

Topline Final Report

Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan



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Adopting A Gender Lens To Improve And Sustain Polio Vaccine Uptake In Afghanistan

Topline Final Report

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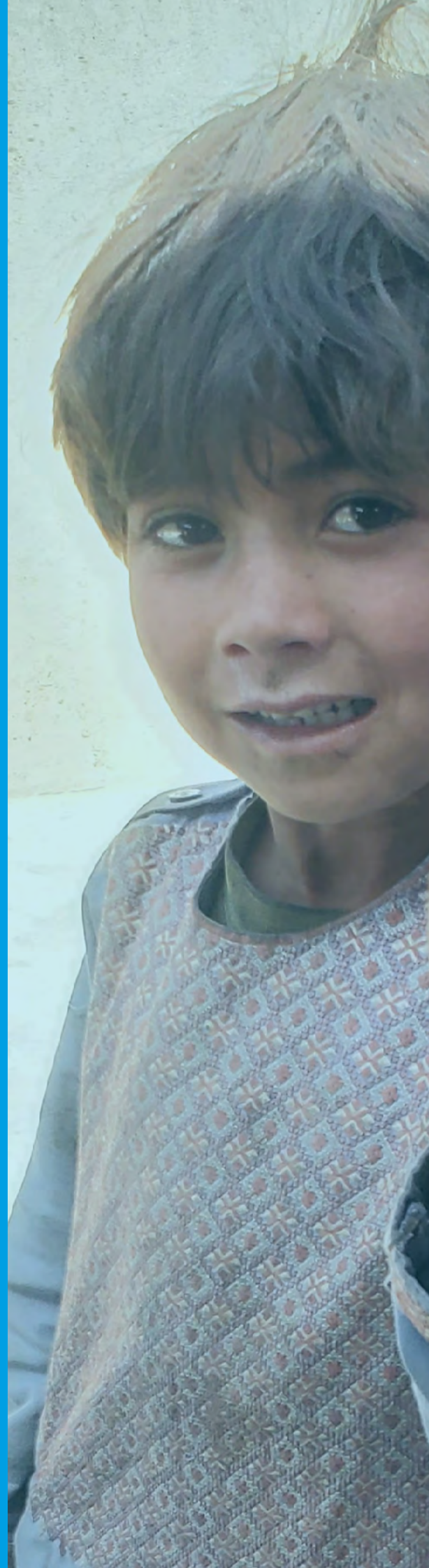
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Abbreviations

ACO	Afghanistan Country Office
C4D	Communication for Development
COVID-19	coronavirus disease 2019
GPEI	Global Polio Eradication Initiative
ICN	Immunization Communication Network
IMB	Independent Monitoring Board
PSEA	Prevention of Sexual Exploitation and Abuse
ROSA	Regional Office for South Asia
SIGAR	Special Inspector General for Afghanistan Reconstruction
TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

Executive Summary

Women play a vital role in Afghanistan's efforts to end polio. This study was conducted in 2021 to understand the role of women in the polio programme. The study aimed to identify pre-existing and emerging gender challenges, assess internal policies and procedures to identify challenges and opportunities for women's participation, review communication for development (C4D) and social and behaviour change materials through a gender lens, and provide actionable advice on adapting to the country context.

The study was based on a qualitative assessment using the following data-collection methods: literature review, in-depth interviews with Afghanistan Country Office (ACO) staff and partners, a focus group discussion with female front-line health workers, and content analysis of United Nations Children's Fund (UNICEF) C4D campaign products, other communication and training materials in local languages.

It is important to note there were significant challenges in undertaking this assessment due to the changing internal situation in Afghanistan during the research period (February to December 2021).

Communication and community engagement



A five communication strategies plan was reviewed, but only two explicitly drew on gender theories or frameworks. Through interviews, it was evident that communities are not included in the design and implementation process. All key informants agreed that there is a need to strengthen the capacity of local staff to use participatory approaches, and to design culturally tailored C4D strategies, tools and communication materials. Key informants highlighted that affected communities must be included "in decisions to ensure that the humanitarian response is relevant, timely and effective." They also pointed out that more coordinated, cross-sectoral interventions could present a strategic opportunity to integrate polio into maternal, newborn and child health messaging, as well as other community activities. Additionally, they stated that it is vital to tailor programme materials to different audiences; this would include appealing to religious norms and addressing topics such as rumours and misinformation. Social media can play a crucial role in this respect, by debunking false information.

Women's participation



This assessment is based on the InterAction *Gender Audit Handbook's*¹ Gender Integration Framework and theory of change, which suggest that transformation can only occur when there is political will, technical capacity, accountability and organizational culture.

Most participants agreed that there is political will within the UNICEF and World Health Organization (WHO) leadership to build gender-responsive programming and increase women's participation in the programme. While external factors need to be considered, women's involvement in campaigns is still well below the standard set by the UNICEF Gender Parity and Equality Policy and Gender Action Plan, which call for 50/50 gender distribution at all levels. Women in Afghanistan are not afforded independent decision-making power when pursuing job opportunities, although women with higher levels of education, economic status and who live in urban areas were more likely to be allowed to be employed.

The workplace in Afghanistan adopts the policy of segregation between men and women. This became mandatory after August 2021. However, according to all the interviewees, no one perceives this as a significant limitation. Senior ACO staff confirmed the need to invest financial and human resources in gender-related training and capacity-building for staff. The issue of women attending meetings in the community has also been raised, as they no longer feel welcome in certain places.

Challenges within the internal working environment include stereotypes concerning women's ability to work effectively in a challenging operational context. On the topic of security, interviewees also cited campaign visibility as a security risk for female front-line workers and social mobilizers.

Engaging communities to reach every child through campaigns



Social mobilizers (both men and women) who participated in the interviews ranked the effectiveness of campaign modalities in overcoming gender-based barriers to vaccination as follows:

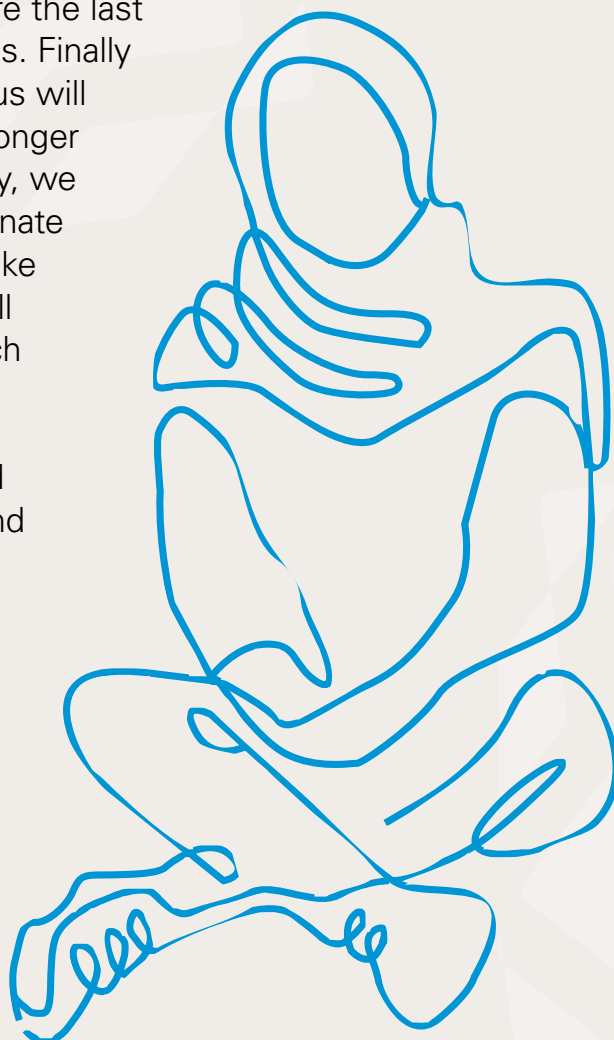
- ┌ **House-to-house:** where coverage typically reaches 90–95 per cent and the female vaccinators can visit women in their homes and count their children, meaning that mothers do not leave the house.
- ┌ **Site-to-site:** especially when the site chosen is an elderly community leader's home that women can access easily and female vaccinators can participate in the campaign, usually when the community leader's wife and daughters are at home. Also, selecting houses over schools can mean that more sites are offered within a community, increasing access for women.
- ┌ **Mosque-to-mosque:** cultural and religious norms restrict women from entering mosques.

Specific recommendations for each of the above areas is proposed at the end of the report.

¹ InterAction, *The Gender Audit Handbook: A tool for organizational self-assessment and transformation*, InterAction, Washington, D.C., 2010

Introduction

Afghanistan and Pakistan are the last two polio-endemic countries. Finally ridding the world of this virus will mean that children will no longer be paralysed and, eventually, we will no longer need to vaccinate them against polio. It will take a massive effort involving all members of society to reach this point, and women play a significant role. Hence, understanding this role, and reviewing the challenges and opportunities in meeting it, are critical in achieving the eradication of polio.



To find out how women contribute to ending polio, the Global Polio Eradication Initiative (GPEI) developed a technical brief² in 2017 that analysed how the gender of the child, caregiver and front-line worker influenced the likelihood that a child would be immunized against polio. This brief, the first in a series, is based on the understanding that gender roles, norms and associated power dynamics represent significant determinants of health outcomes. Based on the evidence collected from the GPEI 16 priority countries at the time, the technical brief introduced four gender-sensitive indicators to monitor progress towards ensuring equal access to the vaccine and women’s engagement in polio eradication efforts.

The GPEI Gender Equality Strategy (2019–2023)³ was subsequently developed, building on a growing body of evidence that demonstrates that immunization and health programmes that include women are likely to foster improved outcomes, and that gender-equitable and diverse organizations produce more effective results.^{4,5,6} The GPEI Gender Equality Strategy (2019–2023) is divided into two main sections: gender-responsive programming and organizational culture and systems.

This assessment was commissioned following discussions between the UNICEF social and behaviour change stream of the Polio Hub in Amman and the UNICEF ACO. The specific objectives of the assessment were to:

- ┆ Identify pre-existing and emerging gender challenges and other social norms influencing polio vaccine uptake.
- ┆ Conduct a gender assessment of internal policies and procedures to identify challenges and opportunities for women’s participation at all levels of the ACO polio programme under the current conditions.
- ┆ Conduct a gendered review of crucial communication and C4D materials and provide actionable advice on adapting to the county context.

2 Global Polio Eradication Initiative, *Technical Brief: Gender*, World Health Organization, Geneva, 2018.

3 Global Polio Eradication Initiative, *Gender Equality Strategy 2019–2023*, World Health Organization, Geneva, 2019.

4 Global Health 50/50, *The Global Health 50/50 Report: How gender-responsive are the world’s most influential global health organisations?*, Global Health 50/50, London, 2018

5 Global Health 50/50, *The Global Health 50/50 Report 2019: Equality works*, Global Health 50/50, London, 2019.

6 Devillard, Sandrine, et al., *Women Matter 2016: Reinventing the workplace to unlock the potential of gender diversity*, McKinsey & Company, 2016.

Methodology and conceptual framework

This assessment was based on a qualitative assessment using the following data-collection methods: literature review, in-depth interviews, focus group discussions with female front-line health workers and content analysis of UNICEF campaign products and training materials (in local languages), which were reviewed with the support of national ACO staff. Data sources were based on information provided through consultations with the UNICEF ACO, in addition to data collected through the methods mentioned above.

The overarching assessment framework was based on the GPEI Gender Strategy⁷ and the UNICEF ROSA Immunization and Gender Guide⁸ (see Figure 1). Findings related to gender-responsive communications and community engagement were assessed using the WHO gender responsive assessment scale and the UNICEF ROSA publication on mapping and assessment⁹. While findings related to women's participation in the programme were assessed in line with the InterAction Gender Audit Handbook's¹⁰ Gender Integration Framework and theory of change. The socioecological model and human-centred design approach, with a focus on the journey to immunization, were considered in analysing the determinants and causes of gender inequities that affect front-line health workers. This approach includes barriers and opportunities affecting the uptake of the polio vaccine. It is important to note that we could not travel to Afghanistan to conduct field visits due to the changing internal situation in Afghanistan during the research period (February to December 2021). Additionally, some relevant materials were unavailable during the data collection and analysis time, due to the relocation of some ACO staff. In addition, 4 out of 19 informants were unable to participate in the assessment.

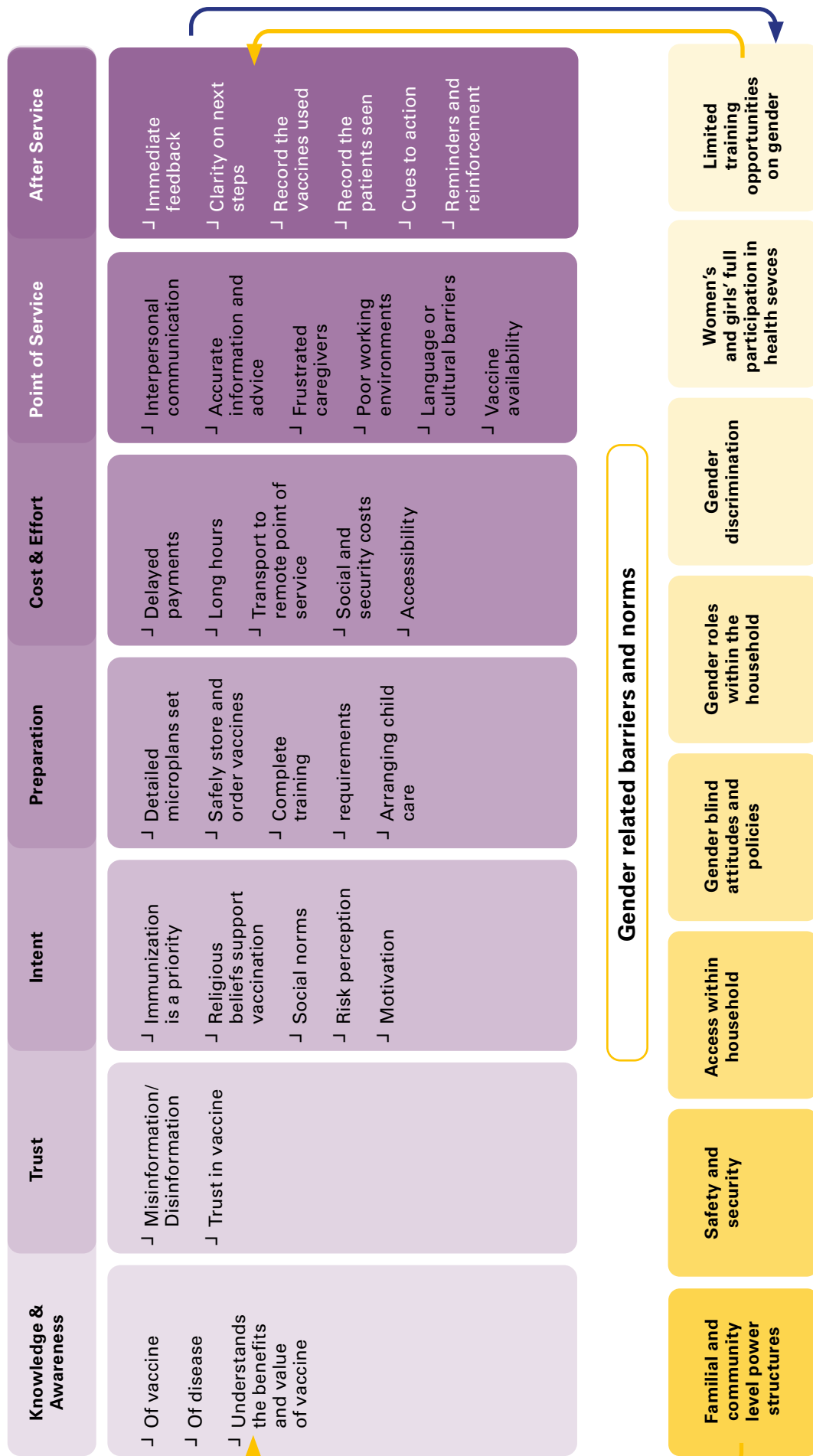
7 Global Polio Eradication Initiative, Gender Equality Strategy 2019–2023, World Health Organization, Geneva, 2019.

8 United Nations Children's Fund Regional Office for South Asia, Immunization and Gender: A practical guide to integrate a gender lens into immunization programmes, UNICEF ROSA, Kathmandu, July 2019.

9 United Nations Children's Fund Regional Office for South Asia, Gender Responsive Communication for Development: Mapping and assessment of UNICEF initiatives in Afghanistan, Bangladesh, Nepal and Pakistan, UNICEF ROSA, Kathmandu, February 2018.

10 InterAction, The Gender Audit Handbook: A tool for organizational self-assessment and transformation, InterAction, Washington, D.C., 2010.

Figure 1: Frontline Healthworker Journey

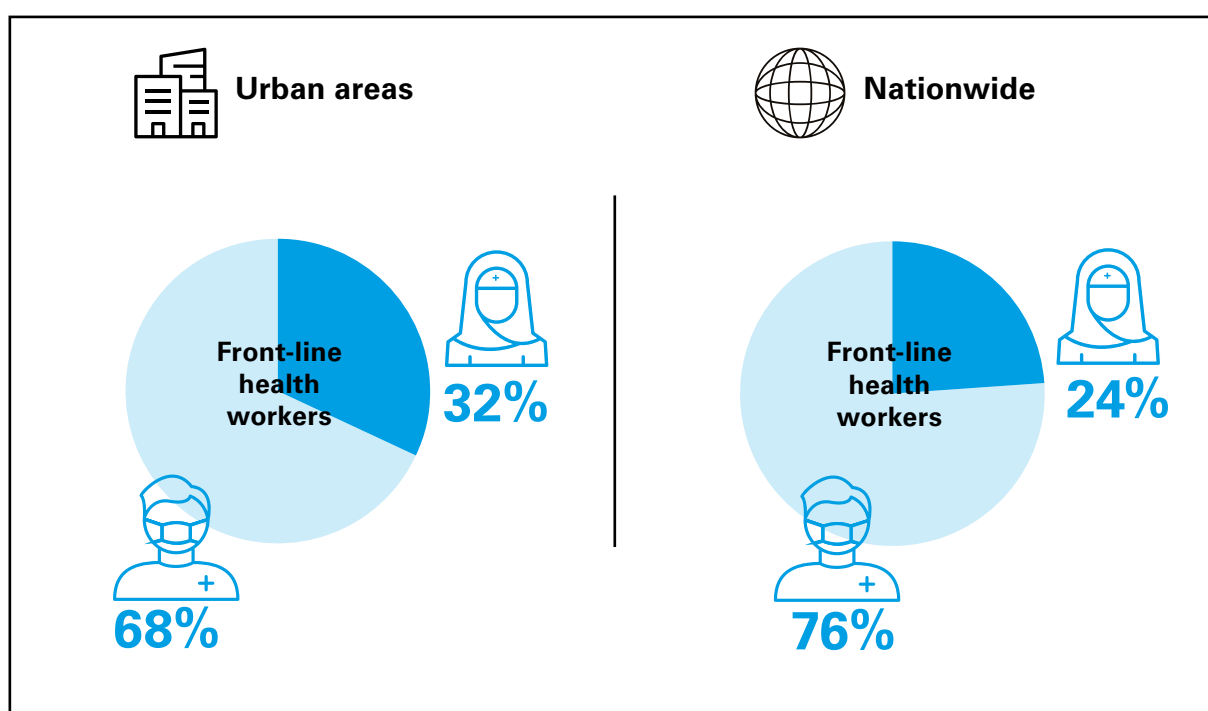


1. Social and gender context

When conducting this type of research, it is important to consider how the historical context has shaped cultural norms and men and women's socially defined roles and responsibilities. There are lessons to be learned from the numerous periods of social reform that have favoured raising women's status within Afghan society, such as granting women the right to vote in 1964, progress towards gender equality in the 2003 Constitution, adopting the law on the elimination of violence against women in 2009 and progress in access to education after 2001.¹¹ However, these efforts have been met with strong resistance, particularly among rural communities and, at times, by women themselves. Additionally, different religious interpretations have influenced the gender roles of rural and urban Afghan women in several ways, resulting in a considerable

gender gap for different Sustainable Development Goal indicators. This has also become tangled within the social context. Therefore, there is a need to translate current concepts into a local context that relates to women and the practice of employing a gender lens within Afghanistan's polio eradication initiative.

According to data reported to the UNICEF ACO, 32 per cent (513) of the front-line health workers in urban areas were women and 68 per cent (1,604) were men. Nationwide, 24 per cent (912) of front-line workers were women, while men made up 76 per cent (2,848). These figures account solely for full-time social mobilizers and represent a decline in women's participation from previously reported figures, reflecting a stark difference in the programme post-August 2021. Of the 1,767 campaign-specific social mobilizers recruited, 100 per cent were men. However, as of the December 2021 campaign, more female mobilizers were recruited.



11 Amnesty International UK, 'Women in Afghanistan: The back story', Amnesty International UK, 9 May 2022, <www.amnesty.org.uk/womens-rights-afghanistan-history#:~:text=Until%20the%20conflict%20of%20the,States%20were%20allowed%20to%20vote>, accessed 26 May 2022.

2. Status of gender mainstreaming in communications, social and behaviour change and, community engagement

A. SITUATION ANALYSIS

As regards primary research on polio vaccine acceptance over the last four to five years, the ACO was only able to share two surveys. One was conducted with social mobilizers and communication supervisors from the Immunization Communication Network (ICN) in August 2019, and the other targeted caregivers who had chronically refused the vaccine but then chose to vaccinate their children in the November 2020 campaign. Both surveys were conducted in the south region of Afghanistan, and no recent knowledge, attitude and practices studies, message validation or pre-testing reports were available.¹²

A shortage of subnational social data significantly hampered the programme, including data-gathering mechanisms and proactive timely mechanisms for integrating social data that clarifies the impact of gender norms on vaccine updates. Anthropological studies and documentation were also lacking, as well as in-house awareness-raising on gender implications for various roles,

and functions on cultural and local sensitivities and dynamics, particularly for new staff.

While interviewees clearly stated that affected people and communities must be included “in decisions to ensure that the humanitarian response is relevant, timely and effective,”¹³ there was no evidence of coordination of collective approaches to integrate a gender lens into polio messages. However, front-line health workers frequently attest to the effectiveness of integrating maternal, newborn and child health messaging and services within community engagement activities. Comprehensive guidance on how to tailor programme materials to appeal to religious norms was also commonly cited.



- 2 When this assignment was initially conceptualized, it involved a community assessment of social norms and power structures that govern decision-making within households and communities in high priority areas in the south and the south-east. There was also a knowledge, attitudes and beliefs study planned to take place this year. However, the field research component of the assessment was cancelled, and the knowledge, attitudes and beliefs study was postponed due to COVID-19 and the security situation in Afghanistan.
- 3 United Nations Children’s Fund, Accountability to Affected People Working Group, *Afghanistan: Recommended actions-indicators for mainstreaming AAP*, October 2020

B. PROGRAMME DESIGN

The ACO shared five polio communication strategies for 2021: the national communication strategy and four strategies for the east, west, south and south-east regions. The multisectoral C4D strategy (2020–2025) and the most recent digital and social media strategy (2019–2020) were also shared.

Only two of the communication strategies presented explicitly draw on gender theories or frameworks, and two regional strategies include a brief description of demographic and ethnic profiles. However, neither strategy specifically notes how gender-related norms, attitudes or practices are perceived to influence vaccination behaviour. The multisectoral C4D national strategy is the only document that references gender-specific norms affecting progress of women in Afghanistan.

All the strategies – including the national strategy – lack comprehensive, measurable key performance indicators. While the national strategy recognizes the importance of appropriately packaging and disseminating key messages to vaccinators and mobilizers, there seems to be little guidance on how to tailor communication interventions to overcome some of the most cited gender-related barriers to immunization. This is especially true when it comes to dispelling misinformation and myths. Moreover, there appears to be some disconnect between the strategies, and a lack of opportunities for the regions to share and build on effective approaches and lessons learned for gender mainstreaming through their ongoing plans.

The rapid spread of misinformation is a pervasive challenge facing the polio team. It was also observed that the current training materials do not offer enough advice to community mobilizers on tailoring messages and engaging with different population groups. For example, materials that speak directly to the significant number of adolescent Afghan mothers who face competing priorities and choices should be different from those of older mothers or grandmothers.

Meanwhile, mechanisms to rapidly capture and respond to evolving public perception and the needs of the target population were not found. Also, there was no evidence suggesting that any of the strategies were developed in consultation with girls, boys, women or men from the community during planning or vetting of the strategy documents.



C. IMPLEMENTATION

A national ACO staff member reviewed 10 YouTube videos, 16 Facebook posts and 19 training resources published by the polio programme in local languages. Based on the information provided, it was not possible to obtain a clear sense of the extent of gender integration in the implemented community engagement activities or training. Also, most of the content reviewed was gender blind, and one was gender negative.

When it comes to messaging, only 1 out of 10 YouTube videos included elements considered gender sensitive. None of the videos reviewed included messaging that promoted gender equality. UNICEF produced Facebook posts on @PolioFreeAfghanistan were selected at random based on the number of engagements with the post; the period August to November 2021 was prioritized. All 16 Facebook posts reviewed were rated as gender blind, and most attempts at gender sensitivity were typically reflected through visuals rather than messages. Some negative comments, including misinformation, were cited on the @ PolioFreeAfghanistan Facebook page but these received no response from the ACO Facebook page administrators. These comments included questions about why the vaccine was haram and now halal, corruption within the polio programme, recruitment of specific ethnic groups, the ineffectiveness of the mosque-to-mosque campaign modality and cancellation or postponement of the most recent campaign, western imposition, delayed or insufficient payment of polio workers, and questions about vaccine ingredients.

D. MONITORING

We reviewed monthly monitoring reports from 2021. While specific activities were carried out with girls, women and grandmothers, behaviour tracking for men and women who received the messages was unclear. This was also the case on social media platforms, where it was not clear if there was a tracking process that could differentiate the type of issues flagged according to gender and/or when they were addressed, and improvement recorded in reducing those incidents of misinformed comments.



E. EVALUATION

We reviewed external evaluation reports including the Gender Equality and Rights Gender Programmatic Review 2018. However, it is unclear if recommendations were adopted and implemented as part of the programme. Similarly, Technical Advisory Group and Independent Monitoring Board reports serve a critical function in pushing for accountability and effective programming. However, it was not evident if priority is given to ensuring that their findings and recommendations on gender are systematically tracked and acted on. Monitoring and evaluation are not useful if the findings cannot be fed back into programmes in real-time or used to inform new programme design.



3. Women's participation in the polio programme

This section explores the participation of women at all levels of the programme, emphasizing the situation of female front-line workers and social mobilizers, including programme and contextual opportunities, challenges and risks. It follows the Gender Integration Framework and theory of change from the InterAction Gender Audit Handbook. The framework suggests that transformation can only occur when four organizational dimensions are ready for gender integration: political will, technical capacity, accountability and organizational culture. Both internal programme factors and external factors were considered in this assessment. Most of the information reported in this section was gleaned from either interviews or focus group discussions with ACO staff, front-line workers and partners, including WHO staff.

A. Internal level

1. Leadership commitment towards women's participation and gender integration

Most of the participants in the interviews, both men and women, agreed that there is political will within the UNICEF and WHO leadership to build gender-responsive programming and increase women's participation in the programme – and not just in the field among front-line health workers and social mobilizers. However, a few female respondents, who are not in senior positions or outside of the ACO, pointed to a need for increased political will to bring women on board. They cited examples such as the lack of women in senior-level positions in the polio programme. In fact, gender-related matters beyond increased female front-line worker participation would be critical to achieve the desired change of the programme.

2. Technical capacity

All key informants occupying senior positions from the ACO polio team and outside Afghanistan confirmed the need to invest in gender-related training and capacity-building for staff. They also noted the need for adequate financial and human resources to realize the objectives of gender-responsive programming and a gendered workplace.

A gender focal point has recently been appointed to the office at the national level. However, further resources are necessary to fill gender gaps across programme sectors and provide training and awareness to field offices. An interviewee also mentioned that gender experts coming to Afghanistan often lack opportunities for field experience as they rarely leave the compound for direct interaction with communities. This situation creates a disconnect between experts and local communities and hinders their ability to understand the concrete needs of Afghan men and women.

All interviewees working in Afghanistan responded negatively when asked about their capacity to work on gender. All but one participant mentioned receiving gender training or awareness-raising sessions, and the one who did, noted that it was embedded within C4D training. Gender support from different actors outside of Afghanistan, including support offered by the Regional Office Hub and headquarters, were cited. Initiatives aimed to motivate best-performing female front-line workers was noted, such as opportunities for free English and computer classes.

3. Organizational environment

The workplace in Afghanistan is segregated between men and women due to strict cultural and social norms, which became mandatory after August 2021. All partners within the programme follow this same approach. Although, according to all interviewees, especially women in the focus group, they do not perceive this as a significant limitation. They mention that they can collaborate with male colleagues on assignments while respecting cultural and social norms, including dress code and culturally appropriate distancing.

However, an emerging issue has been raised concerning women attending meetings in the community, as they no longer feel welcome in certain places. Further challenges within the internal working environment include stereotypes concerning a woman's ability to work effectively under a challenging operational environment. They also felt their contributions were often undervalued. The perception also exists that women are taking all the jobs, and therefore their participation is perceived as a threat to men's roles, which resulted in resistance to gender issues.

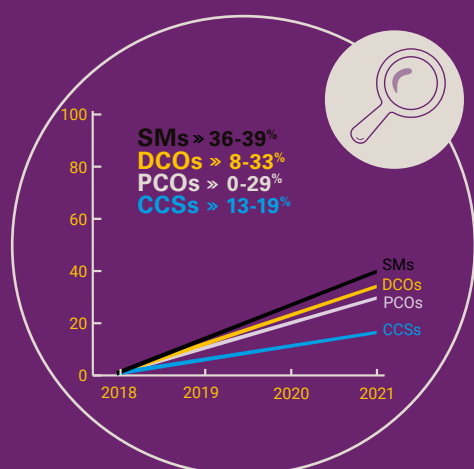


4. Accountability¹⁴

Between 2018 and 2021, recruitment of female field staff by third-party agencies increased: ICN in general 33 to 36 per cent, including social mobilizers (SMs) 36 to 39 per cent, communication cluster mobilizers (CCSs) 13 to 19 per cent, district communication officers (DCOs) 8 to 33 per cent, and provincial communication officers (PCOs) 0 to 29 per cent.



Between 2018 and 2021, recruitment of female field staff by third-party agencies increased:



While significant, these are external contracts as per the UNICEF supply manual and not UNICEF staff.

Despite the increase, these figures are still well below the UNICEF Gender Parity and Equality Policy.¹⁵ Standards and Gender Action Plan states:

“The parity goal set by the Secretary-General is to achieve a 50/50 gender distribution at all levels. This goal applies throughout UNICEF, in every office and division. It applies to all posts, irrespective of their type, source of funding, duration of the appointment, or series of Staff Rules governing their appointment.”

14 This section focuses on recruitment and retention, as reflected in the terms of reference for this exercise.

15 UNICEF (2007) Gender Parity and Equality Policy-The Gender Balanced Workplace.

Furthermore, as confirmed through interviews, women working in the UNICEF polio programme in Afghanistan, in general, occupy lower-level positions. However, this is sometimes linked to the difference in educational levels men and women can access in Afghanistan due to cultural norms. Women are constricted by what is known as a “sticky floor”, where they are recruited to fill traditionally “female-type” occupations.

The few women who occupy senior-level positions at the district level are subjected to deeply rooted discriminatory social norms. Women front-line workers contracted by third parties confirmed that they benefit from family-friendly policies, including three months of maternity leave and breastfeeding allowances.



B. External level

1. Gender and security factors affecting women's participation

Women in Afghanistan are not afforded independent decision-making power in pursuing job opportunities. In line with cultural norms, women typically require approval from male family members before they can commit to a job. Within the focus group, female front-line workers explained that women from families with higher levels of education, higher economic status and urban women were more likely to be allowed to join the programme. This was thought to be because urban women have increased access to education, media and infrastructure. At the same time, the lack of investment in rural areas has severely hampered women's educational and economic opportunities. Restrictive cultural norms are also more entrenched in rural areas.

The security of staff is a priority for the programme. However, security officers working in United Nations agencies are only responsible for staff, consultants and volunteers directly contracted by UNICEF, which does not account for most front-line health workers hired by third-party agencies.

Interviewees also felt that campaign visibility was a security risk for female front-line workers and social mobilizers. Finally, one female participant raised a particularly poignant concern alluding to public suspicion that polio workers operate as spies on behalf of The International Security Assistance Force and the government.

On the campaign side, one promising strategy, which emerged in the focus group discussion with women, confirmed that one effective way of overcoming vaccine refusals was to discuss broader health issues concerning women and children, such as malnutrition, pregnancy and breastfeeding. This reality should be another critical reason for cross-sectoral integration to meet the urgent, unmet needs of the most vulnerable Afghan families.



One key informant explained,

“For example, in February, there was an attack against civil groups of female vaccinators in and around Jalalabad. And I think after the first attack, we advised them to get off the streets. But we don’t have direct control over these groups of vaccinators. And then the second attack happened, then the third attack happened. It would be very different if we had direct contracts with these vaccinators, but that is probably impossible. If we had a different arrangement, we would be able to provide advice directly and conduct security training and so on.”





2. A case study of the November 2021 campaign

The mosque-to-mosque campaign held in November 2021 was the first in three years to access certain areas and review outcomes from a gender perspective. According to the UNICEF ACO staff consulted in interviews, all areas of Afghanistan were accessible for the November campaign, except those controlled by Islamic State-Khorasan in the east of the country. However, according to consultations and comments on social media, many areas of the country had to postpone their campaigns due to the last-minute need to pivot from a house-to-house to a mosque-to-mosque campaign modality, under agreements made with the de facto authorities. The campaign was initially planned to be conducted house-to-house. However, just five days before, it shifted to a mosque-to-mosque campaign modality following

concessions made between polio programme implementing partners and the de facto authorities.

Social mobilizers (both men and women) who participated in interviews ranked the effectiveness of campaign modalities in overcoming gender-based barriers to vaccination as follows:

- └ House-to-house: where coverage typically reaches 90–95 per cent and the female vaccinators can visit women in their homes and count their children, meaning that mothers do not leave the house.
- └ Site-to-site: especially when the site chosen is an elderly community leader's home that women can access easily and female vaccinators can participate in the campaign, usually when the community leader's wife and daughters are at home. Also, selecting houses over schools can mean that more sites are offered within a community, increasing access for women.



- ┌ Mosque-to-mosque: cultural and religious norms restrict women from entering mosques. One male participant mentioned one exception:

“The only woman we saw bringing a child was the wife of our colleague, and in fact, it took about 20 minutes to reach the mosque.”

When modalities such as mosque-to-mosque campaigns are used, and vaccinators cannot reliably count the number of boys and girls in each household being vaccinated or missed, data may be misrepresented. The lack of reliable population and social data represents a challenge for the polio programme. It was not possible to obtain further gender-disaggregated data, as typical record-keeping practices were not allowed under this campaign modality.

Within this section of the report, findings from interviews and focus group discussions of gender-related barriers were also plotted along the journey to immunization. According to data from interviews, coverage for this campaign was extremely low: six informants cited between 20 and 25 per cent coverage, and one participant mentioned that the campaign did not exceed 5 per cent coverage in his area. Official data reported to the ACO was cited as exceeding 40 per cent at the national level.



Nevertheless, compared with previous campaigns, this level of coverage was extremely low. Data refers to the following gender-behavioural barriers, which were noted along the journey to immunization during interviews and the focus group:



Table 1. gender-behavioural barriers

<p>Knowledge and awareness</p>	<p>Most of the participants agreed that family educational background plays a critical role in the uptake of polio vaccination.</p>
<p>Trust</p>	<p>Only 5 out of 11 front-line workers interviewed reported community acceptance for this campaign. During previous campaigns, refusal and lack of access were politically led. However, the social mobilizers consulted in the focus group mentioned that some Imams and Mullahs were not supportive of recent campaigns.</p>
<p>Intent</p>	<ul style="list-style-type: none"> └ Even if women intended to participate in the mosque-to-mosque campaign, they would not have been allowed to enter the mosque or exit their house without Mahram, or a male guardian. The campaign was conducted during the day while men are typically out of the house working or at the Bazar. └ Decision-making at the household and community level is male dominated, especially in rural areas. └ Social mobilizers mentioned that some families with low financial status have more immediate basic needs, such as food. Therefore, they may not see the polio vaccination as a priority and lack intent. └ Conversely, families with good economic status are also cited as likely to refuse vaccination, reasoning that they can seek health services whenever they need to.



<p>Preparation</p>	<ul style="list-style-type: none"> ┆ In rural areas with no ICN staff or active social mobilization activities, megaphones were used at the mosques for outreach and to announce the campaign. According to three social mobilizers, this approach is not adequate to motivate families to bring their children. ┆ Women social mobilizers mentioned that the short duration of the campaign event at the mosque was one of the main challenges. In most cases, vaccinators were there for two and a half hours. The timing was inconvenient for many families, especially as men were unable to bring their children as they are out of the house during the day.
<p>Cost and effort</p>	<p>Mosques are often located far from people’s houses, presenting security concerns and risks for women who might consider travelling to the mosque, even though they are not allowed to enter. According to focus group respondents, women are not allowed to go to public spheres, so they find it challenging and risky to bring their children to the campaign.</p>
<p>Point of service</p>	<ul style="list-style-type: none"> ┆ Women are not allowed to enter the mosque. ┆ In rural areas, the mosque-to-mosque modality is deemed more feasible than in urban areas, as the population is more limited, and there are usually only one or two mosques. <p><i>“Women in remote areas cannot even get medicine at the health facility unless they come with a male. They don’t even have access to a doctor; they’re not giving us medicine unless we’re accompanied by a man. And that is the level of segregation and deprivation that these women go through, It’s not just related to the male-dominated household. It’s also that there’s the culture of masculinity inside the health service facilities.”</i></p> <p>– Female informant.</p>



Recommendations

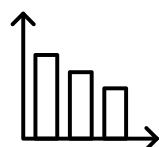


To mainstream gender in communications and community engagement



1

Encourage capacity-building to help polio staff better integrate the gender aspect, given the context of Afghan culture. This means the programme can evolve for optimal implementation within the cultural frameworks that govern specific villages, towns and cities by promoting local ownership and accountability for the immunization of children.



Improve social data and knowledge management, and coordinated and collective approaches to research are also needed. Additionally, systems are needed to collect actionable qualitative data to inform C4D, communication interventions and adaptive programme management.

2

3

There is an urgent need for design workshops at the national and regional levels¹⁶ to draft gender sensitive and specific messages to respond to common rumours and appeal to different target audiences. These workshops should identify appropriate communication channels and delivery platforms to inform the design of a reimagined suite of C4D and capacity-building materials that are gender and culturally sensitive.

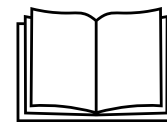


It is essential that all materials produced be pre-tested and validated before distribution, and multisectoral actors should be involved in formulating messages and identifying effective communication channels.

4

5

Given potential challenges to airing content on radio or TV, pre-recorded radio drama episodes/ spots and discussion guides could be produced with the relevant gender content integrated for different audiences and used in listening and/ or reconciliation circles. Entertainment education and other behavioural approaches that leverage storytelling could provide a useful medium for subtly communicating gender issues.



¹⁶ Should regional design workshops not be possible, the messages and products will still need to be pre-tested before distribution in these areas.

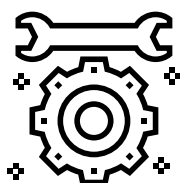


Design a suite of social media assets delivering gender-sensitive integrated messaging on health (including polio, routine immunization, and maternal, newborn and child health), water, sanitation, nutrition and possibly digital literacy. Tactics are also needed to ensure that gender issues are addressed more directly in writing by the ACO (instead of mainly through visuals) for digital platforms.

6

7

Collect, document and action robust qualitative social data, particularly gender-related data, including data on knowledge, attitudes and beliefs that is reflective of public perception and the perceptions of implementing partners. Incorporate structured and frequent opportunities for regional and global partners to share best practices and lessons learned into the programme calendar.



Polio programme to leverage and adapt gender-related indicators from cross-sectoral and accountability to affected people and gender teams. Tools and mechanisms should be in place for field staff to collect and report gender-disaggregated data, including measures to report changes in gender roles or relationships. There is also a need to include girls, boys, women and men in evaluation design and to account for gender differentials such as access, mobility, workload, educational attainment and literacy in study design and data collection. Finally, a greater focus on evaluation that can yield lessons learned to improve the gender sensitivity of programming is also encouraged.

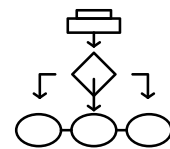
8

To strengthen women's participation in the polio programme



1

In-country programme leadership (UNICEF and WHO) should highlight and stress the importance of women's participation in the programme in all meetings and with governing authorities.

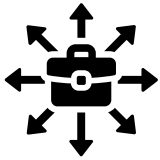


At the UNICEF and WHO level, an accountability framework with clear indicators should be developed to assess progress on women's participation at all levels and achievements towards gender responsiveness.

2

3

Concrete efforts to improve knowledge and skills related to gender concepts, gender mainstreaming and the influence of gender on immunization are recommended for leadership, senior managers and district managers and investing in capacity-building interventions for local staff (at all levels), including female front-line workers, social mobilizers and third-party contractors.

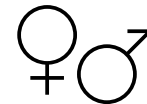


Family-friendly policies specified in the terms of reference and UNICEF policy documents should be adhered to, and training opportunities specifically for women, such as digital literacy training, are encouraged, which will also help them in the future if they move to another programme.

4

5

Ensure that all job advertisements and terms of reference are gender sensitive in language and content, and that women and other under-represented groups are encouraged to apply. Ensure that all positions are open to men and women, regardless of the grade, and include women in the recruitment process, especially when the candidate is a woman.



It is vital that Prevention of Sexual Exploitation and Abuse (PSEA) is functioning at the community level, and all staff (UNICEF, WHO and extenders) should be reminded about PSEA regularly, potentially through once yearly online training, regular reminders and sharing PSEA reports internally every 90 days.

6

To improve gender and security factors affecting women's participation including for mosque to mosque campaigns



1

Consider creating a pool of older women who can support the programme if young women who are front-line workers or social mobilizers cannot participate in the campaign.



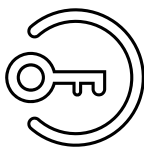
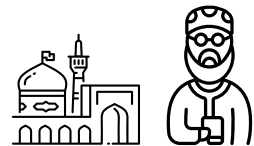


Explore new entry points for the polio programme with other humanitarian actors, for example, working with the World Food Programme (WFP). The reach of WFP activities and the urgent need for adequate nutrition and other basic needs in the country potentially attract less of a security risk for front-line workers.

2

3

Continue to encourage or develop Imams who are engaged in child health, who can mobilize men during the Friday prayers and expand mobilization to include fathers and grandfathers.



To increase access to polio vaccinations and other services at the household level, recruit more women for the campaign to increase outreach in areas only reached by males.

4



Annexes

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Annex 2.

Key terms and concepts

The definitions below are drawn from UNICEF ROSA (Kathmandu, July 2019), United Nations Children's Fund Regional Office for South Asia, *Immunization and Gender: A practical Guide to Integrate a Gender Lens into Immunization Programmes*.

<https://www.unicef.org/rosa/media/2336/file>

Gender

Socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men that vary from one society to another and at different points in history. The term 'sex' is defined to mean the biological and physiological differences between females and males.

Gender analysis

A critical examination of how differences in gender roles, activities, needs, opportunities, and rights/entitlements affect women, men, girls and boys in certain situations or contexts.

Gender blind programming

Ignores gender norms, roles and relations and very often reinforces gender-based discrimination.

Gender equality

Is understood to mean that women (girls) and men (boys) enjoy the same status on political, social, economic and cultural levels. It exists when women (girls) and men (boys) have equal rights, opportunities and status. Gender equality in health means that women and men, girls and boys have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results.

Gender equity

Gender equity is the process of being fair to both women (girls) and men (boys) in distribution of resources and benefits. This involves recognition of inequality and requires measures to work towards equality of women (girls) and men (boys). Gender equity is the pathway to gender equality.

Gender integration/mainstreaming

It is the process of assessing implications for women, men, girls and boys of any planned action including legislation, policies or programmes at all levels. It refers to a strategy for making women's and girls', as well as men's

and boys' concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes so that women and men and girls and boys benefit from equality, and inequality is not perpetuated.

Gender-neutral programming

Programming and policies that do not centre gender concerns or distinguish between genders in their design, interventions and monitoring.

Gender norms

Accepted attributes and characteristics of female and male gendered identity at a particular point in time for a specific society or community.

Gender relations

Social relations between and among women and men, girls and boys that are based on gender norms and roles. They often create hierarchies between and among groups of women and men, girls and boys that can lead to unequal power relations, disadvantaging one group over another.

Gender-responsive programming

A programme that considers gender norms, roles and inequality, with measures taken to actively reduce their harmful effects.

Gender roles

Social and behavioural norms that, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex. These often determine the traditional responsibilities and tasks assigned to women, men, girls and boys.

Gender-transformative programming

Programming that addresses the causes of gender-based inequities to transform gender relations and achieve gender equity.

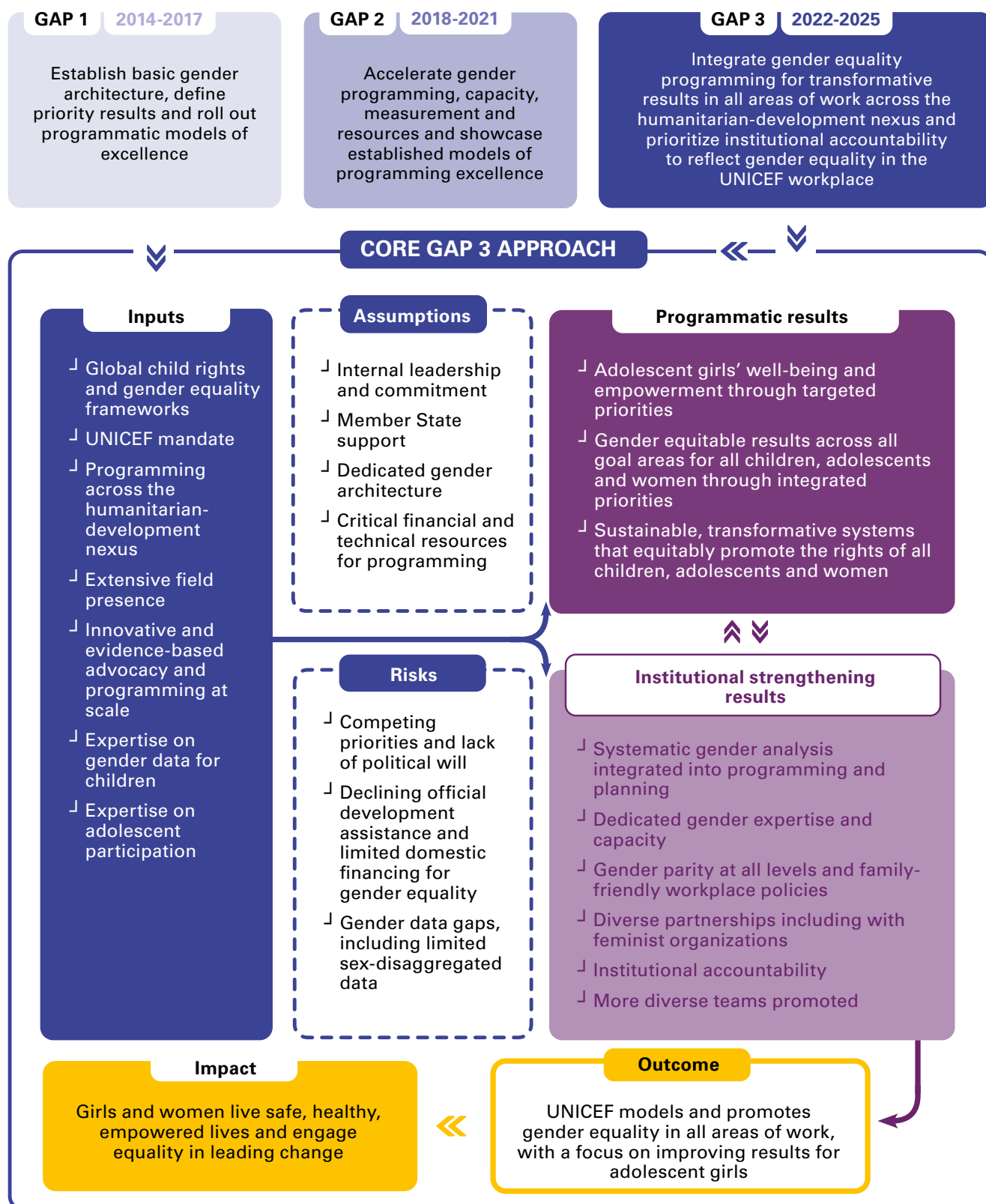
Annex 3.

List of key informants for interviews

Interviewees	Affiliation
Aminullah Mahboobi	Social Mobilization and Development Officer, Kandahar
Shafiqullah Bashar	Social Mobilization and Development Specialist, Jalalabad
Pa Ousman Manneh	Social Mobilization and Development Manager, Kandahar
Painda Mohammad Khaikhawh	Social Mobilization and Development Officer, Gardez
Roya Hamdard	Social Mobilization Specialist, Head of Midwifery Association
Shamsher Ali Khan	UNICEF Polio Team Lead
Godwin Mindra	UNICEF Polio Deputy Team Lead
Hamid Syed Jafari	Programme Director, Hub
Jean Munro	GAVI, The Vaccine Alliance
Charlotte Demars	UNICEF Regional Security Adviser
Heather Monnet	Global Gender Focal Point
Ayesha Wolasmal	Bill & Melinda Gates Foundation
Janet Omogi	Inter-Agency PSEA Taskforce Coordinator
Manpreet Singh Khurmi	Primary Health Care

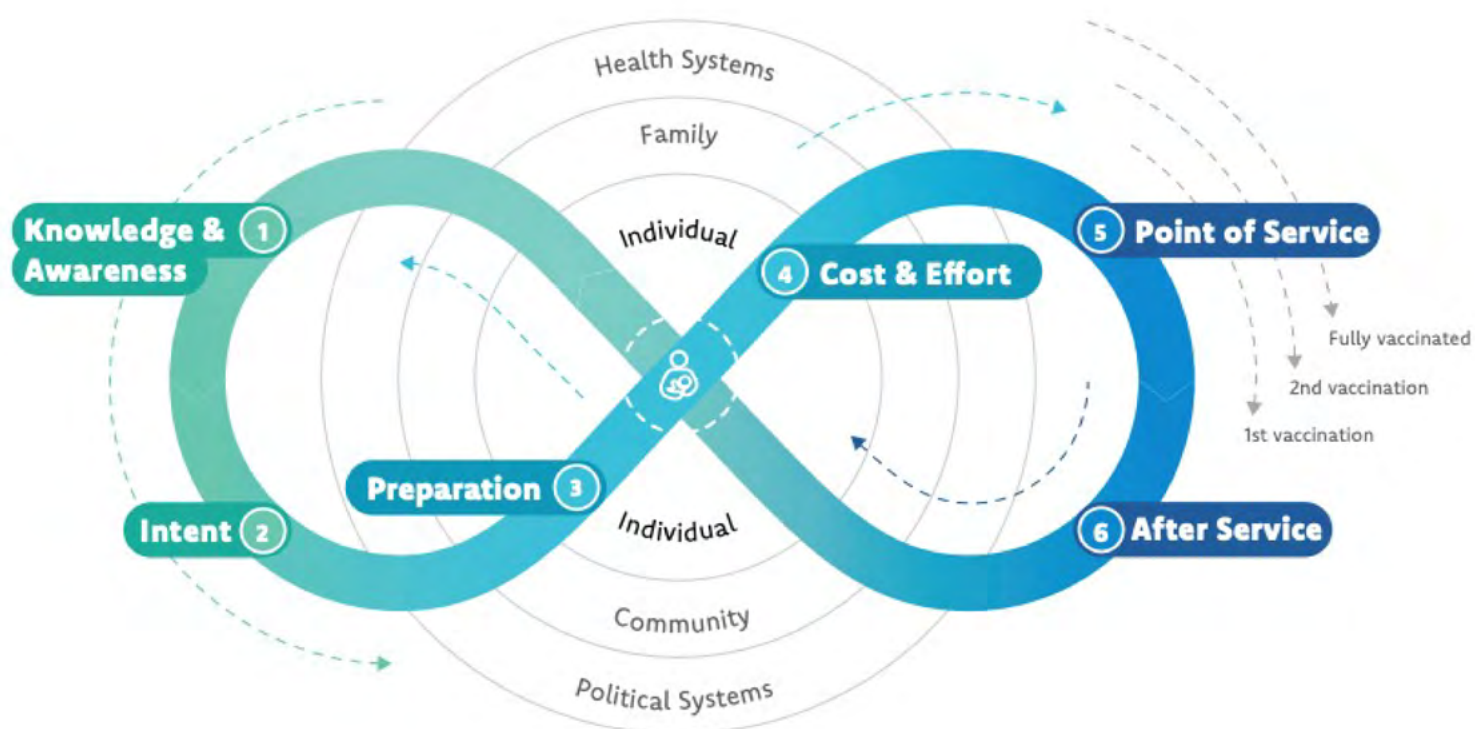
Annex 4. GAP 2022-2025

Theory of Change



Annex 5.

Journey to Immunization



Annex 6.

Commitments within the GPEI Gender Equality Strategy 2019-2023

GPEI commitments to Gender parity within the GPEI Gender Equality Strategy 2019-2023

- ┆ Introduce quotas and commit to reaching gender parity (50–50%) in TAGs and panels, and governance and oversight bodies by the end of 2020
- ┆ Where currently missing, include specific strategies, targets and actions in each GPEI organization’s human resource strategies to increase the pace towards gender parity in staffing
- ┆ At a senior leadership level, commit to recruiting and promoting more women to address the current gender imbalance, especially in senior-level posts across the organizations
- ┆ Ensure that policies and training for the prevention of harassment and abuse of authority, conflict resolution and protection against retaliation are in place and implemented in each GPEI organization;
- ┆ Provide training to senior management and human resource units on unconscious bias, and review language in job descriptions to ensure it is genderneutral;
- ┆ Foster gender-responsive workplaces, supporting all staff to take advantage of family-friendly policies, such as maternity and paternity leave and flexible work arrangements; ensure each entity has a breastfeeding policy in place, including designated nursing zones with appropriate facilities; and
- ┆ Put in place concrete measures to increase women’s participation as FLWs in areas where stark gender imbalance currently exists, while ensuring their security and safety, and:
 - ┆ Ensure that at least one third of polio worker selection committee members are women;
 - ┆ Adopt and enforce a quota of 30% women of all newly recruited FLWs, including vaccinators and social mobilizers, where possible; and
 - ┆ Invest in equal training opportunities for women and men, addressing the specific challenges and barriers faced by women.

GPEI commitments to Capacity for gender mainstreaming within the GPEI Gender Equality Strategy 2019-2023:

- ┆ Ensure that all staff working for the GPEI complete mandatory training in the prevention of sexual exploitation and abuse (PSEA) and sexual harassment, and that a mechanism is in place to monitor compliance with training completion;
- ┆ Provide training, especially to gender focal points, and to staff members and national partners on gender analysis and gender-responsive programming;
- ┆ Ensure that senior management enable staff participation in learning activities related to gender, health and polio, when relevant;
- ┆ Systematically share new guidelines, tools and resources developed on gender and polio with all staff;
- ┆ Disseminate, via senior management, a list of available online training on gender mainstreaming and gender analysis, encouraging all staff at various levels to complete at least one technical training session;
- ┆ Produce and make available checklists to help staff responsible for gender integration develop proposals, reports, guidelines and strategies;
- ┆ Make concerted efforts to ensure gender balance in training activities, especially at the field level, to ensure women's equal participation as well as the engagement of men;
- ┆ Appoint gender focal points in each GPEI organization to provide coordination and technical support for gender analysis and integration through the GPEI Gender Network;
- ┆ Facilitate collaboration with respective organizational gender focal points and units, ensuring that each organization has a specific gender focal point with clear terms of reference; and
- ┆ Ensure that senior management include gender issues in their official speeches, as well as briefings and presentations to staff, and regularly circulate materials related to gender and polio with all staff, at all levels.

GPEI commitments to Senior leadership commitment and cultural change within the GPEI Gender Equality Strategy 2019-2023:

- ┆ Assign formal oversight responsibility and accountability for the implementation of this Gender Equality Strategy to the Chair of the GPEI Strategy Committee and the POB;
- ┆ Ensure senior management support their staff, specifically their gender focal points, in gender mainstreaming, including through making training opportunities available;
- ┆ Ensure senior management include references to gender and women's empowerment in public speeches and encourage all staff to do the same in their technical work;
- ┆ Add gender mainstreaming and gender equality criteria in the performance evaluation systems of all senior managers;
- ┆ Incorporate gender into any new polio strategies, guidelines and action plans under development;
- ┆ Provide the necessary financial resources for gender mainstreaming to ensure adequate budgets for gender expertise and capacity-building, as well as for the sustained and consistent implementation of gender equality programming (including research and analysis);
- ┆ Systematically document and share knowledge internally and publicly on gender equality and women's empowerment and on the tools and good practices needed to achieve them; and
- ┆ Ensure senior management enforce a strict zero tolerance policy to sexual exploitation, abuse and harassment, regularly following up on staff completion of mandatory training sessions and disseminating information to staff about existing policies and confidential reporting mechanism

Annex 7. Gender Responsive Assessment Scale

Gender Negative	<ul style="list-style-type: none"> ⌋ Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations ⌋ Privileges men over women (or vice versa) ⌋ Often leads to one sex enjoying more rights or opportunities than the other
Gender Blind	<ul style="list-style-type: none"> ⌋ Ignore gender norms, roles and relations ⌋ Very often reinforces gender-based discrimination ⌋ Ignores differences in opportunities and resource allocations for women and men ⌋ Often constructed based on the principle of being 'fair' by treating everyone the same
Gender Sensitive	<ul style="list-style-type: none"> ⌋ Considers gender norms, roles and relations ⌋ Does not address inequality generated by unequal norms, roles or relations ⌋ Indicates gender awareness, although often no remedial action is developed
Gender Specific	<ul style="list-style-type: none"> ⌋ Considers gender norms, roles and relations for women and men and how they affect access to and control over resources ⌋ Considers women's and men's specific needs ⌋ Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs ⌋ Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles
Gender Transformative	<ul style="list-style-type: none"> ⌋ Considers gender norms, roles and relations for women and men and how they affect access to and control over resources ⌋ Considers women's and men's specific needs ⌋ Addresses the causes of gender-based health (and other) inequities ⌋ Includes ways to transform harmful gender norms, roles and relations ⌋ The objective is often to promote gender equality ⌋ Includes strategies to foster progressive changes in power relationships between women and men

Annex 8.

Gender Responsive C4D Materials – YouTube videos

Gender Responsive C4D Materials – YouTube videos										
Checklist	1	2	3	4	5	6	7	8	9	10
Do the materials and products challenge negative gender norms and promote gender equality?	Gender Blind	Gender Negative	Gender Sensitive	Gender Negative	Gender Negative	Gender Sensitive	Gender Sensitive	Gender Negative	Gender Blind	Gender Blind
Do the messages respond to the needs of girls, boys, women and men?	Gender Blind	Gender Blind	Gender Sensitive	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Blind
Do the messages challenge negative gender norms and promote gender equality?	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Negative	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Blind
Do the materials, messages and products have different acceptance and appeal with girls, boys, women and men?	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Negative	Gender Blind	Gender Blind	Gender Blind	Gender Blind	Gender Blind
Were the materials, messages and products pre-tested with different groups of girls, boys, women and men?	No evidence provided									
Do the materials include messages on gender equality?	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive	Gender Sensitive
Have appropriate measures been taken to promote equitable access to the materials, messages, products and activities?	No evidence provided									

	Gender Sensitive
	Gender Blind
	Gender Negative

Annex 9.

Interviews protocol

Interviews protocol		
Theme 1: Gender-Responsive Programming		
<p>The current assessment will focus on 2 key elements of gender-responsive programming: gender assessment and project management & gender-responsive communications. The specific commitments of the GPEI within these domains have been included in Annex B (verbatim).</p>	<p>The responses to questions related to gender-responsive programming will be assessed using WHO’s gender-responsive assessment scale and in consideration of the Rosa Publication Gender Responsive Communication for Development: Mapping and Assessment of UNICEF Initiatives in Afghanistan, Bangladesh, Nepal and Pakistan also included in Annex B.</p>	
Theme 2: Organizational Culture and Systems		
<p>According to GPEI Gender Equality Strategy 2019-2023 “Gender balance in GPEI staffing mirrors the GPEI’s commitment to gender equality. Currently, the GPEI is not on track to reach adequate levels of gender balance as decision-making power remains in the hands of men, and the GPEI is largely led by men.”</p>	<p>The current assessment will focus on 4 key elements of organizational culture and systems as they pertain to gender: leadership political will; capacity for gender mainstreaming; organizational culture; and accountability systems. The specific commitments of the GPEI within these domains have been included in Annex C (verbatim).</p>	<p>The responses to questions related to organizational culture and systems will be assessed in consideration of the InterAction Gender Audit Handbook and the Gender Analysis Framework included within the ROSA guide: Immunization and Gender: Practical Guide to Integrate a Gender Lens into Immunization Programmes.</p>



Interviews protocol

Theme 3: Gender norms affecting uptake of the polio vaccine and the experience of frontline health workers

Despite the importance of improving understanding around the influence of evolving gender norms on the polio programme in Afghanistan, the current assessment will be limited in its capacity to assess gender norms, given the quantity of interviews possible (max 20) and due to lack of access to community informants given security concerns.

Questions around theme three within the interview protocol will center on needs barriers and opportunities faced by frontline health workers on their journey to immunize Afghan girls and boys against polio and what lessons can be learned/ best practices distilled.

The Socio-Ecological Model & a Human-Centered Approach focused on the Journey to Immunization will be considered in analysing the determinants/causes of gender inequities affecting frontline health workers as well as the following domains: Enabling Environment, Supply, Quality & Demand. Please reference Annex D to reference the conceptual models shaping the assessment of Theme 3.

Audience

Front Line Workers – community engagement personnel (Social mobilizers, Social mobilization officers, managers, specialists, and FMVs)

UNICEF Afghanistan Country Office (programme staff within Gender & polio section (including C4D personnel and senior leadership)

GPEI, Hub and partners outside of Afghanistan (WHO, IMB, among others)

Colleagues who worked closely with the polio programme in Afghanistan between 2001- 2021 (not part of the programme now)

Relevant colleagues from UN agencies, NGOs, INGOs (especially local Women Rights Organisations if possible)

