PMC7233290.

"Girl Power!": The Relationship between Women's Autonomy and Children's Immunization Coverage in Ethiopia. Ebot, JO. 1, 2015, *Journal of Health, Population and Nutrition*, vol. 33, p. 18

Global Center *for* Gender Equality (2021). Gender and Polio Profile.

Global Patterns and Determinants of Sex Differences in Smoking. Pampel, F.C. (2006). *Int J Comp Sociol*. 2006;47(6):466-487. doi:10.1177/0020715206070267

Global Polio Eradication Initiative (GPEI) (2019). GPEI Gender Animation. https://www.youtube.com/watch?v=4zQjnaDFOrQ&t=15s

Global Polio Eradication Initiative (GPEI). (n.d.). FAQ: Gender and Polio Eradication.

Global Polio Eradication Initiative (GPEI). (n.d.). Gender Barriers to Immunization.

Global Polio Eradication Initiative (GPEI). Gender. https://polioeradication.org/gender-and-polio/

Global Polio Eradication Initiative (GPEI). (n.d.). Monitoring for Gender Equality.

Immunisation and Gender: A Practical Guide to Integrate a Gender Lens into Immunization Programmes, UNICEF Regional Office for South Asia (ROSA) (2019).

Jhpiego (2016). Gender Analysis Toolkit for Health Systems.

Martin Hilber, A. et al. (2010). Gender and immunisation: Summary report for SAGE. Geneva: s.n.

Maternal autonomy and attitudes towards gender norms: associations with childhood immunization in Nigeria. Singh, K., Haney, E., Olorunsaiye, C. (2013). 5, 2013, *Maternal and Child Health Journal*, vol. 17, pp. 837–841.

Maternal reasons for non-immunisation and partial immunisation in northern Nigeria. Babalola, S. (2011). 5, 2011, *Journal of Paediatrics and Child Health*, vol. 47, pp. 276–281.

MEASURE Evaluation (2017). The Importance of Gender in Emerging Infectious Diseases Data. https://www.measureevaluation.org/resources/publications/fs-17-205a/at_download/document

Paralytic poliomyelitis during the pre-, peri- and post-suspension periods of a polio immunization campaign. Lamina, S., Hanif, S. (2008). 3, 2008, *Tropical Doctor*, vol. 38, pp. 173–175.

Parental acceptance of inactivated polio vaccine in Southeast Nigeria: a qualitative cross-sectional interventional study. Tagbo, B.N., Ughasoro, M.D., Esangbedo, D.O. (2014). 46, 2014, *Vaccine*, vol. 32, pp. 6157–6162.

Polio immunity and the impact of mass immunization campaigns in the Democratic Republic of the Congo. Voorman, A. et al. (2017). 42, 2017, *Vaccine*, vol. 35, pp. 5693–5699.

Poliomyelitis in the United States, 1969–1981. Moore, M. et al. (1982). 4, 1982, *Journal of Infectious Diseases*, vol. 146, pp. 558–563.

Poliovirus seroprevalence before and after interruption of poliovirus transmission in Kano State, Nigeria. Iliyasu, Z. et al. (2016). 42, 2016, *Vaccine*, vol. 34, pp. 5125–5131.

Reasons related to non-vaccination and undervaccination of children in low and middle income countries: findings from a systematic review of the published literature, 1999–2009. Rainey, J.J. et al. (2011). 46, 2011, *Vaccine*, vol. 29, pp. 8215–8221.

Smoking increases the risk of infectious diseases: A narrative review. Jiang, C., Chen, Q., Xie, M. (2020). *Tob Induc Dis*. 2020;18:60. Published 2020 Jul 14. doi:10.18332/tid/123845

Socio Cultural and Geographical Determinants of Child Immunisation in Borno State, Nigeria. Monguno, A.K. (2013). 1, 2013, *Journal of Public Health in Africa*, vol. 4, p. e10.

The Bill & Melinda Gates Foundation (2021). Gender Equality Lexicon. Second Edition.

The Bill & Melinda Gates Foundation (2020). Gender and Malaria Evidence Review.

Tools for assessing gender in health policies and programmes. Health Policy Project (2011).

Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. White Hughto, J.M., Reisner, S.L., Pachankis, J.E. (2015). *Soc Sci Med*. 2015;147:222–231. doi:10.1016/j.socscimed.2015.11.010v

UNICEF (2019). Immunization and Gender: A Practical Guide to Integrate Gender into Immunization Programmes, p. 7.

USAID and MEASURE (2017). Integrating Gender in the Monitoring and Evaluation of Health Programs: A Toolkit.

Vaccine-Associated Paralytic Poliomyelitis: United States: 1973 through 1984. Nkowane, B.M. et al. (1987). 10, 1987, *JAMA*, vol. 257, pp. 1335–1340.

Variations in the Uptake of Routine Immunization in Nigeria: Examining Determinants of Inequitable Access. Olorunsaiye, C.Z., Degge, H. (2016). 1, 2016, *Global Health Communication*, vol. 2, pp. 19–29.

Woldemicael, G. (2007). Do women with higher autonomy seek more maternal and child health-care? Evidence from Ethiopia and Eritrea. Stockholm University. Stockholm: Stockholm Research Reports in Demography.

World Health Organization (WHO). (2007). Addressing sex and gender in epidemic-prone infectious diseases. Geneva: World Health Organization.

World Health Organization (WHO). (2011). Gender mainstreaming for health managers: a practical approach. Facilitators' guide. Participant's notes.

World Health Organization (WHO). (2018). Global Polio Eradication Initiative technical brief: gender. Geneva: World Health Organization; 2018 (WHO/Polio/18.05). https://polioeradication.org/wp-content/uploads/2018/07/GPEI-Gender-Technical-Brief-2018.pdf

World Health Organization (WHO). (2019). GPEI Gender Equality Strategy. 2019–2023. https://polioeradication.org/wp-content/uploads/2020/07/Gender_Strategy_EN.pdf

World Health Organization (WHO). (2021). Road traffic injuries. https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries