

Gender analysis

for routine immunization, HPV and COVID-19 vaccination programmes in select countries in East Asia



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List of Acronyms

AEFI	Adverse Effects Following Immunization
BARM	Bangsamoro Autonomous Region of Muslim Mindanao
BCG	Bacillus Calmette–Guérin
COVID-19	Coronavirus Disease 2019
ECD	Early Childhood Development
FGD	Focus Group Discussion
GAP	Gender Action Plan
HIV/AIDS	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
HPV	Human Papillomavirus
IBI	Ikatan Bidan Indonesia (Indonesian Midwives Association)
KAP	Knowledge, Attitude, and Practice
KII	Key Informant Interview
KIPI	Kejadian Ikutan Paska Imunisasi (AEFI)
LGBTQ	Lesbian, Gay, Bisexual, Transgender And Queer
LGU	Local Government Units
NGO	Non-governmental Organization
NIP	National Immunization Program
OPD	Outpatient Department
PDR	People’s Democratic Republic
PPNI	Persatuan Perawat Nasional Indonesia (Indonesian Nurse National Association)
RPJMN	Rencana Jangka Panjang Menengah (Mid-term National Action Plan)
SRH	Sexual and Reproductive Health
ToR	Terms of Reference
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Glossary

Glossary¹

Adolescence is the second decade of life, from 10 to 19. Young adolescence is between 10 and 14, and late adolescence is between 15 and 19. This period between childhood and adulthood is a pivotal opportunity to consolidate any losses/gains made in early childhood. All too often, adolescents—especially girls—are vulnerable to violence, limited by a lack of quality education, and unable to access critical health services. UNICEF focuses on helping adolescents navigate risks and vulnerabilities and take advantage of opportunities.

Empowerment: Refers to increasing the personal, political, social, or economic strength of individuals and communities. Empowerment of women and girls concerns women and girls gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources, and actions to transform the structures and institutions that reinforce and perpetuate gender discrimination and inequality.

Gender: A social and cultural construct that distinguishes differences in the attributes of men and women, girls and boys, and accordingly refers to the roles and responsibilities of men and women. Therefore, gender-based roles and other attributes change and vary in cultural contexts. The concept of gender includes the expectations held about the characteristics, aptitudes, and likely behaviors of both women and men (femininity and masculinity). This concept helps analyze how commonly shared practices legitimize discrepancies between sexes.

Gender analysis: A critical examination of how differences in gender roles, activities, needs, opportunities, and rights/entitlements affect men, women, girls, and boys in certain situations or contexts. Gender analysis examines the relationships between females and males, their access to and control of resources, and their relative constraints.

Gender equality: The concept that women and men,

girls and boys have equal conditions, treatment, and opportunities for realizing their full potential, human rights, and dignity, and for contributing to (and benefitting from) economic, social, cultural, and political development. Gender equality is, therefore, the equal value society places on the similarities and differences between men and women and the roles they play. It is based on women and men being full partners in the home, community, and society. Equality does not mean that women and men will become the same; it means that their rights, responsibilities, and opportunities will not depend on whether they are born male or female.

Gender equity: The process of being fair to men and women, boys and girls, and, notably, the equality of outcomes and results. Gender equity may involve temporary special measures to compensate for historical or systemic bias or discrimination. It refers to fair differential treatment that positively addresses a bias or disadvantage due to gender roles, norms, or differences between the sexes. Equity ensures that women, men, girls, and boys have an equal chance at the starting point and when reaching the finishing line. It is about the fair and just treatment of both sexes that considers the different needs of men and women, cultural barriers, and (past) discrimination of the specific group.

Gender mainstreaming: A strategy to accelerate progress on women's and girls' rights and equality between men and boys. This is the chosen approach of the United Nations system and international community toward the implementation of women's and girls' rights as a subset of human rights to which the United Nations dedicates itself. Gender equality is the goal. Gender mainstreaming assesses the implications of any planned action for girls, boys, and men and women, including legislation, policies, and programs. It is a strategy for making girls' and women's, as well as boys' and men's, concerns and experiences an integral dimension of the design, implementation, monitoring, and evaluation of policies and programs so that girls, boys, women, and men benefit equality, and inequality is not perpetuated.

Gender norms: Accepted attributes and characteristics of male and female gendered

¹ All listed definitions come from United Nations Children's Fund Regional Office for South Asia, 'Gender Equality: Glossary of Terms and Concepts', Nepal, November 2017.

identity at a particular time for a specific society or community. They are the standards and expectations to which gender identity generally conforms within a range that defines a specific society, culture, and community. Gender norms are ideas about how men and women should be and act. Internalized early in life, gender norms can establish a life cycle of gender socialization and stereotyping.

Gender relations: A specific subset of social relations uniting men and women as social groups in a particular community. Gender relations intersect with all other influences on social relations – age, ethnicity, race, religion – to determine the position and identity of people in a social group. Since gender relations are a social construct, they can be changed.

Gender roles: Social and behavioral norms within a specific culture are widely considered socially appropriate for individuals of one sex. These often determine the traditional responsibilities and tasks

assigned to men, women, boys, and girls. Gender-specific roles are often conditioned by household structure, access to resources, specific impacts of the global economy, occurrence of conflict or disaster, and other locally relevant factors such as ecological conditions.

Masculinities / Femininities: These are dynamic socio-cultural categories used in everyday language that refer to certain behaviors and practices recognized within a culture as being “feminine” or “masculine,” regardless of which biological sex expresses them. These concepts are learned and do not describe sexual orientation or biological essence. They change with culture, religion, and class over time, as well as with individuals and other factors. The values placed on femininities and masculinities vary with culture also. Any person may engage in forms of femininity and masculinity. As an example, a man can engage in what are often stereotyped as “feminine” activities, such as caring for a sick parent or staying home to raise children.

Sex: Refers to the biological differences between women (girls) and men (boys).



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This study was conducted by UNICEF East Asia and Pacific Regional Office (EAPRO). The purpose of this project is to conduct a comprehensive gender analysis aimed at understanding the intricate interplay of social norms, power dynamics, and gender factors that significantly influence vaccination patterns. The analysis will encompass three crucial vaccination areas: 1) childhood routine vaccinations; 2) COVID-19 vaccinations; and 3) HPV vaccinations across four countries in East Asia and the Pacific: Indonesia, Lao PDR, Philippines, and Mongolia.

The initiative is implemented as part of the Global Affairs Canada support to COVAX-UNICEF project that supports gender and immunization and for Laos, the initiative is implemented as part of the DFAT project to “Support a safe and effective COVID-19 vaccine rollout in Lao PDR”.

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Executive Summary

The HPV vaccine is the first to target adolescent girls, and COVID-19 is the first large-scale vaccination to target adults. Skepticism about vaccination has increased with these vaccines, and routine childhood vaccination coverage is slipping. In 2023, globally, 14.5 million children were classified as ‘zero-dose,’ meaning that they had not received any routine childhood vaccinations.¹ An estimated 2.5 million children in the East Asia region missed out on one or more scheduled vaccinations² between 2019 and 2021 as a result of the disruptions incurred during the COVID-19 pandemic.³ The pandemic exacerbated existing inequalities in vaccination coverage.

Understanding the drivers of zero and low dosage is essential to overall health outcomes and life chances. This research provides insights into the intricate interplay of social norms, power dynamics, and gender inequality influencing vaccination patterns, explicitly focusing on routine childhood vaccinations,

the HPV vaccine, and COVID-19 vaccination. The data collected from interviews, focus groups, and surveys reveal that the most significant gender dynamics are not in vaccination uptake but in how women and girls are treated as caregivers, parents, and health workers. This research aims to pave the way for a more inclusive and effective vaccination strategy that addresses gender disparities in healthcare systems and maximizes healthcare outcomes in the East Asia and Pacific region.

Data was collected in Indonesia, Lao PDR, Mongolia, and the Philippines. These countries represent the diversity of the East Asia region, especially in terms of geography, income, and population size. Indonesia and the Philippines are populous nations (277.5 million and 117.3 million, respectively), comprising thousands of islands, while Mongolia and Lao PDR are landlocked with populations of 3.4 million and 7.6 million, respectively.⁴ Lao PDR and the Philippines are low-middle-income countries, while Indonesia and Mongolia are classified as upper-middle-income countries. These countries represent different parts of the region, and the findings presented here relate to the regional level. Across the four countries, 131 key informant interviews (KIIs), 149 focus group

1 World Health Organization, ‘Immunization Coverage’, 2024, <<https://www.who.int/news-room/fact-sheets/detail/immunization-coverage>>, accessed 9 December 2024.

2 World Health Organization/UNICEF, ‘Immunization regional snapshots’, 17 July 2023, <<https://data.unicef.org/resources/regional-immunization-snapshots/>>, accessed 9 December 2024.

3 United Nations Children’s Fund, The State of the World’s Children 2023: For every child, vaccination, UNICEF Innocenti – Global Office of Research and Foresight, Florence, April 2023.

4 World Bank Databank, ‘Population estimates and projection’, 2023.

discussions (FGDs), and 761 surveys were collected.

Findings

Policy and Coordination: The enabling legislative environment for gender equality exists in all countries, yet all countries lack gender-responsive vaccination strategies and outreach policies. HPV policies are the most gender-aware policies, as they are primarily given to adolescent girls. Other policies offer limited attention to the gender dynamics of vaccination and limited attention to the majority female health workforce. Policymakers lack awareness of gender issues, and the lack of sex-disaggregated data and gender analysis remains a critical barrier to creating these policies and improving equitable health outcomes. Further, the lack of women in systems of power (at all levels) impedes women's representation during policymaking, planning, and implementation.

Health Care System: Healthcare systems across all countries are strained, underfunded, and understaffed, which has ramifications for utilization and trust. A shortage of funds leads to infrastructural deficiencies, vaccine distribution shortages, and low salaries of health workers. Underfunded healthcare facilities struggle to offer separate sex waiting areas or toilets, and the lack of private consultation rooms and confidentiality was raised as a concern for women and girls. Healthcare workers, primarily women, face high workloads, long hours, and burnout. They are not offered sufficient training and mentorship and face harassment and insecurity when traveling to give vaccination services outside of the safety of the health centers.

Stigma and discrimination directly impact individual trust in the healthcare system, especially if associated with a healthcare worker. Healthcare workers' lack of empathy and negative attitudes based on age, pregnancy, and social status discourage women, particularly pregnant adolescents and elderly women, from seeking health services. If they are well-trained (and vaccinate their children and themselves), healthcare workers can impact vaccination behaviors and mitigate misinformation about all vaccination types.

COVID-19 Spotlight: The specific circumstances of COVID-19 make it unique, with vaccination uptake driven primarily by work requirements and avoidance of penalties and potential death. COVID-19 decisions were reportedly made collectively, in family groups, and showed the highest impact of family, friends, and neighbors as information sources. However, reports indicate that men were more likely to be vaccinated - mainly through job requirements - and women were less likely to get vaccinated if they were not subject to these conditions. As women do the bulk of the caring and family members could still get sick from COVID-19 following vaccination, women had an even more significant care burden than the other vaccines studied. All this, along with rumors about side effects and scaremongering about where the vaccines were made and with what ingredients, deterred some people from getting vaccinated.

Community level: Community norms are deeply implicated in vaccination decisions, particularly for HPV and COVID-19. The lack of quality, informative, and accessible healthcare information about vaccinations remains a central challenge in delivering vaccination services. Misinformation, rumor, and myth are barriers to all vaccination types, mainly where access to social media and the influence of elderly family members in vaccination decisions is higher. The lack of easy-to-understand information about side effects increased skepticism toward all vaccinations. Parental consent for HPV given in schools has varied, reducing trust in the vaccination. Social norms and community members are crucial in shaping attitudes and misinformation around immunization.

Household: Vaccination remains largely a woman's role, especially regarding routine childhood immunization and HPV. Male caregivers and other men are less likely to attend check-ups and vaccinations than women but predominantly make vaccination decisions for the household. However, the evidence indicates that these norms are weakening, particularly among young families. COVID-19 showed unique dynamics, with family decision-making being more common. Family influence is more substantial when vaccine stigma is high, in the case of HPV and COVID-19. Unpaid care and time burdens resulting from vaccination and vaccine side effects are significant considerations for household vaccine choices.

Individual: Gender differences in education, literacy, and digital access keep some women from having full access to vaccination information and outreach. Men are more likely to attain information from social media than women, who prefer to consult medical professionals. Findings that women have low decision-making power, low confidence, and low knowledge about vaccination juxtapose women's responsibility. Despite all of this, vaccination campaigns and health workers target women as the primary caregivers, perpetuating gender norms and inequalities.

HPV Spotlight: The HPV vaccine is deeply gendered, as it relates to women's sexual and reproductive health, and is, in most countries, only offered to girls. As a result, adolescent boys and girls experience unique challenges, including misinformation, fear of side effects, and parental influence. Adolescent girls rarely make an independent choice or get consulted about getting the vaccine. Their parents make this decision if parental consent is sought.

Vaccine knowledge is relatively low among both sexes, and girls often experience teasing from male classmates. The low level of information contributes to low uptake among girls, along with the circulation of misinformation that the vaccines may cause infertility. Schools and social media are crucial in disseminating information, but out-of-school children remain a missed cohort.

Recommendations: By implementing the following recommendations, stakeholders can work towards creating a more inclusive and effective vaccination strategy, ultimately enhancing public health and promoting gender equality in health care.

Supply-side recommendations

Policy and regulatory system:

- Policymakers need training to design and implement gender-responsive policies.
- Healthcare policies should prioritize privacy, confidentiality, consent rights, gender-sensitive rapport, and sharing side effect information.
- Immunization policies must prevent sexual exploitation and abuse within the health workforce, improve pay, and offer family-friendly provisions like flexible hours and carers' leave.
- Data collection should be sex-, age-, ethnicity-, and disability-disaggregated and analyzed to inform better policies and practices.

- Review HPV parental consent policies and require adolescent girls' permission.
- Amend the regulatory system to ensure minority communities, such as Kazakhs, are included in national identity and immunization systems to access healthcare services.
- Regional dialogues and south-south collaboration can share best practices to enhance immunization coverage. Strong government commitment is essential to advocate for and implement these policies.

Healthcare system:

- Adequate funding is essential for health centers to offer confidential vaccination services and reach low-dose communities through outreach. All healthcare centers must implement zero-tolerance policies on sexual abuse and exploitation, ensuring protection for employees and women delivering outreach services, followed by appropriate training.
- Healthcare workers should receive fair wages, addressing the gender wage gap in many countries. Training must also ensure all healthcare workers provide nondiscriminatory, respectful, and confidential care, particularly for pregnant women, adolescents, and persons with disabilities, supplemented by regular refresher courses.
- Strategies are necessary to mitigate burnout and overload among healthcare workers, especially in rural areas. Well-trained workers who spend more time explaining AEFI and vaccination benefits to patients will enhance trust and vaccination uptake.
- Health workers should be supported to allocate extra time during consultations to educate caregivers about childhood immunization, linking performance rewards to care quality and patient feedback rather than vaccination numbers alone.
- Enhancing feedback channels from women and communities, notably rural, ethnic minorities, and persons with disabilities, will enable the healthcare system to address better their needs, including reducing financial and time burdens on families, particularly women.

Demand-side recommendations

Community level

- Adopt an inclusive approach by targeting and increasing resources for zero-dose and low-dose communities. Publicly recognize high-dose communities and facilitate visits from low-dose areas to learn effective outreach strategies.
- Strong spiritual and superstitious beliefs in all countries can hinder vaccination coverage if

misinformation and skepticism are not addressed. Campaigns should reduce stigma and educate communities on supporting healthcare access for all, including adolescents and marginalized groups like children with disabilities and ethnic minorities.

- Vaccination information must be reliable, accessible, and informative, delivered in clear local languages, and use analogies, case studies, and visual aids to effectively communicate with those with lower literacy levels.
- Collaborate with ethnic leaders to validate materials before dissemination. Create leadership cohorts within each ethnic group to guide development and strategy, ensuring equal representation of females and males. Incorporate leadership and gender sensitivity training into meetings.
- Post-COVID, the public is more aware of vaccine production processes, and rumors about vaccine origins and ingredients have spread. Informing the public about these differences and offering an informed choice of vaccines may increase trust in vaccines and the health system.
- Design and implement a public awareness campaign for the HPV vaccine to explain its importance for adolescent girls and boys. Involve adolescents in designing this campaign.
- Integrate a comprehensive health education curriculum in schools and partner with educational institutions for development and implementation.

Household-level

- Festivals and ceremonies are widely accepted for community gatherings. Leverage these events to boost vaccination rates by organizing family fun days during campaigns and providing vouchers, samples, or toys for vaccinated children. These cultures prioritize family and community solidarity and respect for elders. Engaging an elder 'champion' to promote vaccination and holding on-site clinics to reduce work-time loss and simplify household vaccination logistics could

be effective. Promote collective care for children during and after vaccination and encourage collective decision-making.

- Encourage collective care for children during and after vaccination and collective decision-making.

Individual level

- All immunization communications should depict men as caregivers and target both genders, countering the stereotype that women are the primary caregivers since men often make vaccination decisions. Outreach efforts must engage and educate men about childhood vaccination through father support groups or workplace programs and encourage them to take their children for vaccinations and subsequent care. Male role models and influencers should promote health-seeking behaviors among boys by sharing personal stories and stressing the importance of regular check-ups and vaccinations.
- In remote and traditional societies, word of mouth is crucial for communication, as social and mass media may be less effective and often perpetuate gender inequities. Encourage individuals to share positive vaccination experiences and enlist community leaders as advocates. Family case studies showcasing the benefits of childhood immunization and addressing side effects should be developed in large fonts with pictures for parents to share with family members.
- Specific interventions are needed to reach out-of-school adolescents with vaccination information.

The challenges are great, but there are also great examples and opportunities for change. With enhanced collaboration and a gender-responsive approach, vaccination coverage can increase in the EAPRO region.

Chapter 1

Introduction

UNICEF has a long history and significant experience working with governments and partners to support child nutrition and reaching zero-dose (unvaccinated) children and missed communities, as well as programming to provide HPV vaccines to adolescents in and out of school. The UNICEF Immunization Roadmap 2022–2030 outlines and updates UNICEF’s immunization priorities through 2030. The roadmap commits to mitigating the impact of the COVID-19 pandemic and future pandemics and epidemics. At the same time, its work remains focused on immunization efforts to reach the 2030 Sustainable Development Goals and the UNICEF Strategy for Health 2016–2030 strategic goals of ending preventable newborn and child deaths and promoting the health and development of all children.

Over the past several years, global immunization coverage continued to backslide, leaving 21 million children un- or under-vaccinated (zero dose: 14.5 million and dropout: 6.5 million).⁵ Within countries, zero-dose children are concentrated in remote rural, urban poor, and fragile and conflict-affected locations and tend to live in households facing multiple deprivations. Gender-related social and structural barriers can often intersect with these vulnerabilities and amplify immunization barriers among the most disadvantaged groups. The root causes of immunization barriers are frequently found in gender norms and power dynamics between men and women that too often circumscribe women’s agency, overburden their responsibilities, and restrict their decision-making as well as their access to and control over individual and family resources. Systemic and structural barriers, including health workforce overload, inequitable work environments, inconvenient service delivery locations, and disrespectful and discriminatory practices by health workers, compound access to and uptake of immunization.

This regional report focuses on the findings from four studies conducted in Indonesia, Lao PDR, Mongolia, and the Philippines. These countries represent the diversity of the East Asia region, especially in terms of geography, income, and population size. Indonesia and the Philippines are populous nations comprising thousands of islands and hundreds of millions of citizens (277.5 million and 117.3 million, respectively), while Mongolia and Lao PDR are landlocked with populations of 3.4 million and 7.6 million, respectively.⁶ Lao PDR and the Philippines are low-middle-income countries, while Indonesia and Mongolia are classified as upper-middle-income countries.

While there are many differences, the countries have some similarities. All struggled to vaccinate the population during COVID-19. As the first adult vaccination, COVID-19 illuminated many underlying issues associated with vaccine hesitancy and trust in the healthcare system. This led to parents and caregivers questioning the safety of even routine childhood vaccines. The HPV vaccination has always been complex to message as it is associated with reproductive health and is given before children become sexually active. Table 1 shows the HPV and COVID-19 vaccination rates and compares to global and East Asia and Pacific averages. The table reveals that some countries in the study meet or surpass global averages while others fall short. The countries are committed to increasing the vaccination coverage of their populations but face challenges with reaching zero-dose children and disadvantaged populations.

⁵ World Health Organization/UNICEF, ‘Progress and Challenges with Achieving Universal Immunization Coverage: 2023 WHO/UNICEF Estimates of National Immunization Coverage (WUENIC)’, 2024, <https://data.unicef.org/wp-content/uploads/2023/07/progress-and-challenges_wuenic2023rev_20-September.pdf>, accessed 9 December 2024.

⁶ World Bank Databank, ‘Population estimates and projection’, 2023.

Table 1: Vaccination rates for HPV and COVID-19 comparing countries of interest, regional, and global values, most recent year available

	Indonesia	Lao PDR	Mongolia	Philippines	East Asia and the Pacific	Global
HPV- females - first dose*	82%	68%	N/A	26%	22.5%	26.7%
HPV- males - first dose*	N/A	N/A	N/A	N/A	0%	7.4%
HPV females - last dose*	29%	44%	N/A	10%	1.3%	20%
COVID- at least 1 dose^	75%	87%	70%	75%	N/A	70.7%*
COVID- primary series^	64%	78%	67%	72%	N/A	67%
COVID - at least 1 booster ^	25%	34%	32%	22%	N/A	32%

Source: *UNICEF, HPV immunization coverage estimates, July 14, 2024; ^WHO COVID-19 dashboard, as of December 31, 2023; *Our World in Data (2024) use of World Health Organisation data, accessed August 12, 2024.

Ensuring that immunization and essential health services reach all children and adults equitably, including those in the poorest and most disadvantaged communities, remains the primary focus of UNICEF support.

Enhancing immunization coverage and sustainably reaching zero-dose children and disadvantaged populations for vaccines, including HPV for adolescents, requires understanding and addressing the multifaceted intersections of gender with socioeconomic, geographic, and cultural factors affecting vaccine access, uptake, and delivery. The gender barriers and opportunities related to vaccination uptake have received little attention.

1.1 Purpose and approach of the study

A comprehensive gender analysis was completed to understand the intricate interplay of social norms, power dynamics, and gender factors influencing vaccination patterns across East Asia and the Pacific. The analysis prioritized three crucial vaccinations: 1) routine childhood, 2) COVID-19, and 3) HPV. For each vaccination, specific research objectives were

shaped by the following research topics:

- Identify gender inequalities that lead to structural and infrastructural barriers within the household and the community.
- Identify gender differences and determinates that hamper access to immunization services;
- Capture intra-household gender power relations, social norms, access to and control over resources, roles, responsibilities, knowledge, and agency that affect demand for vaccinations (and any links to broader health service demands);
- Identify and analyze gender norms that influence the health-seeking behavior of adolescent girls and boys, particularly regarding sexual and reproductive health and rights, with a specific focus on the influence of masculinity in adolescent boys.

As such, the research queries gender-related barriers at multiple levels, from the systematic directives of policymakers and health care services to supply immunizations to the individual motivations that shape vaccine demand. Figure 1 provides a complete breakdown of the five levels of analysis used in this research.

Figure 1: Analytical framework for identifying gender-related immunization barriers at key levels of analysis

The specific objective of the assignment is to identify gender-related bottlenecks and issues which pose a barrier for care givers and their children and adolescents to access routine immunization and essential health services including for HPV vaccines across the socio-ecological framework.



System-level

- Vaccines available at different times? Affordable?
- Gender barriers?



Service delivery

- Services non-discriminatory, respectful, of good quality, provided by trusted providers?
- Health personnel motivated and trained on the Prevention of Sexual Exploitation and Abuse?
- Female workforce empowered in their jobs?
- Attitudes towards female/male community health workers?



Community

- Gender and social norms influencing vaccine uptake and access?
- Role of religious leaders and other influencers?



Household-level

- Care givers' roles in childcare?
- Literacy level of care givers?
- Knowledge, attitude, and practices of care givers?
- Costs and domestic burdens for care givers to access vaccination?
- Decision-makers in regard to vaccination or child-wellbeing?



Individual level

- Motivates or demotivates adolescent girls and boys to apply for HPV vaccinations?
- Where to receive information on HPV vaccinations?
- Have autonomy in the decision of taking HPV vaccines or not?

Together, these analysis levels allow the research to holistically identify gender dimensions that impact vaccination initiatives in the East Asia region. The socio-ecological model was combined with the Five Domains Gender Analysis Matrix (GAM). Five key domains include patterns of decision-making, access to and control over resources, roles and responsibilities, cultural norms, beliefs, and values, and laws, policies, regulations, and institutional practices. This framework provides a social-relational lens that can account for issues around power and control, decision-making, and systemic and structural policies that influence social and cultural norms.

The findings of this study have been used to design capacity-building workshops and training packages for relevant stakeholders in the region to ensure a direct operationalization of this work to address gender-related factors in vaccination.

1.2 Data collection tools, sample, and analysis

Efforts were made to ensure comfort and trust among the participants. Male and female enumerators were used to collect the data from the same sex. This extended to training adolescent girls as enumerators and peer support during data collection. The following data collection tools were used:

Key informant interviews (KIs) with UNICEF staff, government representatives, international agencies,

implementing partners, community influencers, health workers, and non-traditional health partners to understand the context, gaps, and potential partners who can be mobilized to address the identified gender barriers.

Focus group discussions (FGDs) were conducted with senior citizens, adolescent girls and boys, and caretakers to identify and understand the characteristics—barriers, interests, behaviors, and needs—of caregivers (male and female) that influence their health-seeking decisions and actions. FGDs were also conducted with the health workforce to identify and understand how gender influences their perceptions of and experiences in the health system. Further, FGDs explored how gender biases among health workers could influence their performance and decision-making and the consequences of these biases.

Hybrid surveys were completed offline (e.g., face-to-face or phone) and online (e.g., sending a survey link through email or WhatsApp) to reach the most respondents. A paper-based survey was conducted for beneficiaries and those at the community level. The SoGoSurvey platform was used for the online survey, and continuous follow-up with the survey respondents ensured a high response rate. The questionnaire was kept short, mostly with dichotomous or multiple-choice questions engaging the respondents for up to 30 minutes. The surveys provided an understanding of the situation of children and adolescents across their life course by analyzing the social, political, economic, and technological trends affecting them and their vaccination decisions.



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Table 2: Final sample distribution in all research areas

Country and Province	KIs	FGDs	Survey (hybrid)
Indonesia - Aceh, West Kalimantan, East Java	34 79% (27) females 21% (7) males	44 50% female and 50% male groups	278 72% (201) females 28% (77) males
Lao PDR - Vientiane capital, Phongsaly, Savannakhet	33 70% (23) females 30% (10) males	36 58% (21) female 42% (15) male	219 61% (133) females, 32% 71 males 7% (15) Government ⁷
Mongolia - Bayan-Ulgii, Dundgovi, Dornod	33 76% (25) females 24% (8) males	33 55% (18) female 45% (15) male	81 67% (54) females 33% (27) males
The Philippines - Metro Manila (NCR), Antique (Western Visayas), Cotabato (Bangsamoro Autonomous Region of Muslim Mindanao (BARMM))	31 58% (18) females 42% (13) males	36 50% (18) female 50% (18) male	183 63% (116) females 37% (67) males
Total sample	131 71% (93) females 29% (38) males	149 53% (79) female 47% (70) male	761 66% (504) females 32% (242) males 2% (15) Government

Recruitment of participants: For each data collection type, recruitment was informed by inclusion and exclusion criteria (as shown in Table 3). The UNICEF country offices primarily selected individual participants for each country. Purposive sampling was used to select study participants in each country (Indonesia, Lao PDR, Mongolia, and the Philippines) with the highest relevance and potential contribution to the research.

Key informant interviews were asked for a list of survey participants who worked on immunization and health. Thus, snowball sampling was also used for the survey respondents. The final sampling distribution is shown in Table 2.

⁷ N.B. Government respondents did not respond to the 'gender of the participant' question so the respondents cannot be disaggregated by sex.

Table 3: Inclusion criteria for recruitment of participants

Gender analysis	Inclusion criteria
Government representatives - national/sub-national/ local levels WHO and other international agencies UNICEF staff Implementing partners/female-led and female-focused organizations Community influencers/ civil society representatives and medical societies Non-traditional health partners (e.g., religious leaders, youth, tribal leaders) Health cadres/community health workers/adolescent health workers and other health staff	• Part of UNICEF initiatives * Involved in routine immunization, HPV or COVID-19 vaccination • 50% female participants • Individuals willing to give consent
Right holders/beneficiaries target groups: • Male and female caregivers of adolescent girls • Male and female caregivers of 1st baby (under 2 years) • Male and female caregivers of two or more kids under 5 years • Men and women senior citizens • Non-parenting adolescent boys and girls	• Part of UNICEF initiatives • Adolescents, adults, senior citizens, and caregivers (mothers/pregnant women, fathers, and grandparents) with children under 5 (residents of zero-dose communities) • 50% female participants • Individuals willing to give consent



Analysis: The GAM framework was used to design the questions in the research tools (KIs, FGDs, surveys) and analyze the research findings. The Statistical Package for Social Sciences (SPSS) was used to analyze the survey data using bivariate analysis with sex as the independent variable. Excel was used to help code the qualitative data and identify themes according to the GAM framework and the socioecological model.

Validation workshops allowed key stakeholders to endorse and validate the findings and provide strategic input for the reports. In Indonesia, the country-level workshop included representatives from the UNICEF country office and government officials. All other findings were validated in a regional workshop with UNICEF HQ and EAPRO representatives, UNICEF country office representatives, and government officials. To facilitate key stakeholders' attendance, both workshops were conducted in a hybrid format (i.e., participant surveys were conducted online and in person).

1.3 Limitations of the study

This study has overall limitations as well as country-specific limitations. These limitations include the following:

Overall limitations of the study:

- **Data is not nationally representative:** the primary goal is *not to generate nationally representative data* but to gain insights into the specific dynamics at play. The sites selected for research were selected in consultation with UNICEF regional and country offices and with the understanding of the research timeline and budget constraints.
- **Data is not regionally representative.** No Pacific Island countries were included in the study.
- **Time and budget constraints:** The sample size, distribution, and number of provinces reflect the research's timeline, budget, and ToR, as well as discussions with UNICEF regional and country offices.
- **Discrepancy in targeted and achieved survey responses:** The targeted number of survey participants at the organizational level could not be met due to the unavailability of some targeted respondents. For example, in organizations where ten survey participants were targeted, only five participants working on health and

- immunization were available.
- **Out-of-school adolescent girls.** Due to budget constraints, the study did not reach out-of-school adolescent girls, which limited the exploration of their awareness of HPV and other vaccinations.

Some country-specific limitations have been identified in Annex 1.

1.4 Research Ethics

Ethical clearance was sought from the relevant ethics bodies in each country (Table 4). In each of these countries, UNICEF country offices suggested the ethical review boards and facilitated the application process with the national consultants. The country office checked all documents before the applications were sent.

Table 4: Research ethics sought by country

Countries	Ethics board
Indonesia	Universitas Katolik Indonesia - Atma Jaya Institute of research and community service
Lao PDR	Ministry of Health, University of Health Science, Research Ethics Committee
Mongolia	Medical Ethics Review Committee of the Ministry of Health
The Philippines	Single Joint Research Ethics Board, Ministry of Health

Consent: Informed consent statements were used before any data was collected from individuals. A copy of the consent statement was left with respondents, and an email address and phone number for complaints and additional information were included. Each tool had its own consent statement read out by the enumerator/interviewer at the time/place of the interview. For the online surveys, there was an explicit agreement to participate in the text preceding the survey that reminded participants that participation was completely voluntary and that they could withdraw at any time. Completion of the survey represented implied consent to participate.

Chapter 2

Gender Dynamics: Individual, Household, and Community Levels

This chapter presents an analysis of the influence of demand-side gender dynamics that emerged from the research, specifically focusing on the influence of these dynamics across multiple immunization types, including (1) early childhood immunization, (2) HPV vaccination, and (3) COVID-19 vaccination. The findings are presented according to socio-ecological model levels of community, household, and individual.

2.1 Early childhood immunization

Mongolia has the lowest prevalence rates of zero-dose children in the East Asia and Pacific region, with only 3.9 per cent of rural and 2.5 per cent of urban children classified as zero-dose in 2023.⁸ In the case of Lao PDR it is one of the ten countries with the highest wealth inequalities in vaccination, zero-dose children are four times likely to be in the poorest decile (45.6 per cent) compared to the wealthiest decile (11.4 per cent).⁹ In the case of the Philippines, only 62 per cent of the eligible children are considered fully immunized, and is no longer in the top five countries for zero dose children (2023).¹⁰ In Indonesia, the full vaccination coverage dropped from 93.7 in 2019 to 84.5 in 2021, leading to an increase in zero dose children.¹¹

2.1.1 Individual Level

Gendered roles and responsibilities are changing in the region, but women are still largely responsible for unpaid care work, including domestic duties and childhood vaccinations.

Women in East Asia and the Pacific had among the highest rates of female labor force participation in the world, with 67 percent of women (compared with the global average of 53 percent) participating in some form of work.¹² Men also work but are less involved in domestic and caregiving tasks traditionally associated with women's roles. Thus, while fathers are considered unavailable to take children for vaccinations because of work, mothers have to figure out how to manage their children's vaccinations in addition to their other productive and reproductive tasks.¹³ When there are multiple children in a household, getting a child vaccinated may involve taking siblings to the clinic as well:

When one child needs an immunization, a mother of four must weigh the opportunity, social, and economic costs of going to a healthcare facility. At times, these barriers may feel like insurmountable obstacles, creating an unwillingness to pursue timely immunizations.¹⁴

Mothers are also responsible for dealing with any adverse effects of immunizations (AEFI). When considering the costs of traveling to the vaccination clinic (e.g., bus ticket or taxi ride), the lost time to complete other domestic tasks, or the need to take time off paid work to care for a sick infant experiencing AEFI, the mother has to really believe in vaccination to bother.

Domestic responsibilities limit the time available for women and girls to participate in information-sharing activities. Men in Mongolia with two or more children under five and men in Indonesia with a first child under

8 UNICEF 2023. State of the World's Children 2023.

9 *ibid.*

10 Philippines no longer in the top 5 list of unvaccinated children. UNICEF. <https://www.unicef.org/philippines/press-releases/philippines-no-longer-top-5-list-unvaccinated-children-0>

11 Indonesia targets low vaccination areas to tackle decline in childhood immunization. UNICEF. <https://www.unicef.org/indonesia/press-releases/indonesia-targets-low-vaccination-areas-tackle-decline-childhood-immunization>

12 World Bank Group, 'Labor force participation rate, female (percent of female population ages 15-64 years) (modeled ILO estimate), East Asia & Pacific, World, 2022,' <<https://data.worldbank.org/indicator/SL.TLF.CACT.FE.ZS?locations=DEKADEM>>, accessed 9 December 2024.

13 FGDs with female caregivers, Laos and Indonesia.

14 FGDs with female caregivers of two or more children below 5, Aceh.

2 showed particularly high access to information across all information types (Annex-Table 3). The exception is Lao PDR, where male and female caregivers reported the least access to knowledge, especially about immunization facts and how to track immunization records. Men in the study had more information on vaccinations and their benefits than women.

Men also had different information preferences than women. Men are less likely to consult friends and family and more likely to use digital technology and social media for vaccine information. In Indonesia, male caregivers report much higher use of digital and social media (100 percent) than female caregivers (67 percent use digital technology, increasing to 89 percent if a female caregiver's 1st child was under two). Lao PDR and Mongolia results show similar trends of sex and age around social media and digital technology use. In the Philippines, however, these trends do not hold, with all caregiver groups reporting low technology use. Known as the digital gender divide, women's access to the internet may be as much as 20 percent less than men in low-and-middle-income countries in Asia.¹⁵ Social media platforms like Facebook, YouTube, and Instagram are increasingly used in both countries to spread awareness, although they also present challenges due to the potential spread of misinformation.

Traditional media, such as local TV and radio, are still widely used to disseminate information but are utilized primarily by men and senior citizens in all countries except Lao PDR. Senior citizens, male in Indonesia (40 percent) and both male and female (50 percent) caregivers in the Philippines heavily rely on TV and radio. In Mongolia, male caregivers are most likely to use radio and TV but show different preferences based on the number and age of children.¹⁶ Lao PDR faces unique challenges due to language barriers in ethnic communities, making it difficult for some populations to understand health education messages and resulting in the limited influence of TV and radio reported by participants. One community influencer in the Philippines identified social media as "the number one issue" in vaccination misinformation.

15 UN Women, 'Digital gender divide prevents the Asia-Pacific region from benefiting from untapped talent in women and girls', 2023, <<https://asiapacific.unwomen.org/en/stories/press-release/2023/03/digital-gender-divide-prevents-the-asia-pacific-region-from-benefiting-from-untapped-talent-in-women-and-girls>>, accessed 9 December 2024.

16 Male caregivers of the first child under two years are less likely to use TV (33 per cent) and radio (33 per cent) compared to male caregivers with two or more children under five (caregiver percent for each).

These findings emphasise the need to consider intersectional categories of sex, age and location when designing awareness raising and information campaigns.

Community leaders are also a significant information source. This is particularly true for senior citizens, especially women (43 percent) and men (20 percent) in Indonesia and women (50 percent) in the Philippines. Interestingly, in Lao PDR, community leaders are a critical component of routine childhood vaccine information with male and female caregivers, especially male caregivers of two or more children under five years (100 percent) and female senior citizens (50 percent).

Gender differences in education, especially the literacy levels of caregivers, play a critical role in their ability to understand vaccination information and make informed decisions. Caregivers, primarily women with limited literacy, need help to grasp medical information provided by healthcare staff, leading to potential misunderstandings and hesitation in vaccinating their children. The impact of gender differences in literacy is likely to be highest in Lao PDR, where in 2022, the literacy rate among adults was 92 percent for men compared with 83 percent for women.¹⁷

The behaviors of community leaders, including teachers and healthcare workers, can impact community behaviors and decision-making in ways that shape vaccination uptake. When teachers and health workers do not vaccinate themselves or their children, it can fuel hesitancy and mistrust.¹⁸ A male caregiver from Indonesia echoed this sentiment when he expressed his disappointment that a teacher had not vaccinated their child against diphtheria, *"I was told to get the diphtheria vaccine for my child, but I was disappointed because the teacher's child wasn't vaccinated. I felt let down."* Teachers and healthcare workers should be well educated on the benefits of vaccination. Understanding their specific resistance could illuminate ways to influence the anti-vaccination community.

17 World Bank Group, 'Literacy rate, adult male & female (% of males and females ages 15 and above), most recent year', <<https://data.worldbank.org/indicator/SE.ADT.LITR.ZS?display=defa&locations=XD>>, accessed 24 April 2024. Compared to Lao PDR, the rates of male and female literacy in Indonesia (97% men, 95% women, 2020), Mongolia (99% for both men and women in 2020), and the Philippines (98% for men and 99% for women in 2020) leave less room for gender differences in literacy to fuel gender dynamics in immunizations.

18 KII with International Organization, Jakarta.

2.1.2 Household Level

The findings show that traditional gender norms often place men as decision-makers and women as decision executors and caregivers, which affects who takes children for vaccinations and who ultimately decides on vaccination matters.

These traditional gender roles were reported to be very strong in Indonesia, Lao PDR, and the Philippines but more fluid in Mongolia. However, the variance within countries was noted; e.g., in the Philippines in metro Manila, decision-makers are mothers, yet in BARM, they are fathers. In Indonesia and Lao PDR, a strong traditional emphasis on male decision-making was reported, but with strong indications of women's decision-making in ethnic communities (e.g., the Lao Lum in Lao PDR) and when dealing with the HPV vaccine. These results show that while traditional gender norms persist in many areas, they are becoming more fluid in modern households.

Where elders have a strong influence over vaccination decisions in families, traditional gender roles are reinforced, and misinformation is more common.

Respondents in Indonesia, Lao PDR, and the Philippines reported that elders strongly influence decision-making around vaccines but that this influence was often colored by misinformation or outdated knowledge. For example, in Indonesia, elders promoted breastfeeding as a replacement for vaccinations as a result of the immunity transfer from mothers to babies via breast milk (Box 1). In Lao PDR and the Philippines, the elders' strong influence meant that misinformation, particularly concerning the potential side effects or long-term impacts of the COVID-19 and HPV vaccines, shaped family decision-making around these vaccines. In Mongolia, there was a strong emphasis on medical staff as the primary information source for vaccination, and the influence of elders was not reported in this way.



Box 1: Family influence, breastfeeding, and immunization in Indonesia

In Aceh, Indonesia, a mother stopped vaccinating her third and fourth children, influenced by a doctor's emphasis on breast milk as the primary source of immunity and the lack of clear communication about the complementary role of vaccinations. A community leader in Pontianak confirmed that a belief in the sufficiency of breastfeeding for immune strength persists in other communities, such as the Madura community.

In these areas, families may face pressure from other family members, particularly from grandmothers, which discourages vaccination. For example, in Kalimantan, grandmothers advocate for exclusive breastfeeding and use negative anecdotes about vaccination side effects to discourage vaccination.

These insights highlight the need for clear, culturally sensitive communication about the importance of vaccinations alongside breastfeeding. Ante-natal and post-natal visits can convey this message.

Women's lack of time and access to information, along with traditional decision-making norms, culminate in women's low confidence. Across the region, women are more likely to feel that they lack confidence in making vaccination decisions (Annex-Table 2). A significant majority of female caregivers agree or strongly agree that they lack confidence in making informed vaccine decisions, especially in Indonesia (58% of female caregivers with two or more children under 5 years); Lao PDR (100% of female caregivers with two or more children under five and 75% of female caregivers of their first child under 2); and the Philippines (67% of female caregivers of two or more children under 5 years). Female caregivers in Mongolia and female caregivers with their first child under 2 years in the Philippines and Indonesia were the only groups to buck this trend, with 60%, 75%, and 56%, respectively, disagreeing or strongly disagreeing that they lack confidence. These findings suggest that, in addition to sex, a mother's age may impact her confidence to make vaccination decisions.

2.1.3 Community Level

Ethnic minority and rural communities require specific attention in vaccination strategies and

outreach. In Lao PDR, a primary challenge is ensuring that vaccination information and services reach all ethnic groups and address any particular cultural beliefs and practices that may influence vaccination decisions. For example, among the Hmong, a strong patriarchal structure and traditional practices emphasize men as decision-makers, which may limit women's autonomy and participation in vaccine decision-making. The Khmu community, while generally supportive of health care, has strong cultural norms that dictate that reproductive health, pregnancy, and childbirth should only be attended to by women and that men should not engage in these arenas. In addition to the social challenges of early marriage and gender norms limiting women's healthcare autonomy, the Akha community also faces geographical barriers that make it difficult for healthcare services to reach them. While ethnic communities were not explicitly mentioned for Indonesia, Mongolia, and the Philippines, rural and remote communities in each of these countries will pose unique challenges in ensuring vaccine access and outreach, especially for children with disabilities within these hard-to-reach communities.

Isolation of these communities, lack of accessible information in local languages, lower education levels, and traditional norms all contribute to misinformation about vaccination and, ultimately, fuel vaccination hesitancy. In all four countries, concerns about vaccination side effects, the safety of vaccination ingredients, and the fears that vaccines are related to developmental issues such as allergic reactions, autism, and other disabilities persist. In Indonesia and LAO PDR, negative personal experiences related to AEFI deepen vaccine hesitancy even when health workers have provided correct counter information. In Mongolia, this hesitancy is also geared towards a need for more trust in the government to provide safe and effective vaccination.

In many communities, village, religious, and ethnic group leaders (predominantly men) play an important albeit overlooked role. When motivated, these leaders leverage their influence to encourage vaccine uptake and address community hesitations. Their endorsement significantly impacts the success of vaccination campaigns, as highlighted by health center medical staff and village volunteers across provinces. In the Philippines, religious leaders, such as *Ustad*¹⁹ in BARMM, hold significant sway over their communities. In Indonesia, an interview with an organization for persons with disabilities

19 *Ustad* is only used for qualified Islamic scholars.

in Surabaya revealed that some parents refuse to vaccinate their children due to Islamic prohibitions on pork-derived ingredients in vaccines. There are also concerns about ingredients considered *Subhat*, whose halal status is uncertain. These religious and cultural beliefs significantly influence vaccination decisions among some Muslim parents in Indonesia and the Philippines. Leadership endorsement of vaccination greatly enhances community acceptance and participation.

2.1.4 Summary

The findings in this section indicate multiple, intersecting impacts of gender dynamics, age, and education on routine childhood immunizations. These impacts suggest that while traditional gender roles may shape perceptions and expectations of vaccine delivery and uptake, clear evidence exists that multiple factors impact vaccination knowledge, confidence, and decision-making within households and communities. Barriers to vaccination include financial and time costs for families, challenges in reaching rural and remote communities, and reshaping traditional social norms around vaccination. Still, the impacts of these are most heavily felt by women who end up bearing the direct costs of vaccination. The circulation of quality, accessible, and reliable information is necessary to all communities, especially in communities where social media and digital technologies may be more heavily consulted than medical professionals.

2.2 HPV vaccine

The Human Papillomavirus (HPV) vaccine is a critical intervention aimed at preventing HPV infections, which are linked to various types of cancers, including cervical cancer. Table 5 shows the current status of HPV vaccination programs and their target populations. Efforts to promote the HPV vaccine involve extensive orientations and education campaigns to ensure that parents and guardians understand its benefits. However, challenges persist.

Table 5: HPV vaccination programs for adolescent girls in reviewed EAPRO countries

Countries	HPV vaccine launch year	Adolescent girls' age group
Indonesia	2015	The first dose of HPV immunization is given to girls in the 5 th grade of elementary schools (or 11 years old for children who are not in school), and then the second dose is given to girls in the 6 th grade of elementary schools (or 12 years old).
Lao PDR	2020	Girls aged 10 to 16 years.
Mongolia	2024*	Girls and boys, age 11 years, <i>not yet implemented*</i>
The Philippines	2015	Girls aged 10 to 16 years.

*The 2020 National Strategic Plan on Prevention and Control of Cervical Cancer (2020-2024) outlines a national program for full vaccination of 74% of 11-year-old girls. In 2023, this was amended (via Resolution 472) to include boys.

2.2.1 Individual

There are clear gaps in reported access to HPV vaccination information among adolescent girls and boys (Annex, Table 6). Boys in Lao PDR report higher access to most information types than girls (e.g., 50 percent of boys versus 20 percent of girls reported knowing where to go for immunizations). The Philippines shows significant gender disparities, particularly in understanding the importance of immunizations, with boys being far more informed than girls (83 percent versus 50 percent). Limited understanding of the benefits of vaccination leads to

misinformation. The knowledge that HPV vaccination helps prevent cervical cancer did not seem to be prevalent.

Strong gender dynamics around healthcare behaviors challenge HPV vaccination uptake.

Some boys question the necessity of vaccines for males, which leads to skepticism. Adolescent boys often exhibit lower health-seeking behavior compared to girls. Adolescent boys, in particular, are less likely to seek medical help compared to girls, as health check-ups are perceived as a “girl thing.” This is influenced by social norms and gender stereotypes that discourage boys from expressing health concerns or seeking medical care. For example, in Mongolia, deeply rooted gender norms shape men’s low engagement with the healthcare system, and these attitudes extend toward the HPV vaccine. For men in Mongolia, the medical examination given as a requirement for their mandatory military service at age eighteen is often one of the few interactions they have with health care services. According to a health worker from Bayan Ulgii, there may be gender dynamics at play, as *“Men don’t like to get vaccinated by nurses in general.”*

This could also reflect the cultural perception that health care, especially sexual and reproductive health (SRH), is an issue for women, not men. This attitude reflects a broader cultural belief that vaccines

are more important for females, particularly for HPV, and raises concerns among boys about not getting vaccinated.

Low knowledge of SRH among boys and girls reduces the capacity of adolescents and parents to understand the risks of HPV and the benefits of vaccination.

In Mongolia, despite mothers engaging in conversations about SRH with their daughters, key informants highlight significant gaps in adolescent girls’ knowledge regarding SRH, including critical topics such as sexually transmitted infections. Adolescent boys also lack essential SRH knowledge due to their exclusion from SRH initiatives, which are often primarily directed towards girls. Where female caregivers of adolescent boys have taken the lead in these discussions, for example, mothers and grandmothers, as was reported by caregivers in Bayan Ulgii, adolescent boys are open to and comfortable with talking about SRH.

The HPV vaccination has more stigmatization than other vaccines because of its association with SRH and with women and girls.

HPV vaccination programs only include girls in Indonesia, Lao PDR, and the Philippines. This targeting supports the stigma that women are responsible for SRH, and can make it harder to include boys and men in HPV vaccination outreach and, ultimately, uptake. Parental hesitancy has an undue influence on



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reinforcing this stigma and, ultimately, on adolescent decision-making.²⁰

The fear of needles and side effects, including short-term effects like fever, pain, and severe reactions and long-term effects like infertility, are a significant challenge to HPV vaccination among adolescent girls. Multiple participants mentioned fear of needles as a reason for avoiding vaccination.²¹ Fear that the HPV vaccination causes infertility was also heard across countries.

The attitude of peers, especially male peers, can reduce HPV vaccination among boys and girls. Boys often create apprehension among girls about getting vaccinated by making negative comments, which discourages girls from seeking vaccinations. For example, participants from Indonesia and Lao PDR mentioned hearing male friends making jokes about the vaccination process being painful, leading to fear and reluctance among girls to get vaccinated.

Peer pressure and community support can increase vaccination uptake when adolescents see others getting vaccinated. Parents, especially in Lao PDR, noted that their children saw friends getting vaccinated and wanted to do the same, even if they were afraid of needles. Positive community attitudes and support from medical staff, village heads, and village volunteers are key in spreading the benefits of vaccination and encouraging uptake. However, this pressure should be complemented with awareness campaigns and support for open communication.

Out-of-school girls cannot access vaccinations in the schools, and specific campaigns to reach these girls are limited. Some adolescent girls are out of school due to early or forced marriage, devaluation of girls' education, or pregnancy. The challenges associated with this population are complex and multi-faceted. According to a key informant in Lao PDR, uptake of the HPV vaccine and other preventative health care services is lacking among girls who marry early (e.g., between 15 and 18 years). In addition, this early transition to the status of wife and (potentially) mother rapidly replaces the girls' identity away from being a child or adolescent needing vaccination. Pregnant adolescents often drop out of school and lose their peer networks and access to information. Given HPV is mainly given in schools, this cohort misses out when deliberate

efforts are not made to reach them.

2.2.2 Household

Preferences for female health workers giving the HPV vaccine are widespread yet nuanced by country (Annex, Table 7). There is a notable preference among adolescent girls and female caregivers for female health workers in Indonesia and the Philippines. However, more nuance appears when disaggregated by age, with the most potent responses found among adolescents in the Philippines (67 percent) and caregivers in Indonesia (83 percent). Lao PDR also shows a stronger influence of age over gender, with the majority of adolescent girls (67 percent) and boys (84 percent) preferring female health workers. Male caregivers in the Philippines showed the strongest preference for female health workers, with 100 percent reporting that female health workers should give the vaccine. In Mongolia, female caregivers show a small but not overwhelming preference for women health workers in the case of HPV. However, this fact should be treated with caution as Mongolia data lacks a full representation of respondents.

Survey results suggest cultural and familial differences are at play regarding the HPV vaccine (Annex Table 4). Critically, for HPV vaccinations, adolescents may follow the directives of their parents or other influential figures without fully understanding the importance or necessity of the vaccine. Adolescents rarely make independent decisions to be vaccinated. In Lao PDR, adolescent girls and boys each report the same-sex parent as the decision-maker. This trend is replicated among male and female caregivers who report themselves as decision-makers. In Indonesia, there is a different pattern, with adolescent girls and boys both reporting that the mother is the decision-maker regarding HPV vaccination. Here, the pattern diverges when asking male and female caregivers, as well as men (or fathers). Factors such as age, maturity, and understanding of vaccine risks and benefits also play a role in HPV vaccination decision-making, along with gender.

HPV vaccination decision-making is gendered yet follows no discernable pattern across the countries studied (Annex, Table 5). In Indonesia, there is a strong male influence on HPV vaccination decisions, with many female caregivers deferring to their spouses (men and women report men as decision-makers). In contrast, Lao PDR shows more autonomy among female caregivers, though male caregivers still report a significant role in decision-making (men and women report themselves as decision-makers). The Philippines stands out for its

20 FGD with community health workers, Lao PDR.

21 KII with female health worker, Philippines; FGD with adolescent girls, Philippines; FGD with female caregivers, Lao PDR; FGD with male senior citizens, Lao PDR.

high level of female autonomy in HPV vaccination decisions (100% of women reported their decision-making power), with no reports of male spouses making the decision alone. In Mongolia, parental participation in discussions of SRH is subject to clear gender dynamics: mothers are more likely to speak with daughters than fathers are to speak with sons, leading to higher resistance among boys to engage in these discussions. As a result, key informants point to mothers' substantial influence in shaping adolescent girls' opinions. At the same time, fathers are described as "fence-sitting" regarding the HPV vaccine, with overall less information than mothers and less involvement in family health issues. Taken together, these trends also reflect a stronger gendered dynamic around SRH discussions and the potential for HPV decisions to be assigned to women.

Parental consent emerged as a controversial topic, with some frontline workers regarding it as a deterrent. In Indonesia, uptake of the HPV vaccine was higher before parental consent processes were implemented in 2018.²² When parental consent was first introduced, it increased parents' awareness of the vaccine and their concerns. Health workers argue that parental consent (through signing a form) increased misinformation and stigma towards the vaccine. Parents worried about why they had to sign for the vaccination, which they did not do for routine immunizations. National immunization guidelines stipulate the consent practice, but the evidence suggests that these may not always be followed.

The quality of information shared with parents and their level of awareness could be the issue more than seeking consent. Some parents and adolescents interviewed pointed to examples where parental consent was not gained, and parents were not informed until their daughter came home from school after receiving the vaccination. This has reportedly fuelled suspicion and distrust of vaccinations, schools and health workers, too. This was magnified in remote and ethnic communities with literacy and language barriers. There is a spectrum of consent options, from signing a form, being told, opting in or out, and assent (for those under 18). Rarely is assent from adolescents sought for the HPV vaccine, and they do not feel suitably informed, as evidenced by their low awareness about cervical cancer. Transparency by school systems regarding the vaccine's purpose and how and when it would be administered can improve according to parents and adolescents.

2.2.3 Community

Information sources for HPV vaccination vary widely, but family members, health workers, and schools are seen as particularly impactful interlocutors. In Lao PDR, community leaders and organizations are primary sources of HPV vaccination information. In Antique in the Philippines, health workers are assigned to different barangays²³ to ensure the community is well-informed. This includes validating information before disseminating it to ensure accuracy. These health workers also use various communication methods, such as text messages and chat groups, to spread awareness about vaccination schedules and benefits. In Indonesia, outreach and promotion by teachers and medical staff significantly influence adolescents and their caregivers to seek HPV vaccinations. For example, in Aceh, one male participant shared how the school's involvement prompted a family discussion: *"Because there was a letter from the school about the vaccine, I talked to my wife... I googled what HPV was, and it was safe for her to get the vaccine."* Many participants mentioned that teachers encouraged girls to get vaccinated against cervical cancer. Family discussions are important in Indonesia, Lao PDR, and the Philippines, but these results are still based on information disseminated by health workers, schools, and other media channels.

In addition to the information source, the quality, reliability, and accessibility of the information can make a difference. Information must be presented in ways that are accessible and available to the population, including ethnic communities. In Lao PDR, persons with limited literacy and understanding of the Lao language are less likely to take the vaccine. In these information gaps, misinformation, especially anecdotal accounts, spreads through social media and becomes tangled with social norms around vaccination, making it hard for educational outreach. As an example, a girl from Lao PDR posted an experience of hair loss on Facebook, which quickly spread negative rumors against the HPV vaccine. In Lao PDR, community health workers explained that misinformation around the safety and purpose of the HPV vaccine, especially for long-term reproductive health, is a powerful deterrent for adolescent girls and boys. In the BARMM region in the Philippines, religious and cultural beliefs cause many Muslim families to be hesitant about HPV due to a fear of infertility and other health issues. Fears about vaccination safety and efficacy discourage

²² FGD with female health workers, Aceh.

²³ *Barangays* are the smallest administrative division in the Philippines and is the native Filipino term for a village, district, or ward.

both adolescents and their parents from getting vaccinated.²⁴

2.2.4 Summary

Compared with routine childhood vaccinations, the HPV vaccine is subject to greater influence by gender dynamics because of its relation to SRH and targeting of girls. This targeting deepened gender differences in routine medical care between men and women and made full inclusion of men and boys in HPV vaccination efforts more difficult. Further, the sensitive subject matter around HPV also lends it to deeper issues of misinformation and fear, particularly related to pain and infertility. Parents' understanding and support significantly influence adolescents' decisions to get vaccinated, along with informative teachers. Issues around consent and adolescent assent require further examination.

2.3 COVID-19 vaccinations

In contrast with the other vaccination studies, COVID-19 has a broad target population ranging from individuals above five to the elderly. Because of this broadness, people used

individual behavioral factors to initiate and inform vaccination decisions. For working-age people, vaccination decisions were often determined by work requirements. For example, in Mongolia, a female caregiver from Dundgovi noted, *"Many people chose to get vaccinated to facilitate cross-border business."* Similarly, a male caregiver from Dornod emphasized, *"In our community, everyone has been vaccinated due to job requirements."* In Mongolia, compliance with COVID-19 regulations was enforced through police fines as part of a broader strategy to ensure adherence to safety protocols. During the height of the pandemic and early on, governments mandated stringent protocols and measures to control the spread of COVID-19. The population was unhappy with the restrictions placed upon them, which fuelled rumors and the spreading of misinformation. The COVID-19 pandemic presented a unique opportunity to study various government approaches to vaccination roll-out.

2.3.1 Individual

Across all countries, COVID-19 immunizations show the weakest gender linkages among the three vaccinations studied. Compared to routine childhood immunizations and the HPV vaccine, the gender dynamics of COVID-19 are generally well understood (see Box 4).

²⁴ FGD with community health workers, Vientiane. FGD with male caregivers of adolescent girls, Lao PDR.



Box 4: Recognized global gender barriers and impacts of COVID-19

1. Increased gender-based violence: The pandemic exacerbated gender-based violence (GBV) against women and girls, with reports of rising domestic violence cases during lockdowns.
2. Economic insecurity: Women have faced significant economic challenges, including loss of income and employment. Many women work in informal sectors, particularly vulnerable to economic disruptions caused by the pandemic. Moreover, women quit jobs to fulfil caregiving roles resulting from school closures and sick relatives.
3. Access to health care: Women and girls have experienced difficulties in accessing health care services, including reproductive health services. The diversion of healthcare resources to address COVID-19 has limited the availability of these essential services.
4. Education disruptions: School closures have disproportionately impacted girls, who are often expected to take on additional caregiving and household responsibilities, reducing their time for education.
5. Mental health: The mental health of women and girls has been adversely affected by the increased burden of care, economic stress, and exposure to GBV.²⁵

Female caregivers complained less about the COVID-19 vaccination. Female caregivers face the time, travel, and cost burdens of all vaccinations, including the care necessary to treat any side effects. These common discussions were noticeably absent from reports around COVID-19 (except for some female caregivers in Mongolia who emphasized the care burden post-vaccination). This could be because children could only receive the vaccination towards the end of the pandemic, and thus, female caregivers did not need to take children to health clinics, or because the costly restrictions for non-vaccinators outweighed any efforts to be vaccinated.

The elderly were less likely to vaccinate due to misinformation. According to the key informants in Lao PDR, elderly persons of both sexes were less likely to get vaccinated because they considered themselves healthy and, therefore, did not see the need for vaccination, particularly if they did not travel much and had fewer openings to become infected. In Mongolia, specific efforts were made to reach the elderly and rural populations who may have not sought vaccination, positively impacting vaccine uptake (Box 5).



© UNICEF/ UNI313240/Arinacs, Wilander

²⁵ UN Women, From Insight to Action: Gender Equality in the wake of Covid-19, United States, 2020.

Box 5: Spotlight on Mongolia's COVID-19 vaccine outreach for elderly and rural populations

Elderly individuals faced challenges in accessing COVID-19 vaccination sites due to transportation issues. Health facilities' operating hours typically from 8 am to 4 or 5 pm. This is when their adult children are at work and unable to assist them or when grandchildren are at school. Some countries, like Mongolia, implemented specific strategies to improve vaccination uptake among the elderly. The Gerontology Center in Ulaanbaatar deployed a mobile team to deliver COVID-19 vaccines directly to the homes of elderly individuals, ensuring they had access to vaccinations without needing to travel.

Ethnic minorities residing in remote locations showed greater reluctance toward the COVID-19 vaccine and preferred using traditional remedies. Mobile vaccination teams played a crucial role in reaching these populations. Vaccination sites were also established at various locations to increase access, including in universities and colleges. Phone counseling became an essential part of the health strategy in Mongolia during the pandemic, with health professionals using phone calls to reach out to patients, provide health advice, and conduct follow-ups.

Young populations were involved in vaccination promotion and information sharing. In the Philippines, youth groups, including LGBTQ youth organizations, effectively implemented vibrant and energetic vaccination drives, which attracted considerable community interest in vaccines. According to an NGO representative, this approach significantly helped to increase vaccination uptake. Additionally, requiring vaccinations for participation in community sports, such as barangay basketball leagues, has proven effective in boosting vaccine uptake. However, it is noted that these sports activities are predominantly targeted towards young men.

2.3.2 Household

COVID-19 vaccination decision-making shows clear collaborative efforts by families distinct from decision-making patterns for other vaccine types. As reported by respondents in all countries researched, COVID-19 vaccination decisions often involved collaborative processes among family

members, especially parents and grandparents. Adolescents reported limited involvement in the decision-making process; their parents and grandparents decided for them to get vaccinated against COVID-19. Many families reported a collective decision-making process, indicating strong family unity and vaccination support. One female senior citizen from Phongsaly in Lao PDR described how this took place in her family, *"In my family, there are eight people, including two nephews. We discussed together and decided to have everyone in the family vaccinated."* In the Philippines (Antique) female caregivers explained that the whole family should decide on vaccination because everyone needs to be vaccinated.

In the Philippines, it was reported that there may be some gender dynamics in the vaccination process. In some families, men were first vaccinated, followed by other family members. In BARMM, it was reported that men needed the vaccination to keep working, so they took the first vaccines. To date, it is estimated that less than half of the women in this region took the vaccine. This shows how incentives or restrictions can have unintended adverse effects, especially if a gender analysis is not completed prior to implementation.

2.3.3 Community

The distance to the health centers and fear of pain and needles are factors contributing to vaccine hesitancy, particularly among women, rural populations, and persons with existing diseases and disabilities. Like the elderly populations, rural populations reported barriers to access COVID-19 vaccines in all countries studied. In Mongolia, individuals with existing diseases, including persons with disabilities and their caretakers, showed concern that vaccines worsen their condition. Significant logistical and transportation barriers were reported for the herder populations in Mongolia, challenges that were deepened by travel restrictions and isolation. Women from these communities and identity groups face more extreme barriers due to intersecting inequalities.

There is some evidence in academic research that COVID-19 vaccine hesitancy is higher among women than men in countries like the Philippines (Cho et al., 2021). However, the findings from this research did not reveal any further insights into the scope and rationale behind such findings. Misinformation, rumor, and distrust deterred COVID-19 vaccination but influenced men and women equally. Even rumored side effects,

from weakened immunity to reproductive issues, were equally observed in men and women.

Some healthcare staff's refusal to be vaccinated against COVID-19 deeply influenced community trust in the vaccination and healthcare workers.

Some health workers did not want to introduce any virus, including the vaccine, into their bodies. As healthcare staff is overwhelmingly female across the region, specific attention should be given to understanding the rationale behind these decisions and better-educating healthcare professionals. Healthcare workers are role models in vaccination uptake.

While the sources of information about other vaccines observed gender differences, this was not the case with COVID-19 information.

Female participants reported some unique shifts in their primary sources of vaccination information. For example, women in Mongolia usually reported medical staff as their primary information source for vaccination. Still, in the case of COVID-19, they reported a much higher number of sources, including social media. Similarly, women in the Philippines also reported social media and family members as their primary sources of information during COVID, compared with schools and medical professionals being consulted about the HPV vaccine.

With the increased access to information came a desire for more choice over the vaccine maker.

In the early phases of the vaccine introduction, there were rumors about issues such as thrombosis, and death caused by certain vaccine makers. Moreover, citizens understand that certain vaccine ingredients are less halal than others. The population would like more information and autonomy over who makes the vaccine that they take.

2.3.4 Summary

The circumstances around COVID-19, its immediacy, global status, and emergent information created a unique situation where gender dynamics were not as readily ascribed to COVID-19 vaccination as to routine childhood vaccination and HPV. However, issues related to other identity vectors, especially age, location, ethnicity, religion, and disability, strongly impacted COVID-19 uptake. Due to intersecting inequalities, women from these groups face more extreme barriers. While COVID-19 showed a much more collaborative decision-making process among family members than is reported for other vaccinations, vaccination uptake was also driven by the need to meet job requirements and avoid other penalties, which may have driven some gendered outcomes. Women reportedly used a more varied set of information sources for COVID-19, with an increase in the role of social media, community members, TV and radio.



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Chapter 3

Gender Dynamics in Immunization Systems

Supply-side gender dynamics relate to structural, cultural, and institutional obstacles that hinder equitable health outcomes. These include the gender responsiveness of policies and legislation, clinic opening hours and infrastructure, healthcare worker salaries, and working conditions. These dynamics are critical components of how gender shapes the healthcare system and how the healthcare system understands and interacts with the community. Navigating barriers within the health system is a critical challenge that impacts the accessibility and effectiveness of healthcare services for diverse populations.

3.1 Policy and Coordination

While the constitutions of all countries uphold women's rights and all have ratified key international human rights instruments such as the Convention on the Elimination of Discrimination Against Women (CEDAW), immunization policies say little about gender.

- Indonesia's national policy of the Ministry of Health Regulation Number 12/2017 to administer immunization is largely technical and medical in scope and detail. The current National Medium Term Plan of Indonesia does mention women and the importance of mother and child health and sets a national immunization target of 90% by 2024. However, a gender strategy to aid implementation and reach the target was never developed.²⁶
- The Philippines also has an enabling framework for gender equality, but this did not make it into the national immunization policy, which also lacks a specific strategy for reaching populations facing the most barriers in accessing health

care, especially disadvantaged children, ethnic minorities, and rural populations.

- Mongolia's Law on Promotion of Gender Equality (2011) requires all sectors to have internal policies on gender and routine training. Some provinces have engaged in gender training and have some experience with gender-related budgeting. A national committee on gender equality was established in 2021 that focuses on cross-sectorial policy consultation and coordination consisting of different organizations. Mongolia is the only country that includes HPV vaccination for girls and boys in their national policy.
- In Lao PDR, Law No. 77/2019 gives specific attention to promoting gender equality in health care, as well as other areas²⁷ and the Law on Vaccination and Hygiene, Disease Prevention, and Health Promotion (2011) targets specific groups based on age and gender, including newborns, children under five, adolescents, fertile women, and pregnant women. Lao has also tried to reach out-of-school children (box 6). Despite this, various stakeholders confirmed that vaccinations in Lao PDR are distributed without much regard to gender. Healthcare policy is critical to determining the inclusion, accessibility, and affordability of vaccines, but all countries lack gender-responsive policies.²⁸

26 Veronica, Tiurma Juanita, Desk review: Gender analysis for COVID 19, HPV and routine childhood immunization programme in Indonesia, 2024.

27 UNDP Lao PDR, 'Gender equality strategy - UNDP 2022-2026', 2022, <https://www.undp.org/sites/g/files/zskgke326/files/2022-11/undp_lao_pdr_gender_strategy_and_action_plan_2022-2026-signed.pdf>, accessed 9 December 2024.

28 FGDs with health center medical staff and village volunteers, Vientiane capital.

Box 6: Lao PDR HPV spotlight

Lao PDR has implemented specific strategies to increase the inclusion of out-of-school children in vaccination strategies. These strategies involve conducting vaccination campaigns where health staff mobilize people to visit health centers or schools for vaccination. Previously, services were provided in villages with the coordination of village organizations, village leaders, and the Lao Women's Union to mobilize individuals, particularly girls, for vaccination. However, onsite services have budget limitations, which can be costly. Despite this, onsite services have shown higher vaccination rates. The government continues to strategize on how to reach all individuals, including those not attending school, for vaccination.²⁹

Although some countries have made notable efforts, more disaggregated data is needed to inform policies.

In Lao PDR, the 2021 Reproductive, Maternal, Newborn, Child, and Adolescent health policy and strategy sets a minimum set of indicator disaggregation that includes sex, age, ethnicity,

geographic location, and disability.³⁰ The Lao PDR SDNSS 2010-2020 Work Plan on gender statistics commits to producing statistics by gender at the national and provincial levels to address the lack of gender data as well as gender gaps in available data.³¹

In Mongolia, the National Statistics Commission collects sex-disaggregated data in specific locations as part of reporting requirements. However, official data on the HPV immunization rates by sex is unavailable.³² In Indonesia, a new electronic platform SMILE (System Monitoring Immunization Logistics (SMILE), tracks vaccine logistics and helps with data gaps. However, it is still being piloted.

In the Philippines, the 2010 Magna Carta of Women mandates 'the generation and maintenance' of a

30 World Bank, 'HANSA- Gender and Social Inclusion Related Data', 2021, <<https://documents1.worldbank.org/curated/en/099032024044228728/pdf/P17590619c7c69021a3e617d-35d02e096a.pdf>>, accessed 9 December 2024.

31 Bopha, S., 'The sex-disaggregated data produced by Lao National Statistical System,' Presentation at the 5th session of the ESCAP Committee on Statistics, 15-16 December 2016, <https://www.unescap.org/sites/default/d8files/Sex-disaggregated_data_Lao_PDR.pdf>, accessed 9 December 2024.

32 World Health Organization, 'Covid-19 pandemic fuels largest continued backslide in vaccinations in three decades' 2022, <<https://www.who.int/news/item/15-07-2022-covid-19-pandemic-fuels-largest-continued-backslide-in-vaccinations-in-three-decades>>, accessed 9 December 2024.

29 KII with UNICEF, Lao PDR.



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gender and development database, including 'gender statistics and sex-disaggregated data that have been systematically gathered, regularly updated, and subjected to gender analysis for planning, programming, and policy formation.'³³ However, tracking of this mandate shows that weaknesses remain in the collection, analysis, and reporting of sex-disaggregated data, particularly in health facilities, health outcomes, and reproductive health metrics.³⁴

In Indonesia, sex-disaggregated data is unavailable in official government immunization sources. Specifically, data for children aged six to 11 and 12 to 17 for doses three and four is unavailable. A new electronic platform SMILE (System Monitoring Immunization Logistics (SMILE) tracks vaccine logistics and helps with data gaps. However, health care worker workloads have increased as a result of the transition.

The lack of quality, disaggregated data that can track immunization rates by sex, disability, income, age, and geographical location further restricts the capacity to create policies to address these gaps.

3.1.1 Policymaker gender capacity

Policymakers cannot identify and create gender-responsive immunization policies. A comparative analysis of the survey data shows that perceptions regarding the gender awareness of policies and documents on routine childhood immunization, HPV vaccines, and the COVID-19 vaccine are quite low and segmented by the sex of the respondent in all countries (Annex, Tables 8, 9, & 10). Policymakers' confidence in their capacity to recognize and identify gender-responsiveness in immunization policies is lacking for male and female civil servants.

3.1.2 Financing and Coordination

Issues such as facility sanitation,³⁵ misdiagnoses, burnout, and a lack of trust in health care providers³⁶ were commonly reported and related to the lack of funding for immunization

33 Philippine Commission on Women, 'Magna Carta of Women'. RA 9710, 2010, <<https://cws.up.edu.ph/wp-content/uploads/RA-9710-Magna-Carda-of-Women.pdf>>, accessed 9 December 2024.

34 Open Data Inventory, 'Philippines 2020/2021' <<https://odin.akroninc.net/ReportCreator/ExportCountryReportUpdated/PHL/2020>>, accessed 9 December 2024; Data 2X, Open Data Watch, UNESCAP 'Gender and Data Policies: Philippines', 2021 <<https://data2x.org/wp-content/uploads/2021/04/BtG-Asia-Policy-Report-Philippines.pdf>>, accessed 9 December 2024.

35 FGD with female caregivers of two or more children under five years, Pidie.

36 FGD with female caregivers of adolescents, Aceh.

services. Government funding and support, along with assistance from international organizations, play a crucial role in maintaining the affordability of vaccines in many countries. Nevertheless, financial shortfalls reduce the time needed for coordination, vaccine supply, and the training and salary that can be provided to the workforce.³⁷ Box 7 illustrates an innovative approach to securing more gender-responsive findings for immunization in the Philippines.

Box 7 Spotlight on GRB in the Philippines

A robust national policy structure for gender-responsive budgeting (GRB) has existed in the Philippines since 1992. It requires that at least five percent of all budgets for national and local government units be allocated for gender-responsive programs.³⁸ These efforts remain challenged by uneven regional implementation, especially in BARMM, where lower allocations are made for gender-responsive programs compared to other regions.³⁹ Drawing from research on policy challenges for GRB in the Philippines, immunization policies can also be better designed to address institutional capacity limitations (where needed), build awareness and understanding of inclusive vaccination strategies and priorities at the local governmental level, and in attend to cultural and religious barriers that inhibit women's engagement in vaccination.

Increased collaboration can help governments when finances are short; governments do not need to operate in isolation. Non-government organizations and alliances such as GAVI can support governments to manage funding shortfalls. For example, in Indonesia, collaboration with local influencers, religious authorities (e.g., Indonesian Ulama Council), and professional organizations (e.g., Indonesian Midwives Association (IBI; Indonesian National Nurses Association (PPNI), and Komnas KIPPI) have been key in building trust and facilitating vaccine distribution, achieving significant coverage through educational campaigns and unified efforts. See box 8 for an overview of Lao PDR coordination efforts.

37 KII with UNICEF staff, Indonesia.

38 Ibid.

39 Moreno. 2023.

Underfunding the health care system means that patients experience low-quality services, long wait times, and a lack of privacy, thereby undercutting the goals of inclusion.⁴⁰

Reaching remote and nomadic populations requires extensive travel, often in harsh weather conditions and over difficult terrain, making the consistent delivery of health care services, including vaccinations, particularly challenging and costly.⁴¹ Key informants in Mongolia report that these limitations are also relevant to health care provision for persons with disabilities, particularly those located in rural areas.⁴² Participant reports from all four countries indicate that children with disabilities miss out on immunization. ‘Leaving no one behind’ is a central theme of the Sustainable Development Goals (SDGs), and without adequate funding for immunization, countries fall short of their commitments.

Box 8 Spotlight on Lao PDR Coordination Efforts

The Lao PDR Government has implemented comprehensive strategies to ensure vaccination services reach all areas, including remote regions. These strategies include providing vaccinations at health facilities and conducting outreach activities, such as one-day village trips and multi-day mobile team visits.⁴³ A micro-plan system requires health facilities to submit detailed vaccination plans to ensure comprehensive coverage. The National Immunization Program (NIP), under the Mother and Child Health Center, holds annual meetings to discuss plans, challenges, and gaps, ensuring vaccines reach all groups regardless of gender, ethnicity, or location.⁴⁴ For hesitant parents, provincial and district health authorities enlist the Mother and Child Committee, which includes members from various organizations who communicate in native languages to emphasize vaccination importance.

Improvements in onsite services in ethnic villages include timely announcements and collaboration with local organizations to mobilize villagers. Efforts to address immunization challenges in ethnic minorities involve targeted communication strategies using religious leaders and local influencers. UNICEF and WHO are developing specific strategies for routine immunization with the government and campaigns like the measles-rubella campaign.



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40 KII with UNICEF staff, Mongolia and KII with health care workers, Mongolia.

41 FGD with health care workers, Dornod, Mongolia.

42 KII with OPDs, and FGDs with Senior Citizens (Female), Mongolia.

43 KII with community health workers, Phongsaly province.

44 KII with the World Bank, Laos.

3.2 Health care system

Healthcare workers often operate in facilities with limited resources and inadequate infrastructure.

Many health centers lack sufficient space, affecting patient privacy and overall quality of care. In Mongolia, privacy is a critical issue when related to sexual and reproductive health, such as the HPV vaccine and sexually transmitted infections. In smaller communities, there is often no assurance of privacy, leading to widespread knowledge of individuals' health conditions, especially for young girls. This lack of confidentiality further discourages men from seeking health care and leaves women to bear the brunt of health-related stigma.⁴⁵ In Mongolia, it is common for health centers to have two doctors practicing in the same room, which produces issues regarding privacy and patient comfort. In response, many patients will either wait longer to ensure confidential treatment or will leave the center without being seen.⁴⁶

Female caregivers report logistical and service challenges at health centers that hinder their ability to access these services effectively.

In Mongolia, these challenges include managing long queues and waiting times, difficulties in scheduling appointments via phone or electronic systems, and the limited availability of health workers. The electronic registration system is often unavailable, leading to increased workloads for healthcare workers and longer client wait times. A quarter of male and female senior citizens surveyed in Lao PDR mentioned the barriers caused by not having separate waiting areas and restrooms for males and females. Long waiting times were also raised during interviews in Savannakhet and Vientiane. In Indonesia, the wait times for medical staff were also long, and caregivers, frequently mothers, were deterred. These wait times caused inconvenience and discomfort⁴⁷ and were sometimes linked to negative attributes of health care workers (e.g., indifference, rudeness).⁴⁸ In the Philippines, nepotism was listed as a contributing factor to long wait times, with health workers prioritizing acquaintances or those with influence over other patients, which leads to longer waiting times and reduced access to care for those without connections.⁴⁹ Various logistical and

service challenges culminate in all countries needing to streamline service delivery, improve gender responsiveness, and the collection of feedback from clients.

Stockouts are another consequence of weak service delivery.

A participant in Surabaya explained, *"When I was two months pregnant, it was difficult to get vaccines at the health center. There was a stock out, and we were scolded for going to a different community health center [to get the vaccine]."* While the Ministry of Health utilizes SMILE, an online electronic logistics monitoring system, the system's effectiveness depends on proper updates by all levels of healthcare centers:⁵⁰

Without proper planning regarding the quantity of vaccines needed, they may experience stockouts, meaning no vaccines are available. In such cases, the vaccination cannot proceed, and if there is no immediate solution to resupply the vaccines, the community members may return home and not return for vaccination."⁵¹

Limited vaccine supplies reduce vaccine uptake.

Respondents from the Philippines also reported regular stockouts across all three regions examined, especially for HPV and routine childhood vaccinations.⁵²

Respondents also complained that vaccine rollout dates are often only known at the last minute, leaving just a day for informing *barangay* households on the availability of vaccines and less than that for women to make the necessary arrangements to visit the center. Further, there are reports that some vaccines are "almost expired," putting pressure on households to get an injection quickly.⁵³ In Antique, male health workers reported that the vaccine supply delivery is only sufficient for 30 individuals, which does not last long—a lack of sufficient vaccination locations⁵⁴ and information compounds the shortage of vaccines. Health workers highlighted that patients sometimes do not know the center and instead go to private clinics where *"they need to pay, even though it should be free,"⁵⁵* indicating a gap in information dissemination. Outreach programs are crucial in

45 KII with Mongolian Association of Family Health Specialists.

46 KII with Mongolian Association of Family Medical Specialists, Ulaanbaatar.

47 FGD with male caregivers of first child under two years, Aceh.

48 FGD with female caregivers of adolescents, Aceh.

49 FGD with female caregivers of two or more children under 5

years, Manila. FGD with male caregivers with first child under two years, Manila.

50 KII with Ministry of Health.

51 KII with international organization, Jakarta.

52 FGD with male caregivers with two or more kids under five years, BARMM; FGD with male and female caregivers, Manila; KII, male health workers, Antique; KII with OPD, Manila.

53 FGD with female caregivers with two or more children under 5, Metro Manila.

54 KIIs with community influencers and medical societies, Antique.

55 FGD with male caregivers of adolescent girls, Metro Manila.

reaching remote populations, yet the campaigns lack gender-responsive planning and strategies specifically for adolescent girls in rural health centers.^{56 57}

Neither gender is satisfied with the quality, reliability, and accessibility of immunization outreach and education materials. Across all countries, the most prominent barrier identified by both men and women government representatives is the inadequacy of vaccination information, with many respondents indicating that the knowledge provided needs to be sufficiently informative and reliable. In Mongolia and the Philippines, many respondents expressed concerns about the reliability and accessibility of vaccination information, which undermines trust and compliance with vaccination efforts. In the Philippines, a key healthcare informant highlighted the challenge of communicating vaccine information to individuals with lower education levels or illiteracy:

“Regarding the complex understanding of vaccines, it is challenging for people with lower education levels. Often, speakers use language that is difficult for these individuals to understand, making it harder to convince them to immunize their children. Simplified language is crucial in these cases.”

In Lao PDR, lack of literacy and knowledge of the Lao language was also a barrier, likely to unfairly impact women given the large gender gap in literacy in Lao (92 percent for men versus 83 percent for women in 2022) and ethnic minorities.⁵⁸ The quality and accessibility of these materials are a front-line defense against misinformation that promotes fear and rumors.

3.3 The Health Workforce

Various issues with the health workforce were uncovered. The Philippines and Lao PDR participants expressed needing more staff and better facilities and equipment. As a school teacher from Lao PDR noted, *“The health center should increase the number of medical staff. Currently, there are very few medical staff at the health center, only*

three people.” In Lao PDR, male caregivers were specific in identifying the lack of support and follow-up by medical staff, particularly when side effects occur, which feeds a lack of trust in the vaccination process.⁵⁹ Other respondents complained about the distance to health clinics and transport costs, which became more problematic during AEFI. Travel costs to district hospitals can be significant, with a Lao PDR participant estimating these costs between USD 25 and 50.⁶⁰ Should a child develop an adverse reaction or side effect requiring medical attention, these costs continue to mount.⁶¹

High workloads and burnout among healthcare workers are a source of deep strain on the healthcare system, with specific impacts on maintaining service delivery, conducting outreach programs, and managing vaccine distribution. As women comprise an estimated 67 percent of the workforce in the Asia-Pacific region’s health and social work sector,⁶² such burnout directly impacts their employment standards and access to quality care. This is exacerbated by the additional responsibilities of outreach programs and managing vaccine distribution in remote areas. To deliver outreach services, healthcare workers must travel and often stay overnight, straining scarce health center resources.⁶³

In addition to the burnout experienced by healthcare workers, female workers must balance a dual workload of professional responsibilities and unpaid household chores. In Lao PDR, for example, one key informant reported that *“Healthcare workers depend heavily on volunteers, raising concerns about sustainability and equity, as these volunteers deserve proper remuneration.”*⁶⁴ Low salaries compel healthcare workers to seek additional income, impacting their livelihoods and leading to burnout. The added burden of unpaid household chores, such as cooking, cleaning, and caring for their own families, leaves them with limited time and energy to dedicate to additional tasks, such as educating families about vaccine side effects. The idea of flexible working hours and a family-friendly workplace has not yet been socialized. These constraints impede their ability to

56 KII with health care workers, Dundgovii, Mongolia and KII with National Center on Gender Equality, KII with World Bank, Mongolia, KII with Mongolian Association of Family Medical Specialists.

57 KII with UNICEF representative, Ulaanbaatar.

58 World Bank Group, ‘Literacy rate, adult male & female (% of males and females ages 15 and above), by sex’, <<https://data.world-bank.org/indicator/SE.ADT.LITR.ZS?display=defa&locations=XD>>, accessed 24 April 2024.

59 FGD with male caregivers of adolescent girls, Vientiane.

60 Ibid.

61 FGD with female caregivers of adolescent girls, Phongsaly.

62 International Labour Organisation, Asia-Pacific Sectoral Labour Market Profile: Health and social work, ILO Brief, 2022.

63 KII with health workers, Mongolia, KII with UNICEF representatives, Mongolia.

64 KII with representatives from the National Center for Mother and Child Health.

provide comprehensive education and support to the community, affecting vaccination uptake.

Healthcare workers need a safe working environment. In the Philippines, cultural norms in some regions prevent Muslim girls from being vaccinated by male health providers, meaning female health workers must do the outreach.⁶⁵ Female health workers, especially those in outreach, need safe accommodation and support, which are often inadequate in rural and remote locations.⁶⁶ For example, healthcare workers from Indonesia, Lao PDR, and the Philippines report experiencing sexual and other forms of harassment in the course of their duties, primarily from patients and other service users. Additionally, female health workers sometimes face hostility and threats from community members who are resistant to vaccination efforts. When these health workers travel, they must work in unpredictable and isolating circumstances without their colleagues' support. The incidence of harassment and violence against healthcare workers underscores the importance of developing policies to prevent sexual exploitation and abuse (PSEA).

Female healthcare workers often face male-dominated power structures at the village level, which can impede efforts to reach vulnerable populations. These structures, particularly around predominantly male religious and village leaders, wield substantial influence over public opinion and decision-making processes. This, in effect, allows these men to play a 'gatekeeper' role that allows them to interfere in health care service delivery. This power imbalance puts women in dangerous situations. It creates mental stress for female health workers, who must work through such issues to gain the necessary support and trust from these male leaders to disseminate vaccination information and mobilize the community effectively.

Discriminatory perceptions fuelled by traditional gender norms may also create an unfriendly working environment. These perceptions, including beliefs that men perform better, have higher capabilities, or are better drivers, contribute to undercutting women health care workers' capacity to work effectively in a community. For example, in Lao PDR, a community health worker in Savannakhet stated that *"most of the village volunteers are men, but men do the job better than women."* Examining all health worker policies to insert anti-discrimination clauses, PSEA, equal pay for equal work, equitable

promotion, and family-friendly policies are needed.

3.3.1 Training and Health Care Worker Support
Healthcare workers provide pivotal front-line interactions that can deepen or remove gender dynamics in vaccination, depending on their training. In Lao PDR and Indonesia, participants generally reported positive experiences with health care providers, noting kindness, good communication, and clean facilities, although there are occasional issues with rudeness.⁶⁷ In Metro Manila, adolescent girls reported feeling comfortable at health centers due to the friendliness and professionalism of the staff.⁶⁸ Thus, when healthcare workers can provide the right service that is age, gender, disability, and ethnic sensitive, vaccine uptake ensues.

However, participants in Indonesia also mentioned that health workers prioritize quotas more than the health of the community members. A male carer of adolescent girls in Aceh said, *"Health workers only chase targets; come to us [community] if they need to target polio coverage. However, when we visit a health facility, they are slow. That disappoints us."* Participants often feel that health workers prioritize quotas more than the health of the community members.

Discrimination against patients can take many forms, including preferential treatment and favoritism, which can unduly impact persons from marginalized communities. In Mongolia, the study highlights several instances of discrimination against women, particularly regarding access to health care and the right to privacy. Pregnant adolescents, for example, face stigma and discrimination from health workers, which extends to other domains such as school and the workplace, leading to further marginalization, especially for those from low-income families. The fear of discrimination often deters young women from seeking essential antenatal care at family health centers, compromising their health and that of their unborn children. As women are less likely to hold positions of influence, female patients are more reluctant to complain about the services they receive than men.

Women with disabilities face even greater violations of human rights and privacy. Instances where the rights of pregnant women with disabilities were disregarded have been recorded. Doctors bypassed women's right to privacy by directly contacting caregivers to determine the safety of delivery. This invasive practice not only undermines

⁶⁵ KII with health workers, BARMM.

⁶⁶ KIIs with community health workers in Phongsaly province, Lao PDR.

⁶⁷ FGDs with non parenting adolescent girls, Vientiane capital.

⁶⁸ FGD with adolescent boys, Metro Manila, Philippines.

the autonomy of women with disabilities but has also led to the separation of couples, further highlighting the effects of discrimination.⁶⁹

Many healthcare workers, especially women, lack adequate training and ongoing professional development opportunities, which limits their ability to follow best practices and medical advancements and to provide confident, informed medical advice to their clients.⁷⁰ In Lao PDR, healthcare workers reported that this lack of confidence and training leads to job dissatisfaction. A lack of support from the health care system, including insufficient supervision and mentorship and inadequate facilities, negatively impacts morale and job performance and can support high turnover rates. Health workers are not routinely provided training related to gender dynamics in health care, gendered issues in vaccination, or the prevention of sexual exploitation and abuse. A health office representative from Surabaya in Indonesia noted, *“Training is not gender-based; we focus on technicalities such as ensuring safety in the vaccination process, but not on capacity building in vaccination and gender itself.”* The survey results support this finding by showing that health workers of both sexes perceive a clear gender order in messaging for routine childhood immunization: mothers are the primary focus, followed by fathers, grandmothers, and finally, grandfathers.

Trained and knowledgeable healthcare workers can improve patient experience and trust in the healthcare system. In the Philippines, women patients reported increased feelings of safety and trust for workers after workers had undergone gender-sensitivity training.⁷¹ Such training may go a long way to addressing the trust for healthcare workers in countries like Indonesia, Lao PDR, and Mongolia, where patients, especially female adolescents and senior citizens, reported experiencing discrimination or stigmatization from their healthcare workers.⁷²

3.4 Summary

This section has presented a detailed analysis of the supply-side gender dynamics in immunization

systems. An enabling environment for gender-responsive policies exists and should be operationalized through gender-responsive action plans and policies. Good examples across the region can be shared and replicated as relevant. Policymakers do not have adequate gender knowledge to do this, and neither do healthcare workers. The policy environment lacks gender-responsive provisions such as PSEA, equal pay for equal work, family-friendly and flexible working arrangements, mentoring and training, and the sex-disaggregated data needed to advocate for changes.

Gender discrimination in health care services is common and applies to women and girls as patients, particularly women with disabilities and pregnant adolescents, as well as women healthcare workers. Traditional gender roles fuel these types of discrimination, which impacts women and girls' capacity to receive quality health care (and vaccination) and health care workers' capacity to deliver quality health care, particularly to vulnerable communities. These norms also impact male health workers, such as when facing issues related to giving health care to female clients. The need for increased funding for gender-responsive immunization and infrastructure, including health worker salaries and protection, is evident.

69 KII with OPDs, Dundgovi Mongolia.

70 KII with hHealthcare worker, Mongolia; FGDs with health workers in all four countries.

71 KII with community influencers, Antique, The Philippines, FGD with community health workers, BARMM, The Philippines.

72 KII with UNICEF, Mongolia, FGD with female care givers of adolescents, Dundgovi, Mongolia; FGD with health workers at Health center in Vientiane capital, Lao PDR.

Chapter 4

Conclusions & Recommendations

Immunization is a crucial public health intervention, preventing diseases and saving lives. It includes developing and distributing vaccines, educating and engaging communities, addressing barriers to ensure equitable access, enhancing health systems, and building resilient infrastructure for overall health and prosperity. Reaching zero dose, children will decrease child mortality and support the achievement of the Sustainable Development Goals. The comprehensive analysis of gender and immunization programs in Indonesia, Lao PDR, Mongolia, and the Philippines unveils many barriers that impede equitable vaccine access, uptake, and opportunities for change. The barriers are rooted in gender norms, socio-economic factors, and structural challenges. These collectively shape the complex vaccination landscape in each country. Understanding the barriers and enablers is crucial for developing targeted strategies to enhance immunization coverage and ensure that all communities, particularly the most vulnerable, can benefit from essential health services. Opportunities for change were also found, along with examples across the region of good practices (see boxes 5-8). These relate to innovative outreach strategies or gender-responsive policymaking.

4.1 Supply-side recommendations

Policy and regulatory system:

- **Immunization policies must include gender-responsive targets and strategies.** Designing effective gender-responsive strategies requires ensuring the availability of gender analysis of program needs and design.
- Policymakers require training on how to design and implement gender-responsive policies.
- Regional dialogues and south-south collaboration can help share the region's best practices that increase immunization coverage.
- Ensure strong commitment from government leaders to advocate for and implement gender-responsive policies.
- Healthcare policies should emphasize privacy, confidentiality, and consent rights for all patients and the importance of building gender-sensitive rapport and sharing side effect information.
- Immunization policies should include ways to prevent the sexual exploitation and abuse of the health workforce, offer better pay for healthcare workers, and include family-friendly provisions such as flexible working hours, carers' leave, etc.
- Additional efforts are needed to ensure data is collected, disaggregated by sex, age, ethnic background, and disability, and analyzed according to these categories to inform policy and practice better.
- Review parental consent practices and policies for HPV and mandate assent by adolescent girls.
- Amend the regulatory system to ensure the inclusion of minority communities (e.g., Kazakh communities) in national identity documentation and immunization systems to ensure their access to health care services.

Healthcare system:

- Adequate healthcare system funding is needed to ensure that health centers can provide private and confidential vaccination services and reach low-dose communities through outreach services.
- **All healthcare centers should have policies on the prevention of sexual abuse and exploitation that stipulate a zero-tolerance approach.** This should concern workers within the healthcare system as employees and protect women when in the community delivering outreach services. Training on these policies should follow.
- Healthcare workers should be paid a decent wage. In these countries, women face a wage gap compared to men, and the healthcare system should not perpetuate this practice by paying women less.
- All healthcare workers must be trained to provide nondiscriminatory, respectful, and confidential care, especially for pregnant women, adolescents, and persons with disabilities, including through

regular training and refresher courses.

- Strategies must be developed to address burnout and worker overload among healthcare workers, especially those in rural and remote communities. When well-trained healthcare workers spend more time with patients explaining AEFI, the benefits of vaccination, and the schedule, trust, and vaccination uptake will ensue.
- Health workers should be encouraged and supported to allocate additional time during regular consultations to inform caregivers, especially caregivers, about childhood immunization and its benefits and side effects. Ensure that performance rewards are linked to the quality of care and patient feedback, not only the number of vaccinations administered.
- Healthcare providers should increase feedback channels. More feedback from women and communities (particularly rural, ethnic minorities, and persons with disabilities) will increase the healthcare system's ability to respond to their needs. This may include gathering information on reducing financial and time burdens on families, particularly women.

4.2 Demand-side recommendations

Community

- Adopt an inclusive approach to leaving no one behind by targeting and increasing resources to zero-dose and low-dose communities. Publicly

recognize high-dose communities and consider having low-dose communities visit these areas to learn from their outreach strategies.

- Strong spiritual and superstitious beliefs exist in all countries. If misinformation and skepticism are not addressed, low vaccination coverage will persist. Campaigns should be designed to reduce stigma and educate communities on supporting all groups in accessing health care, including adolescents and other marginalized groups (e.g., children with disabilities, ethnic minorities, etc.).
- Vaccination information dissemination needs to be reliable, accessible, and informative. It must also be delivered in clear (local) language(s) and use analogies, case studies, and visual aids to communicate effectively with those with lower literacy levels.
- Work with ethnic leaders to validate materials before dissemination. Create leadership cohorts within each ethnic group, or as needed, to help guide development and strategy within each community. Ensure females and males are represented equally. Weave leadership and gender sensitivity training into meetings.
- Since COVID, the population has become more aware of how vaccinations are produced—rumors spread about where vaccines are made and with what ingredients. Informing the public about these differences and giving them an informed choice of vaccines may increase trust in vaccines and the health system.
- A public awareness campaign just for the HPV vaccine should be designed and implemented to



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clearly explain the importance of vaccination for adolescent girls and boys. It is prudent to have adolescents help design this campaign.

- Integrate a comprehensive health education curriculum in schools and partner with schools and educational institutions while developing and rolling out the curriculum.

Household

- Festivals and ceremonies are common and accepted reasons for coming together in these communities. Utilize this to increase vaccination coverage and incentivize households to vaccinate. For example, host family fun days during vaccination campaigns and give out vouchers, samples, or toys for children when they are vaccinated.
- These countries strongly emphasize family and community solidarity, with respect for elders as a cultural norm. Tapping into these values can enhance vaccination outreach. Working with an elder 'champion' in each community, discussing community protection through vaccination, and strategizing how to hold vaccination clinics on-site to minimize work-time loss and ease household vaccination management may be avenues to explore.
- Encourage collective care for children during and after vaccination and collective decision-making.

Individual

- All communications developed around immunization should portray men as carers and aim to target men *and* women. The current norm is to target women, which stereotypes them as caregivers, and in reality, men are making many vaccination decisions.
- Outreach efforts must focus on engaging and

educating men about childhood vaccination. These programs can be father support groups or workplace outreach programs. They should recognize men as critical partners in vaccine decision-making within households and encourage them to take their children for vaccination and care for them afterward.

- Engage male role models and influencers to promote health-seeking behaviors among boys. These role models can share personal stories and emphasize the importance of regular health check-ups and vaccinations.
- Word of mouth remains an important communication tool in remote and traditional societies and for those whose mother tongue is not the lingua franca. In these communities, social media and mass media campaigns may not be as effective (and the media tends to perpetuate gender inequities). Ask individuals to share positive vaccination stories and recruit community leaders as vaccination advocates.
- Develop family case studies to share with caregivers about the benefits of childhood immunization in preventing diseases. These could be in large fonts and pictures and given to parents to take home and share with all family members. Include examples of successfully addressing side effects.
- Adolescents out of school require specific interventions to reach them with vaccination information.

The challenges are great, but there are also great examples and opportunities for change. Vaccination coverage can increase in the EAPRO region with enhanced collaboration and a gender-responsive approach.



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ANNEX 1

Country-specific limitations

Limitations specific to Indonesia:

- **Low participation rates:** Fewer respondents, especially women, with group discussions having five to six instead of eight to ten participants.

Limitations specific to Lao PDR:

- **Unavailability of the key informants:** Despite repeated follow-ups, key informants were unavailable for consultation.
- Apart from the Lao Women's Union, there are no other women-based organizations to be interviewed.⁷³
- **Missing sex data in government participants' profiles:** The Government participants' survey responses did not include answers to the 'sex of the participants' question in the socio-demographic profile section.
- **Low participation rates:** Fewer respondents, especially women, with group discussions having five to six instead of eight to ten participants.
- **Language barrier:** The enumerators required an interpreter to conduct interviews in certain communities. By involving interpreters, the enumerators could engage more effectively with communities, fostering better understanding and rapport. This approach helped bridge language barriers and include voices otherwise excluded; it also represents one additional area between the enumerator and respondent where information could have been lost or misrepresented.

Limitations specific to Mongolia:

- **Limited HPV awareness and data collection challenges:** One-third of the questions in interviews, focus groups, and surveys focused on HPV. However, since the vaccine has only been piloted in Mongolia (2012) and not officially administered, participants were largely unfamiliar with HPV.
- **Challenges in engaging male caregivers:** Data collection was difficult due to low participation from male caregivers. Participants often arrived late or left early, affecting the focus group discussions' effectiveness.
- **Government staff's reluctance to participate in surveys:** Due to the ongoing parliamentary election in Mongolia, government staff hesitated to complete online surveys and disclose personal details. Some key informants also refused voice recording. Without a recording, data collected from these informants cannot be presented as quotations and can only be summarized with other data sources.

Limitations specific to the Philippines:

- **Survey response shortfall:** Targets were unmet due to flooding and heavy rains in BARMM and Antique, varied government coordination timeframes across provinces, and jurisdictional changes in BARMM, including developing a new municipality affecting fieldwork permissions.

⁷³ The Lao Women's Union was established by the government in 1955 and recommitted with the 2009 Decree of Associations which allowed, for the first time, the registration of local NGOs. As a result of this relatively recent legality of local NGOs, the established presence of INGOs in the country, and the continuing evolution of government and civil society cooperation, few local NGOs are active and developed enough to participate in this research. These relations were once again strained when the government passed an act allowing NGOs to be criminally liable in the 2018 Penal Code, further complicating the establishment of local NGOs. As a result, the Lao Women's Union is the only sanctioned, operational women's organization, boasting a membership of over 1 million women across the country. Sources: ADB ["Lao PDR: Country Partnership Strategy 2012-2016: Civil Society Analysis."](#) FAOLEX database ["Women's Union Law"](#) 2009; ["Laos introduces corporate criminal liability"](#) VDB Loi, December 22, 2020.

ANNEX 2

Data tables derived from survey results

Table 1: Who is responsible for child immunization decisions in your house?

Indonesia	Adolescent girls (n=21)	Adolescent boys (n=25)	Female caregivers of 1st child under 2 years (n=9)	Female caregivers two or more children under 5 years (n=7)	Male caregivers 1st child (under 2) (n=2)	Male caregivers two or more children under 5 (n=3)	Male Senior citizens (n=5)	Female senior citizens (n=7)
Father	24%	36%	11%	0%	50%	33%	20%	14%
Grandmother	0%	0%	0%	0%	0%	33%	0%	0%
Mother	71%	56%	78%	100%	50%	33%	80%	71%
Others	5%	8%	11%	0%	0%	0%	0%	14%
Lao PDR	Adolescent girls (n=9)	Adolescent boys (n=6)	Female caregivers of 1st child under 2 years (n=4)	Female caregivers two or more children under 5 years (n=6)	Male caregivers 1st child (under 2) (n=6)	Male caregivers two or more children under 5 (n=10)	Male Senior citizens (n=5)	Female senior citizens (n=4)
Father	22%	67%	0%	17%	50%	60%	60%	25%
Mother	78%	33%	50%	50%	50%	20%	0%	25%
Parents	0%	0%	50%	33%	0%	20%	40%	50%

Table 1: Continued

Mongolia				Female caregivers two or more children under 5 years (n=5)	Male caregivers 1st child (under 2) (n=3)	Male caregivers two or more children under 5 (n=2)		
Father				20%	33%	100%		
Mother				80%	33%	0%		
Others				0%	33%	0%		
The Philippines	Adolescent girls (n=6)	Adolescent boys (n=6)	Female caregivers of 1st child under 2 years (n=8)	Female caregivers two or more children under 5 years (n=6)	Male caregivers 1st child (under 2) (n=6)	Male caregivers two or more children under 5 (n=4)	Male Senior citizens (n=6)	Female senior citizens (n=6)
Father	17%	17%	25%	33%	33%	25%	33%	0%
Grand-mother	17%	0%	0%	0%	17%	0%	0%	0%
Mother	67%	83%	75%	67%	33%	75%	67%	100%
Others	0%	0%	0%	0%	17%	0%	0%	0%

Table 2: I lack the confidence to make an informed decision on vaccinating my children

	Indonesia			Lao PDR		Mongolia	The Philippines	
I lack the confidence to make an informed decision on vaccinating my children	Female caregivers of 1st child under 2 years (n=9)	Female caregivers two or more children under 5 years (n=7)	Female care-givers of 1st child under 2 years (n=4)	Female caregivers two or more children under 5 years (n=6)	Female caregivers two or more children under 5 years (n=5)	Female caregivers of 1st child under 2 years (n=8)	Female caregivers two or more children under 5 years (n=6)	
Strongly agree	0%	29%	25%	33%	0%	0%	50%	
Agree	33%	29%	50%	67%	20%	25%	17%	
Neutral	11%	0%	0%	0%	20%	0%	0%	
Disagree	0%	14%	25%	0%	40%	25%	17%	
Strongly disagree	56%	29%	0%	0%	20%	50%	17%	

Table 3: I have access to the following information on vaccines

Indonesia	Female caregivers of 1st child under 2 years (n=9)	Female caregivers two or more children under 5 years (n=7)	Male caregivers 1st child (under 2) (n=2)	Male caregivers two or more children under 5 (n=3)
Immunization schedule	56%	29%	0%	33%
Where to go for immunizations	89%	86%	100%	33%
Why immunizations are important	56%	71%	100%	33%
How to track immunizations I have received	56%	57%	100%	0%
Facts about the immunizations	44%	57%	50%	33%
Lao PDR	Female caregivers of 1st child under 2 years (n=4)	Female caregivers two or more children under 5 years (n=6)	Male caregivers 1st child (under 2) (n=6)	Male caregivers two or more children under 5 (n=10)
Immunization schedule	50%	67%	83%	20%
Where to go for immunizations	100%	100%	50%	100%
Why immunizations are important	0%	17%	17%	0%
How to track immunizations I have received	0%	0%	17%	0%
Facts about the immunizations	25%	0%	0%	0%

Table 3: Continued

Mongolia		Female caregivers two or more children under 5 years (n=5)	Male caregivers 1st child (under 2) (n=3)	Male caregivers two or more children under 5 (n=2)	
Immunization schedule		40%	100%	100%	
Where to go for immunizations		40%	33%	100%	
Why immunizations are important		60%	33%	50%	
How to track immunizations I have received		0%	33%	50%	
Facts about the immunizations		20%	33%	100%	
The Philippines		Female caregivers of 1st child under 2 years (n=8)	Female caregivers two or more children under 5 years (n=6)	Male caregivers 1st child (under 2) (n=6)	Male caregivers two or more children under 5 (n=4)
Immunization schedule	75%	83%	67%	75%	
Where to go for immunizations	50%	50%	50%	50%	
Why immunizations are important	75%	67%	33%	25%	
How to track immunizations I have received	25%	50%	50%	25%	
Facts about the immunizations	75%	33%	17%	25%	

Table 4: Adolescent responses to the question “Who is responsible for HPV vaccination decisions in your house?”

Who is responsible for HPV vaccination decisions in your house?	Indonesia		Lao PDR		The Philippines	
	Adolescent girls (n=21)	Adolescent boys (n=25)	Adolescent girls (n=9)	Adolescent boys (n=6)	Adolescent girls (n=6)	Adolescent boys (n=6)*
Mother	57%	60%	89%	17%	83%	33%
Father	24%	28%	11%	83%	0%	17%
Grandmother	0%	0%	0%	0%	17%	0%

*These data columns do not add to 100% as the survey respondents were given additional selection choices (e.g., grandfathers, others). These minority choices have not been included in this table.

Table 5: Caregiver responses to the question “Who is responsible for HPV vaccination decisions in your house?”

Who is responsible for HPV vaccination decisions in your house?	Indonesia		Lao PDR		The Philippines	
	Female caregivers of adolescent girls (n=12)	Male caregivers of adolescent girls (n=7)	Female caregivers of adolescent girls (n=10)	Male caregivers of adolescent girls (n=4)	Female caregivers of adolescent girls (n=7)	Male caregivers of adolescent girls (n=4)
Self	17%	43%	60%	75%	100%	50%
Spouse	75%	57%	30%	0%	0%	50%
Joint decision by spouses	0%	0%	0%	25%	0%	0%
Don't know	0%	0%	10%	0%	0%	0%

Table 6: I have access to the following information on HPV vaccines

I have access to the following information on HPV vaccines	Indonesia		Lao PDR		The Philippines	
	Adolescent girls (n=21)	Adolescent boys (n=25)	Adolescent girls (n=9)	Adolescent boys (n=6)	Adolescent girls (n=6)	Adolescent boys (n=6)
Immunization schedule for adolescents	33%	28%	11%	33%	33%	50%
Where to go for immunizations	24%	20%	11%	50%	33%	33%
Why immunizations are important	52%	40%	56%	50%	50%	83%
How to track immunizations I have received	19%	12%	33%	0%	0%	17%
Facts about the immunizations	19%	12%	0%	33%	0%	33%

Table 7: Only female health workers should give the HPV vaccination

On a scale of 1-5, to what extent do you agree with this statement: “only female health workers should give the HPV vaccination”?	Adolescent girls	Adolescent boys	Female caregivers of adolescent girls	Male caregivers of adolescent girls
Indonesia				
Strongly agree/agree	43%	36%	83%	43%
Neutral	24%	12%	0%	0%
Strongly disagree/disagree	24%	20%	16%	43%
Don't know	10%	32%	0%	14%
Lao PDR				
Strongly agree/agree	67%	84%	30%	50%
Neutral	0%	0%	10%	25%
Strongly disagree/disagree	33%	17%	50%	25%
Don't know	0%	0%	10%	0%

Table 7: continued

On a scale of 1-5, to what extent do you agree with this statement: “only female health workers should give the HPV vaccination”?	Adolescent girls	Adolescent boys	Female caregivers of adolescent girls	Male caregivers of adolescent girls
Mongolia				
Strongly agree/agree	NA	NA	50%	NA
Neutral	NA	NA	50%	NA
Strongly disagree/disagree	NA	NA	0%	NA
Don't know	0%	0%	0%	0%
The Philippines				
Strongly agree/agree	67%	33%	43%	100%
Neutral	17%	33%	29%	0%
Strongly disagree/disagree	0%	17%	28%	0%
Don't know	17%	17%	0%	0%

Table 8: On a scale of 1-5, to what extent are policies and documents on routine childhood immunization gender-responsive?

On a scale of 1-5, to what extent are policies and documents on routine childhood immunization gender-responsive?	Government	Government - Female	Government - Male
Very large extent/large extent - Indonesia		52%	43%
Very large extent/large extent - Lao PDR	80%		
Very large extent/large extent - Mongolia		9%	34%
Very large extent/large extent - The Philippines		88%	64%

Table 9: On a scale of 1-5, to what extent are policies and documents on HPV vaccines gender-responsive?

On a scale of 1-5, to what extent are policies and documents on HPV vaccines gender-responsive?	Government	Government - Female	Government - Male
Very large extent/large extent - Indonesia		67%	72%
Very large extent/large extent - Lao PDR	80%		
Very large extent/large extent - Mongolia		9%	0%
Very large extent/large extent - The Philippines		58%	45%

Table 10: On a scale of 1-5, to what extent are policies and documents on COVID-19 vaccines gender-responsive?

On a scale of 1-5, to what extent are policies and documents on COVID-19 vaccines gender-responsive?	Government	Government - Female	Government - Male
Very large extent/large extent - Indonesia		57%	58%
Very large extent/large extent - Lao PDR	73%		
Very large extent/large extent - Mongolia		0%	50%
Very large extent/large extent - The Philippines		71%	45%

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