

GENDER ANALYSIS OF BARRIERS TO IMMUNIZATION IN AFGHANISTAN

A Desk Review

The Gender Analysis of Barriers to Immunization in Afghanistan was commissioned by the UNICEF Regional Office for South Asia and authored by Abha Shri Saxena, Consultant Gender Specialist.

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ACRONYMS

BCG	Bacillus Calmette–Guérin vaccine
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
DFA	De Facto Authority
DTP	Diphtheria, Tetanus and Pertussis vaccine
EPI	Expanded Programme on Immunization
GBV	Gender-Based Violence
HPV	Human Papillomavirus
IDP	Internally Displaced Person
IPV	Inactivated Polio Vaccine
MCV	Measles-Containing Vaccine
NGO	Non-Governmental Organization
PCV	Pneumococcal Conjugate Vaccine
PSEAH	Protection from Sexual Exploitation, Abuse and Harassment
ROSA	UNICEF Regional Office for South Asia
SDG	Sustainable Development Goal
UNICEF	United Nations Children’s Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

Gender roles, norms and relations significantly influence factors related to health risks, access to resources, decision-making and prioritization of health needs, including participation in immunization programmes. Gender intersects with multiple socioeconomic, geographical and cultural factors, further impacting vaccine accessibility and distribution. Addressing the impact of gender on immunization programme performance is crucial to enhance coverage, especially for zero-dose children and among overlooked communities.

Discriminatory gender norms impact female health service providers' ability to reach women and children, hindering the establishment of a well-functioning healthcare system. Limited access to health information and poor literacy levels hinders both men's and women's understanding and usage of immunization services. Lower education levels for women and their limited health literacy contribute to immunization disparities, as maternal education directly correlates with child health and immunization outcomes.

In the current political and economic climate in Afghanistan, restrictions have been imposed on female education, mobility and employment, resulting in rising illiteracy, worsening health outcomes and skewed decision-making dynamics within households that may lead to long-term disempowerment, inequality and reduced female participation in immunization programmes. The economic situation has worsened due to restrictions on women, resulting in job losses, salary cuts and the closure of women-owned businesses. Women-headed households, and families reliant on women as primary breadwinners, face heightened economic challenges. This further disempowers them and impacts immunization coverage.

Security concerns also pose significant challenges to immunization coverage and equity. Female health workers face hostility, threats and attacks, leading to high turnover and limited provision of health services. Gender-based violence (GBV), sexual exploitation, abuse and harassment also affect female frontline workers and caregivers accessing immunization services. Understanding and addressing these gender barriers is essential to enhance immunization coverage.

The report provides key findings on gender barriers to immunization in Afghanistan to help advance the Immunization Agenda 2030, which aims to halve the number of unvaccinated zero-dose children by 2030. The assessment aims to obtain evidence on existing gender-related supply-and-demand barriers to immunization to inform programmatic decisions that will advance immunization coverage in the country.

KEY FINDINGS

Afghanistan faces significant challenges in immunization coverage

1 Full immunization coverage is as low as 36.2 per cent.¹ The country has the lowest coverage in South Asia for five basic childhood vaccines: diphtheria, tetanus and pertussis (DTP), pneumococcal conjugate vaccine (PCV), rotavirus, measles and human papillomavirus (HPV).² Afghanistan, along with Pakistan, is one of the last remaining countries where polio is still endemic.³

The Humanitarian Needs Overview 2023 identifies several vulnerable groups

in Afghanistan, including internally displaced persons (IDP), vulnerable migrants, cross-border returnees, those affected by natural disasters and refugees. Within these groups, women, older individuals, adolescents, youth, children, people with physical and mental disabilities, refugees and migrants are particularly marginalized.⁴

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Certain provinces are more marginalized and require special attention

3 Kandahar, Paktya, Jozjan, Khost, Helmand, Urozgan, Paktika, Zabul, Panjshir, Kabul, Kunar, Nooristan, Kapisa and Bagdis face particular challenges in achieving comprehensive vaccination coverage.

The health landscape in Afghanistan presents significant challenges for women,

both as patients and as health care providers. Only 10 per cent of women can meet their basic health needs, compared to 27 per cent of men. Cultural norms and gender segregation limit women's access to care and professional opportunities. The 2021 takeover by the De Facto Authority (DFA) and subsequent restrictive edicts have exacerbated these issues, making it harder for non-governmental organizations (NGOs) and United Nations agencies to provide services and for women to access essential health care. Only a fifth of healthcare workers are

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¹ ARTE, UNICEF, *Afghanistan Multiple Indicator Cluster Survey (MICS 2022–2023): Summary Findings Report*, Kabul, 2023, available at: https://www.unicef.org/afghanistan/media/8501/file/MICS_Executive_Summary_Report_2023.pdf

² UNICEF, "Data: Monitoring the Situation of Women and Girls", <https://data.unicef.org/countdown-2030/country/Afghanistan/2/>, accessed 2023.

³ Global Polio Eradication Initiative, "Endemic Countries", <https://polioeradication.org/where-we-work/polio-endemic-countries/>, accessed 2023.

⁴ UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at: <https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

women, and the prohibition on girls' education by the DFA has put the future of female health-care provision at risk.

Gendered barriers to health and immunization services exist at multiple levels,

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and impact both demand and supply. Some of these barriers are now emerging as fallout from the DFA takeover in 2021 and subsequent restrictions that are directly impeding efforts to achieve gender equality. At the individual and household level, discriminatory norms, limited education and health literacy and economic marginalization and poverty pose significant challenges. At the community level, security concerns, gendered spatial risks and vaccine hesitancy hinder immunization services. Within the health system, the ban on door-to-door vaccination, challenging working conditions for female health-care workers, suboptimal health service provision and limited technical capacity hinder effective service delivery. At the policy level, systematic discrimination against women and girls creates foundational discrimination, affecting overall gender equality and access to and provision of health and immunization services. These multi-level gender barriers underscore the complex challenges to improving health and immunization coverage in Afghanistan.



INTRODUCTION

Immunization interventions will only succeed in expanding their coverage and reach if gender roles, norms and relations are understood, analysed and systematically accounted for as part of immunization service planning and delivery. Gender inequality is widely recognized as a significant underlying factor influencing decisions to vaccinate, restrict access to, and limit uptake of, immunization services.⁵ It influences both demand for immunization, i.e., health-seeking behaviours, and supply, i.e. the provision of health services. To enhance vaccine coverage, especially among zero-dose children (children who have never been vaccinated against preventable diseases) and overlooked communities, it is vital to understand how gender, combined with other socioeconomic, geographic and cultural factors, affects vaccine access, uptake and delivery.⁶

UNICEF's Immunization Roadmap 2030 marks a strategic shift towards strengthened programmatic approaches that address discriminatory gender norms, roles and relations to expand and sustain immunization reach.⁷ The Immunization Agenda 2030 doubles down on "leaving no one behind", with a strategic focus on coverage equity that envisions a world where "everyone is protected by full immunization, regardless of location, age, socioeconomic status or gender-related barriers".⁸ It is estimated that, globally, nearly 40 per cent of non- and under-immunized children live in fragile and humanitarian contexts like Afghanistan, where it is imperative to examine and address pre-existing inequities.⁹

This analysis explores gender-related barriers to immunization, and the extent of zero-dose and missed groups in Afghanistan, especially focusing on vulnerable groups: those who may be hard to reach because of their remote location, IDPs, persons with physical and mental disabilities, migrant communities, single women and female-headed households, girls, children without caregivers and ethnic and religious minorities. It begins by examining the health and immunization landscape in Afghanistan, focusing particularly on gender issues in access to health care, which also have a bearing on immunization efforts. It examines how pre-existing challenges have been exacerbated

⁵ World Health Organization (WHO), *Why Gender Matters: Immunization Agenda 2030*, World Health Organization, Geneva, 2021, available at: <https://www.who.int/publications/i/item/9789240033948>

⁶ Ibid.

⁷ United Nations Children's Fund (UNICEF), *UNICEF Immunization Roadmap to 2030*. New York, 2023, available at: [https://www.unicef.org/media/138976/file/UNICEF Immunization Roadmap To 2030.pdf](https://www.unicef.org/media/138976/file/UNICEF%20Immunization%20Roadmap%20To%202030.pdf)

⁸ Immunization Agenda 2030, "SP3: Coverage & Equity", <https://www.immunizationagenda2030.org/strategic-priorities/coverage-equity>, accessed 24 July 2023.

⁹ UNICEF, "Immunization and conflict", <https://www.unicef.org/immunization/immunization-and-conflict>, accessed 24 July 2023.

and new barriers to immunization coverage and equity have emerged since the power transition to the DFA in 2021. It looks at the impact of recent edicts issued by the DFA, which limit women's mobility, education and employment opportunities. Finally, it provides actionable recommendations to inform response strategies and identifies entry points to improve vaccine coverage and equity and pathways for future evidence generation. Understanding gender barriers to immunization will assist UNICEF and its partners to accelerate efforts to reach zero-dose and missed communities. The findings of this analysis are also timely for Afghanistan's upcoming application to Equity Accelerator Funding of Gavi, the Vaccine Alliance, to advance efforts to reach zero-dose children and missed communities.

This analysis is based on a rapid desk review of grey and academic literature on the humanitarian situation as well as health, immunization and gender equality in Afghanistan. Supporting information from stakeholders at the UNICEF Afghanistan Country Office was also collected. The gender analysis applies the framework by Steege et al.,¹⁰ examining how gender-based socioecological factors impact women's and children's access to, and utilization of, health services at multiple levels. Key influences include family and household dynamics at the individual level, safety and social norms at the community level and gender policies, norms, roles and responsibilities at the health system level.

The report is divided into three sections: 1) an overview of the context of health service delivery, immunization programming, and gender inequality in Afghanistan; 2) a discussion of gender barriers in immunization coverage, including barriers at the individual/household, community/systemic and policy levels; and 3) recommendations, including entry points for gender-transformative programming and pathways to further evidence generation.

¹⁰ Steege Rosie, Taegtmeier Miriam, McCollum Rosalind, et al, "How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework", *Soc Sci Med*, 2018, vol 209, pp. 1–13. doi: 10.1016/j.socscimed.2018.05.002; Steege, Rosie, Hawkins Kate, Wurie Haja, et al. "Gender and Community Health Worker programmes in fragile and conflict-affected settings: Findings from Sierra Leone, the Democratic Republic of the Congo and Liberia", *Research in Gender and Ethics: Building Stronger Health Systems (RinGS) Research Brief* 2018, <https://www.ringsgenderresearch.org/resources/gender-community-sierra-leone-democratic-republic-congo-liberia/>, accessed 31 July 2023.

CONTEXT

Afghanistan faces unprecedented humanitarian crises. Decades of war, economic downturns, extreme drought and harsh winter conditions have brought misery and displacement to millions of Afghan people.

The near collapse of essential health services following the political changes of August 2021 resulted in immediate serious health concerns across the country. Increasing poverty has been compounded by gender-specific edicts, such as the requirement for women and girls to be accompanied by a mahram (male relative as a chaperon) when leaving home, which negatively impacts the capacity of women and children to access health services including immunization.

Recent health-care data show an infant mortality rate of 45 deaths and a child mortality rate of 58 deaths per 1,000 live births (*see Table 1*).¹¹ Substantial gains have been made in maternal and child health over the years, with a 60 per cent reduction in the maternal mortality rate and a 50 per cent reduction in the child mortality rate, but accessing health-care services remains extremely challenging for the approximately 24,000 women who give birth every month in remote areas of Afghanistan.¹² Both rates remain unacceptably high: the gains made thus far are fragile and need to be safeguarded.

Table 1: Snapshot of child health in Afghanistan

Health snapshot	
Total population (2021)	40,099,462
Birth cohort (2022)	1,446,699
Surviving infants (surviving to 1 year per year, 2022)	1,397,103
Infant mortality rate (deaths <1 year per 1,000 births, 2020)	45/1,000
Child mortality rate (deaths <5 years per 1,000 births, 2020)	58/1,000
World Bank Index, IDA (2020)	2.66
Gross national income (per capita US\$, 2021)	500
Number of districts/territories (2021)	34

Source: Gavi, the Vaccine Alliance, “Gavi country factsheet: Afghanistan”, <https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/afghanistan>, accessed 24 July 2023

¹¹ Gavi, the Vaccine Alliance, “Gavi country factsheet: Afghanistan”, <https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/afghanistan>, accessed 24 July 2023.

¹² United Nations Population Fund (UNFPA), “Afghanistan: An escalating crisis for women and girls”, <https://www.unfpa.org/afghanistan-escalating-crisis-women-and-girls>, accessed 24 July 2023.

Progress on gender equality is slow and has fallen back due to the current challenges. The current regime restricts girls from receiving high school and university education. Women are banned from employment outside the home, with exceptions for those working in the health and education sectors. Sanctions and restrictions, like the need for a mahram, a dress code and face covering, restrict women's mobility and access to basic services and affect intra-household dynamics; women's decision-making, agency and economic empowerment; and contribute to violence against women and girls. Women's political participation is severely curtailed in the absence of a dedicated government ministry and a lack of women members of the cabinet.¹³ Overall, the sociopolitical environment perpetuates discriminatory gender norms, further tilting the power balance in favour of men, and exacerbates vulnerabilities across all development areas.

A. Health service delivery in Afghanistan

In Afghanistan, health services are delivered through a network of over 4,000 health facilities and 16,000 health posts. Health facilities are managed by both the private and the public sectors

Despite this service delivery model, an estimated 10 per cent of Afghans do not have access to health services within two hours. Many underserved communities are reached by mobile health and nutrition teams and, in some cases, through outreach from the nearest health facilities.

Health service delivery model in Afghanistan

- ❖ **Primary healthcare facilities:** first point of contact for patients. Deliver a basic package of health services. Include sub-health centres, basic health centres, and comprehensive centres.
- ❖ **Secondary healthcare facilities:** provide the essential package of hospital services and includes district and provincial hospitals and some regional hospitals.
- ❖ **Tertiary healthcare facilities:** include some regional hospitals and several national and teaching hospitals.
- ❖ **Community-level services:** a network of approximately 28,000 community health workers (CHW) providing promotive and preventive care at household and community levels. Most CHWs are affiliated with the nearest primary healthcare facility and link between the community and the facility. Community structures, such as Health Shura and Family Health Action Groups, empower communities through awareness-raising and social mobilization for the prevention of diseases and improved health-seeking behaviours.

¹³ UN Women, "Press briefing: The situation of women and girls in Afghanistan", <https://www.unwomen.org/en/news-stories/speech/2022/07/press-briefing-the-situation-of-women-and-girls-in-afghanistan>, accessed 24 July 2023.

B. Immunization programming in Afghanistan

The UNICEF Afghanistan Country Office works closely with the Afghanistan Ministry of Public Health on the Expanded Programme on Immunization (EPI) for children and women, to ensure that every child receives crucial vaccinations against nine high-risk diseases, even in the most challenging and remote areas.¹⁴ Enhancing EPI services and vaccine coverage, particularly for zero-dose children, aids in early childhood and adolescent health development, bolsters primary health care, and amplifies high-impact health interventions.¹⁵ Despite the challenging operational environment, UNICEF has continued to provide immunization and essential health-care services in Afghanistan.

Examples of gender-related programme measures in Afghanistan

In 2020, 470 female mobilizers and vaccinators were recruited in the South, East, West, and Southeast regions of the country for polio campaigns. Community mobilizers were recruited in previously inaccessible areas to further expand the reach of health-care services and immunization. The immunization programme ensured that female vaccinators are deployed as members of COVID-19 vaccination teams to make the vaccine available to women and girls. Efforts are underway to deploy 90 female vaccinators at health facilities in hard-to-reach and marginalized rural areas.

Gender is one of the most powerful determinants of health-seeking behaviour and health outcomes, and imperative for strides in the humanitarian-and-development nexus. Gender integration is at the core of UNICEF's strategy and programme.¹⁶ UNICEF's Immunization and Gender Theory of Change emphasizes the need for gender integration and guides the integration of gender lens into the immunization programme cycle. This entails explicitly accounting for gender-based inequalities as an integral part of the initial design, implementation, monitoring and evaluation of immunization interventions and policies.¹⁷

¹⁴ UNICEF Afghanistan, "Health: Ending preventable maternal, newborn and child deaths", <https://www.unicef.org/afghanistan/health>, accessed 24 July 2023.

¹⁵ The UNICEF Transparency Portal, "EXPANDED PROGRAMME OF IMMUNIZATION (EPI): Afghanistan", <https://open.unicef.org/country-output?output-id=0060A007881014000>, accessed 24 July 2023.

¹⁶ UNICEF Regional Office for South Asia (ROSA), *Immunization and Gender: A Practical Guide to Integrate a Gender Lens into Immunization Programmes*, Kathmandu, 2019, available at: <https://www.unicef.org/rosa/media/12346/file>

¹⁷ Ibid.

C. Overview of zero-dose and missed communities

Over 28.3 million people (nearly two-thirds of the population) need humanitarian aid, including 6.4 million women and 15.2 million children.¹⁸ Over 17.6 million individuals are specifically in need of health-care support, including children under five in need of routine immunization services. The health-care system and health service provision have suffered continued setbacks, and resources for the national health-care programme, the Sehatmandi Project, have been especially limited in the aftermath of the Taliban takeover in 2021.^{19 20} Though funding for some areas has been made available by the World Bank under the Health Emergency Response Fund, and support to the health sector is provided by the Asian Development Bank, the substantial needs continue to strain the existing system. Health-care facilities have inadequate infrastructure and a shortage of qualified workers due to conflict-related emigration of health-care professionals, restrictions on women's movement and employment, and a lack of resources for salaries and facility maintenance.²¹ The absence of functional facilities near communities, and a lack of available medicines, treatment options and services add to the barriers to health-care access for communities. Economic distress compels individuals to resort to negative coping strategies.²²

Childhood immunization is vital to achieving the Sustainable Development Goals (SDGs), particularly SDG-3 which promotes good health and well-being. It is one of the most efficient and cost-effective methods to tackle health and well-being issues in resource-constrained countries.²³ Figure 1 provides the estimated immunization coverage in Afghanistan in 2021.²⁴ The coverage for the Bacillus Calmette–Guérin (BCG) vaccine, which protects against tuberculosis, is the highest at approximately 97 per cent. The third dose of the DTP vaccine has a coverage of around 84 per cent. The first dose of the inactivated polio vaccine (IPV1) shows coverage of about 87 per cent, but there is a noticeable drop for the second dose (IPV2), to around 62 per cent. The first dose of the measles-containing vaccine (MCV1) has a coverage of approximately 79 per cent, while

¹⁸ UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at:

<https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

¹⁹ System Enhancement for Health Action in Transition (SEHAT) Project from 2013 to 2018, transformed into the Sehatmandi programme in 2018. *Sehatmandi*, loosely translated, means “wellness”.

²⁰ World Health Organization (WHO), *Afghanistan Emergency Situation Report 29*, May 2023. Available at: <https://www.emro.who.int/images/stories/afghanistan/emergency-situation-report-may-2023.pdf?ua=1>

²¹ Ibid.

²² Ibid.

²³ Remy, Vanessa; Zöllner, York and Heckmann, Ulrike. “Vaccination: The cornerstone of an efficient health care system”. *J Mark Access Health Policy*, vol 3, 2015, doi: 10.3402/jmahp.v3.27041.

²⁴ WHO and UNICEF, “Afghanistan: WHO and UNICEF estimates of immunization coverage: 2021 revision”, available at: https://cdn.who.int/media/docs/default-source/country-profiles/immunization/2022-country-profiles/immunization_afg_2022.pdf

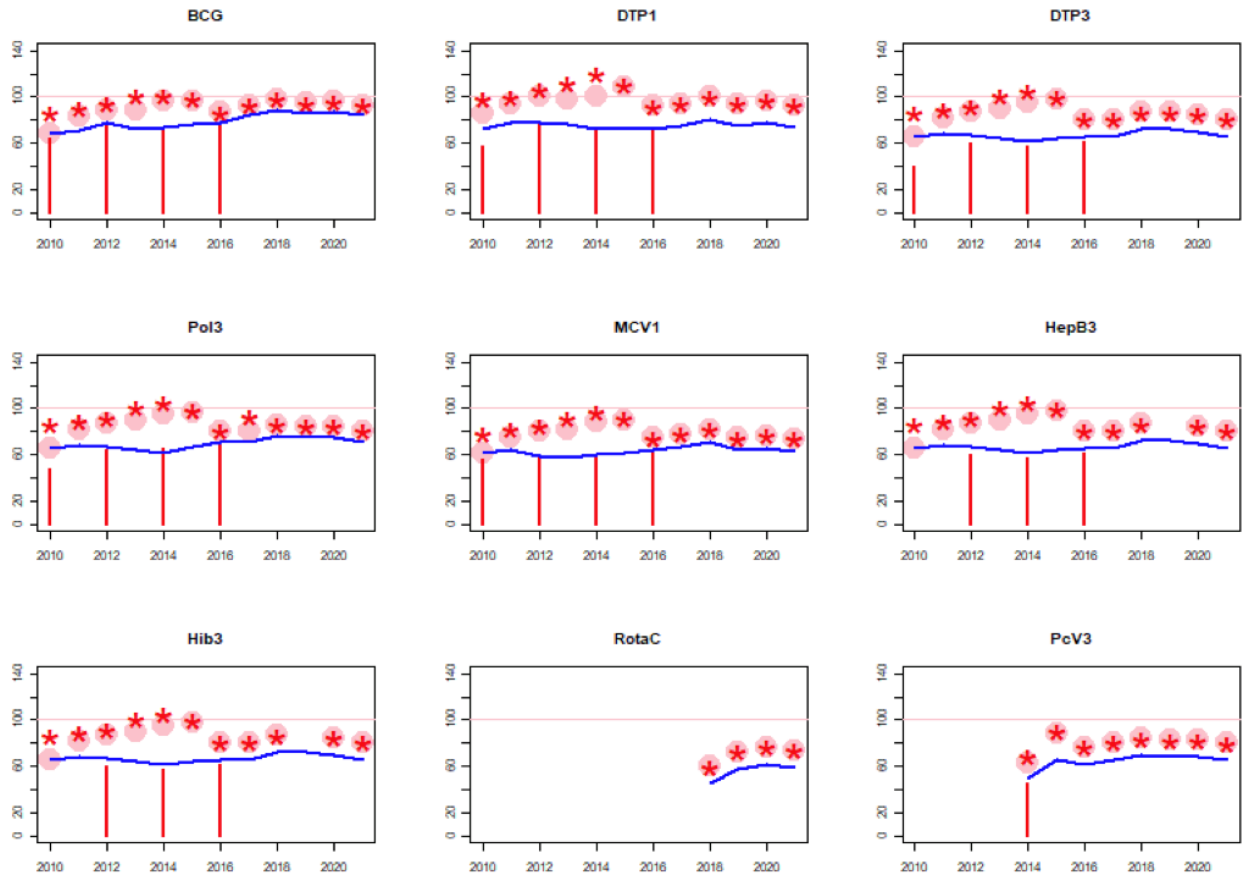
data for the third dose (MCV3) are not provided. The rotavirus vaccine has coverage of about 87 per cent for the first dose but declines to 77 per cent for the third dose. It is to be noted however, that these are estimates for 2021, a turbulent year in Afghanistan due to the transition of power to the DFA, and the mass displacements and disruptions in immunization service provision that followed.



A veiled woman carrying her child in Afghanistan

©UNICEF/UNI403555/Karimi

Figure 1: Estimates of immunization coverage in Afghanistan, 2021



Source: WHO and UNICEF, "Afghanistan: WHO and UNICEF estimates of immunization coverage: 2021 revision", available at: https://cdn.who.int/media/docs/default-source/country-profiles/immunization/2022-country-profiles/immunization_afg_2022.pdf

Immunization coverage is a crucial indicator of a health system’s capability to reach all segments of society, especially the most underprivileged groups. The Humanitarian Needs Overview for 2023 broadly categorizes vulnerable groups in Afghanistan as IDPs and vulnerable migrants, cross-border returnees, those affected by natural disasters, vulnerable people with humanitarian needs and refugees (*see Table 2*). Among these groups, women, older individuals, adolescents, youth, children, people with physical and mental disabilities, refugees and migrants are considered as particularly marginalized.²⁵

²⁵ UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at: <https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

Table 2: Vulnerable groups in need of humanitarian assistance 2023

Population Group	Children (%)	Women (%)	PWDs (%)	Rural (%)
New IDPs and vulnerable migrants	62	50	7.5	80
New cross-border returnees in 2023	29	22	10.9	80
Natural disaster-affected in 2023	54	49	8.3	82
Vulnerable people with humanitarian needs	55	50	8.2	78
Refugees and asylum-seekers	54	53	8.2	99

Source: UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at: <https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

Afghanistan has more than 360,000 zero-dose children.²⁶ Full immunization coverage is only 36.2 per cent (*see Table 3*), and there remain provinces where over half of children have received no vaccinations at all. Vaccination coverage for the five basic childhood vaccines (DTP, PCV, rotavirus, measles and HPV) are the lowest in Afghanistan among the South Asian nations.²⁷ Over the past three years, Afghanistan has experienced epidemics of polio, measles, COVID-19 and other acute respiratory infections. These outbreaks might have had less impact with better immunization coverage. Polio remains endemic in the Eastern part of the country, leaving Afghanistan the only country twith Pakistan where polio is still endemic in the world.²⁸

Table 3: Immunization coverage in Afghanistan

Coverage	Estimate
Number of zero-dose children at the national level (2021) ^a	360,765
BCG ^b	64.7%
Measles ^b	51.2%
OPV3 ^b	58.9%
DTP/Penta-3 ^b	51.1%
Fully vaccinated ^b	36.2%
Per cent reduction in zero doses at the national level, 2019–2021 ^a	8%
Geographic equity: Drop out from DTP1 to last routine dose of MCV at the national level (2021) ^a	41%
DTP3 coverage in the 20 per cent of districts with the lowest coverage (2021) ^a	41%

Source: (a) Gavi, the Vaccine Alliance, “Gavi Country Factsheet: Afghanistan”, <https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/afghanistan>, accessed 24 July 2023; (b) ARTF, UNICEF, *Afghanistan*

²⁶ Gavi, the Vaccine Alliance, “Gavi Country Factsheet: Afghanistan”, <https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/afghanistan>, accessed 24 July 2023

²⁷ UNICEF, “Data: Monitoring the Situation of Women and Girls” <https://data.unicef.org/countdown-2030/country/Afghanistan/2/>, accessed 2023.

²⁸ Global Polio Eradication Initiative, “Endemic Countries” <https://polioeradication.org/where-we-work/polio-endemic-countries/>, accessed 2023.

Multiple Indicator Cluster Survey (MICS 2022–2023): Summary Findings Report, Kabul, 2023, available at: https://www.unicef.org/afghanistan/media/8501/file/MICS_Executive_Summary_Report_2023.pdf

According to the World Bank, 3,209,763 children received immunization in 2021.²⁹ Data from WHO/UNICEF from 2020 show that coverage for the first and second doses of the measles vaccine (MCV1 and MCV2) was 66 per cent and 43 per cent respectively,³⁰ and was lower in six provinces – Kandahar, Paktya, Jowzjan, Khost, Helmand and Urozgan – all of which recorded less than 50 per cent MCV1 coverage (*see Table 4*).³¹ The displacement of people in 2021 further decreased measles vaccine coverage, limited access to health services and increased vulnerability due to overcrowded living conditions. Cross-border travel has escalated the risk of the disease spreading internationally, notably to Pakistan and Iran.³²

In 2022, approximately 8.2 million children aged 6–59 months received measles vaccinations and immunization support. These efforts included technical assistance, capacity-building initiatives, vaccine provision, logistic supplies and communication strategies aimed at driving social and behavioural change. However, challenges persist in expanding coverage, particularly for under-immunized and zero-dose children, including limited access to health care, inadequate infrastructure, socioeconomic disparities, cultural beliefs and low vaccines. Addressing these underlying causes is crucial to ensure comprehensive immunization coverage for every child.³³

UNICEF polio data suggest that 50 districts are highly susceptible to polio, with common problems including inadequate routine vaccination coverage, compromised immunity, constant population displacement, water, sanitation and hygiene (WASH) issues and unstable security conditions.³⁴ In Paktika, Zabul, Khost, Panjshir and some parts of Kabul and Kunar, over 5 per cent of children are recorded as having been missed by polio vaccination (*see Table 4*). While there have been advances in the scope and reach of the polio vaccination programme, it has met significant obstacles, including threats and attacks on frontline workers, harassment, prohibitions on female workers and pervasive misinformation regarding polio.

²⁹ World Bank, “Development Projects: Afghanistan Sehatmandi Project P160615”, <https://projects.worldbank.org/en/projects-operations/project-detail/P160615>, accessed 24 July 2023.

³⁰ WHO, “Measles – Afghanistan”, Disease Outbreak News, 10 February 2022, <https://www.who.int/emergencies/disease-outbreak-news/item/measles-afghanistan>, accessed 24 July 2023.

³¹ *Ibid.*

³² *Ibid.*

³³ UNICEF Afghanistan, *Country Office Annual Report 2022: Afghanistan*, available at: <https://www.unicef.org/media/135286/file/Afghanistan-2022-COAR.pdf>

³⁴ UNICEF Polio Factsheet 2021 (internal).

Table 4: Provinces with low immunization coverage

No vaccination (per cent) ^a		Lowest basic vaccination (per cent) ^a		Lowest measles vaccination (per cent) ^b		Polio >5 per cent missed ^c
Urozgan	60.7	Urozgan	2.6	Urozgan	3.1	Paktika
Nooristan	54.3	Nooristan	5.1	Helmand	18	Zabul
Paktika	51.4	Ghor	7.8	Khost	36	Khost
Kapisa	41	Helmand	8.6	Jowzjan	37	Kabul
Bagdis	40.1	Zabul	10.6	Paktika	38	Kunar
Jowzjan	32.9	Paktika	11.3	Kandahar	40	Panjshir

Source: (a) ARTF, UNICEF, *Afghanistan Multiple Indicator Cluster Survey (MICS 2022–2023): Summary Findings Report*, 2023, available at: https://www.unicef.org/afghanistan/media/8501/file/MICS_Executive_Summary_Report_2023.pdf; (b) World Health Organization (WHO), “Measles – Afghanistan”, *Disease Outbreak News*, 10 February 2022, <https://www.who.int/emergencies/disease-outbreak-news/item/measles-afghanistan>, accessed 24 July 2023; (c) Internal data from UNICEF

D. Gender issues in access to health care

Afghanistan holds the distinction of being the most challenging place on the globe for women and girls.³⁵ Conflict and instability have prevented progress on women’s and children’s rights, compounded by economic distress, food insecurity and displacement. Health infrastructure and services, which are largely funded by foreign aid, are limited and fragmented, especially in rural and hard-to-reach areas. The collapse of the Afghan government in 2021 aggravated these challenges, creating barriers to access to, and provision of, health-care services for women and girls.³⁶

Only 10 per cent of women can cover their basic health needs with the health services available to them, compared to 27 per cent of men.³⁷ Women with complex health needs, like pregnant women, face significant barriers to access due to fear, insecurity, mobility restrictions, long distances to health services, lack of safe transportation and shortage of trained female staff.^{38 39} Those without a mahram are frequently denied access to health

³⁵ Georgetown Institute for Women, Peace and Security and Peace Research Institute Oslo. *Women, Peace, and Security Index 2021/22: Tracking sustainable peace through inclusion, justice, and security for women*, Washington, DC, 2021.

³⁶ Human Rights Watch, *I Would Like Four Kids — If We Stay Alive: Women’s access to health care in Afghanistan*, 2021, available at: <https://www.hrw.org/report/2021/05/06/i-would-four-kids-if-we-stay-alive/womens-access-health-care-afghanistan>.

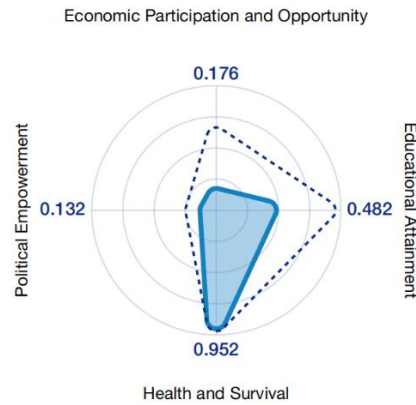
³⁷ Ground Truth Solutions, *Protecting and improving healthcare: Community insight from Afghanistan*, June 2022, available at: https://static1.squarespace.com/static/62e895bdf6085938506cc492/t/63a40d94d9b98870aac88e2b/1671695769228/GTS_Afghanistan_Health_June2022_EN.pdf

³⁸ UN Women, *Gender Alert 1: Women’s rights in Afghanistan – where are we now?*, December 2021, available at: <https://www.unwomen.org/sites/default/files/2021-12/Gender-alert-Womens-rights-in-Afghanistan-en.pdf>

³⁹ UNICEF, *GBV Safety Audits in Health and Nutrition Sites in Balkh, Parwan, Badakhshan, Daikundi, Kunduz, Kandahar and Ghazni Provinces, Afghanistan*, 2022

clinics, and female health workers are required to wear hijab, hindering their professional capabilities, including performing surgery.⁴⁰ Gender segregation is enforced between health workers and patients. In health-care facilities, women’s access to care is contingent on the availability of female health workers, who are in limited supply. Only about 20 per cent of Afghanistan’s doctors and nurses are women, and this proportion is even lower in rural areas.⁴¹ Despite this, female health workers face numerous challenges in career progression, remuneration, having to navigate discriminatory gender norms and concerns for their physical security.⁴² The prohibition on girls’ education is expected to drastically reduce the number of new female health workers, which could have long-term negative effects on Afghan women’s health, given the need for segregated health services.⁴³ These exacting conditions make service provision arduous and dangerous, both for female frontline workers and for women and children in need of essential services.

Figure 2: Afghanistan’s gender inequality scores across four dimensions, 2022



Source: World Economic Forum, *Global Gender Gap Report 2022*, Geneva, 2022, available at: <https://www.weforum.org/reports/global-gender-gap-report-2022/>

Even before the 2021 takeover, 71 per cent of female aid workers perceived an elevated risk, particularly women from minority groups and those with intersecting identities that reinforce and sustain discrimination. Hazara and Shi’a women face heightened threats of discrimination, femicide, forced disappearances or harassment.⁴⁴ Single or divorced

⁴⁰ UN Women, *Gender Alert 4: Back to the 1990s? Women’s rights under the Taliban*, March 2023, available at: https://asiapacific.unwomen.org/sites/default/files/2023-03/af-IWD2023_Gender-Alert-4-ss-020323.pdf

⁴¹ Jung, Laura; Khorsand, Lilly; Afzali, Anita, Dahir, Mariam; Essar, Mohammad Y., and Dhatt, Roopa, “Staring into the Darkness: women health workers in Afghanistan”, *The BMJ Opinion*, 6 September 2021, available at: <https://blogs.bmj.com/bmj/2021/09/06/staring-into-the-darkness-women-health-workers-in-afghanistan/>

⁴² UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report*, 2022, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>

⁴³ Ibid.

⁴⁴ United Nations Human Rights Council, *Situation of women and girls in Afghanistan - Report of the Special Rapporteur on the situation of human rights in Afghanistan and the Working Group on discrimination against women and girls*, A/HRC/53/21, 15 June 2023, available at: <https://www.ohchr.org/en/documents/country-reports/ahrc5321-situation-women-and-girls-afghanistan-report-special-rapporteur>

women might encounter greater harassment or mobility restrictions without a mahram. Women and girls with disabilities, those affected by poverty, undocumented returnees, migrant women and girls, and those who do not identify with their assigned gender at birth, are particularly marginalized and face heightened security challenges.⁴⁵ Both male and female staff working on GBV, reported to also include United Nations staff, which has further reduced access to vulnerable women and children.⁴⁶ Even though women have not been prevented from working in the health-care and education sectors, their work has been hampered by restrictions like strict adherence to the mahram requirement, dress code, gender segregation in vehicles, workstations and distribution points, both for staff providing services and community members accessing them.⁴⁷ If the imposed restrictions are fully implemented, they will present significant, potentially insurmountable, challenges for women in accessing antenatal, labour and postnatal care, making it almost impossible for any health-care provider to deliver fair and equitable medical services in Afghanistan.⁴⁸ The suspension of women's right to work will also have serious intergenerational impacts on Afghanistan's development, as it inhibits women in realizing their full potential to participate equally in economic life.⁴⁹

⁴⁵ Ibid.

⁴⁶ UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.4, April 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-no4-april-2023>

⁴⁷ UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.3, March 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-no-3-march-2023>

⁴⁸ Médecins Sans Frontières, "Women must not be erased from public life in Afghanistan" 29 December 2022, <https://www.msf.org/msf-condemns-ban-women-working-ngos-afghanistan>, accessed 24 July 2023.

⁴⁹ UN Women, *Gender Alert 4: Back to the 1990s? Women's rights under the Taliban*, March 2023, available at: https://asiapacific.unwomen.org/sites/default/files/2023-03/af-IWD2023_Gender-Alert-4-ss-020323.pdf

FINDINGS: GENDER BARRIERS TO IMMUNIZATION

Gender roles, norms and relations have a crucial influence on health risks, access to resources and opinions and decisions are acknowledged and health needs are prioritized, including in immunization programmes.⁵⁰ Multiple socioeconomic, geographical, and cultural factors – including age, ethnicity, religion, marital status, education, wealth, sexual orientation, gender identity, disability and migration status – further intersect with gender to influence vaccine accessibility and distribution. To enhance immunization coverage, especially for zero-dose children and overlooked communities, understanding and addressing gender’s impact on programme performance is crucial.⁵¹

This section aims to understand the gender-related socioecological aspects impacting immunization coverage in Afghanistan, both from a demand and supply perspective.⁵² It is guided by the UNICEF ROSA framework to examine gender-based barriers to immunization both from the demand side, i.e. relating to the gender of the child and the caregiver, and the supply side, i.e. relating to the gender of the health service provider (see Figure 3).

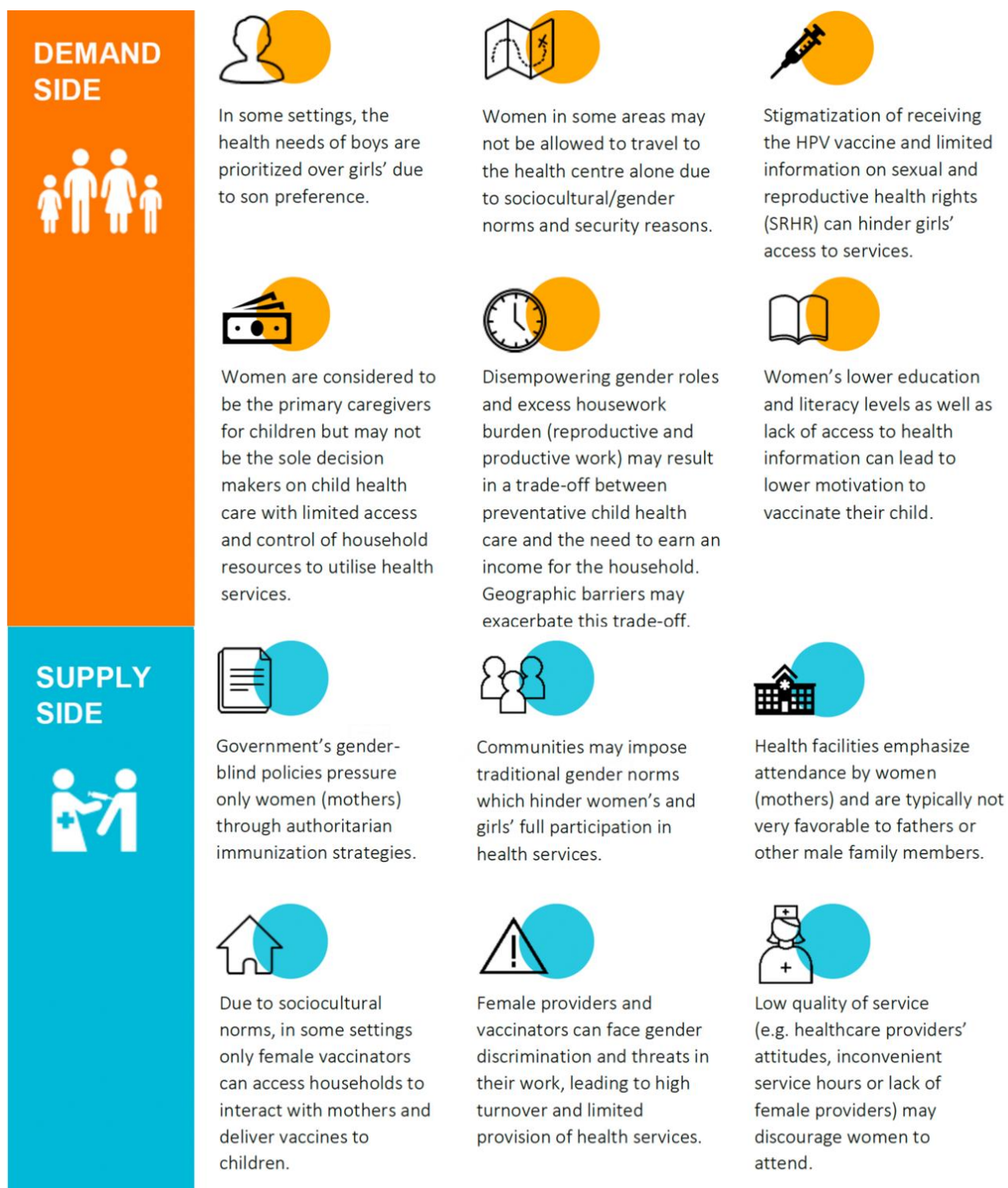
The analysis employs a socioecological framework, considering determinants at the individual/household, community and health system/policy levels to examine the mutually reinforcing mechanisms of gendered immunization disparity in Afghanistan.

⁵⁰Sen, Gita; George, Asha and Östlin, Piroška, “The Case for Gender Equity in Health Research”, *Journal of Health Management*: vol. 4, no. 2, 2002, pp. 99-117, doi: 10.1177/09720634020040020.

⁵¹ Goodman, Tracey; Bullock, Olivia; Munro, Jean; Holloway, Megan and Singh Sagri, “Why Does Gender Matter for Immunization?” *Vaccine*, 2022, doi: 10.1016/j.vaccine.2022.11.071.

⁵² UNICEF Regional Office for South Asia (ROSA), *Immunization and Gender: A Practical Guide to Integrate a Gender Lens into Immunization Programmes*, Kathmandu, 2019, available at: <https://www.unicef.org/rosa/media/12346/file>

Figure 3: Demand and supply side gender barriers to immunization



Source: UNICEF Regional Office for South Asia (ROSA), *Immunization and Index: A practical guide to integrating a gender lens into immunization programmes*, Kathmandu, 2019, available at: <https://www.unicef.org/rosa/media/12346/file>

A. Individual and household level

Discriminatory gender norms, roles, and relations

Women's success in advocating for their children's interests is often intertwined with their relative power and status within the family structure, which is typically determined by both gender and age.⁵³



In Afghanistan, conservative gender norms and a patriarchal social culture have consistently perpetuated biases against women and girls. These have been validated by the DSA, resulting in an escalation of limitations imposed on women and girls by their families and communities and significantly undermining their decision-making power, representation, their access to information, resources and protection, and imposing costs on their mobility.⁵⁴ Afghan women report that this has caused gender norms to regress and increased their subordination and the dominance of men in all aspects of life.⁵⁵ The DFA has also issued edicts enforcing punishments of men based on the behaviour of women and girls, thereby normalizing discrimination and violence against women and

⁵³ Feletto, Marta and Sharkey, Alyssa, "The Influence of Gender on Immunisation: Using an ecological framework to examine intersecting inequities and pathways to change", *BMJ Global Health* 2019, 4:e001711, doi: 10.1136/bmjgh-2019-001711

⁵⁴ UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at:

<https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

⁵⁵ IOM, UNAMA, UN Women, *Afghan Women's Voices- Summary Report of Countrywide Consultations*, March 2023, available at: <https://asiapacific.unwomen.org/en/digital-library/publications/2023/03/afghan-women-voices>

girls, and controlling women's actions indirectly through the men in their lives, further entrenching gender inequalities.⁵⁶

Due to the combined effects of multiple disadvantaged identities, women-led households and groups facing intersectional discrimination – such as families with disabilities, girls with disabilities in rural areas, older women and marginalized ethnic minorities – experience even greater challenges.⁵⁷ While traditional gender norms designate women as primary caregivers for children, men are often the decision-makers within the household, leaving mothers limited bargaining power amidst the gendered (with the male head) and generational (with elderly women and men) power dynamics within the household.⁵⁸ A study conducted in Nooristan province suggests that almost 72 per cent of women did not take health-seeking decisions for themselves. This was especially significant for women and girls in the 15–24-year age group, 82 per cent of whom reported that their husbands or in-laws make health-related decisions on their behalf.⁵⁹

Discriminatory edicts may be misused to impose false or fabricated sociocultural and religious values surrounding women's mobility and autonomy. These become normalized within societies and widen inequities. The need for a mahram to accompany women outside of the house severely restricts the mobility of mothers and female caregivers to access immunization services. The restrictions hinder women's access to timely information and assistance, further disempowering them from making decisions or advocating for the preventative health of their children.⁶⁰

Female vaccinators are essential to reach hard-to-reach children since they can go inside the home where men cannot, because children tend to be in the care of their mothers. Yet discriminatory norms also impact the ability of female service providers to reach

⁵⁶ United Nations Human Rights Council, *Situation of women and girls in Afghanistan - Report of the Special Rapporteur on the situation of human rights in Afghanistan and the Working Group on discrimination against women and girls*, A/HRC/53/21, 15 June 2023, available at: <https://www.ohchr.org/en/documents/country-reports/ahrc5321-situation-women-and-girls-afghanistan-report-special-rapporteur>

⁵⁷ UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at:

<https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

⁵⁸ Goodman, Tracey; Bullock, Olivia; Munro, Jean; Holloway, Megan and Singh Sagri, "Why Does Gender Matter for Immunization?" *Vaccine*, 2022, doi: 10.1016/j.vaccine.2022.11.071.

⁵⁹ UNICEF Afghanistan, C4D Strategy Baseline Assessment, Paroon District, Nooristan Province.

⁶⁰ Feletto, Marta and Sharkey, Alyssa, "The Influence of Gender on Immunisation: Using an ecological framework to examine intersecting inequities and pathways to change", *BMJ Global Health* 2019, 4:e001711, doi: 10.1136/bmjgh-2019-001711

women and children.⁶¹ The need for them to be accompanied by male family members for journeys exceeding 78 kilometres, adhere to a dress code, and exercise gender segregation in vehicles, workstations and distribution points, further limits their ability to serve, and poses a serious threat to the establishment of a well-functioning primary health-care system in Afghanistan.

KEY FINDINGS

Discriminatory gender norms, rules and relations

- ❖ Conservative gender norms in Afghanistan and the DFA's recent edicts disempower women and limit their decision-making power and access to resources. This particularly impacts women-led households and those facing intersectional discrimination.
- ❖ Discriminatory social norms impede women's ability to advocate for their children's health, including immunization, as men are usually decision-makers and women need a mahram to access health services.
- ❖ Discriminatory norms hinder female health service providers, creating barriers to the establishment of a functional primary health-care system in Afghanistan.

Lower education and limited health literacy

The link between maternal education, child health and positive immunization outcomes is well established.^{62,63} Immunization data from Afghanistan shows that the higher a mother's level of education, the more likely her children are to be fully vaccinated.⁶⁴ For children aged 12–23 months, only 30.2 per cent of those who received all basic vaccinations (BCG, DTP,3 MCV1 and the third dose of a polio vaccine) had mothers with no education, while 59.2 per cent had mothers who had finished upper-secondary education. Similarly, 13 per cent of children aged 24–35 months who received all vaccines scheduled for the first two years of life had mothers with no education, whereas 33.5 per cent had mothers who had finished upper-secondary education.⁶⁵

⁶¹ UNICEF, "Afghanistan's Female Vaccinators Protect Hard-to-Reach Kids From Polio", 21 October 2022, <https://www.unicefusa.org/stories/afghanistans-female-vaccinators-protect-hard-reach-kids-polio>, accessed 24 July 2023

⁶² Parashar, Sangeeta, "Moving Beyond the Mother-Child Dyad: "women's education, child immunisation, and the importance of context in rural India", *Soc Sci Med*, vol. 61, 2005, pp. 989–1000, doi:10.1016/j.socscimed.2004.12.023

⁶³ Feletto, Marta and Sharkey, Alyssa, "The Influence of Gender on Immunisation: Using an ecological framework to examine intersecting inequities and pathways to change", *BMJ Global Health* 2019, 4:e001711, doi: 10.1136/bmjgh-2019-001711

⁶⁴ ARTF, UNICEF, *Afghanistan Multiple Indicator Cluster Survey (MICS 2022–2023): Summary Findings Report*, Kabul, 2023, available at: https://www.unicef.org/afghanistan/media/8501/file/MICS_Executive_Summary_Report_2023.pdf

⁶⁵ Ibid.

Lower literacy levels and limited access to health information can hinder men's and women's understanding, usage and access to immunization services. Fathers largely influence immunization status, i.e. whether or not a child is immunized, while mothers influence under-vaccination, i.e. whether or not a child receives full vaccination. Especially among remote and vulnerable population groups in Afghanistan, poor literacy levels and limited access to health information are reported to impede preventative health-seeking behaviours and promote vaccine hesitancy.⁶⁶

Additionally, the recent restrictions on access to high school and university education are viewed by most Afghan women as an attempt to normalize their marginalization and invisibility in Afghan society.⁶⁷ In country-wide community consultations held in early 2023, Afghan women lamented that deteriorating education levels and high illiteracy rates will lead to long-term cycles of disempowerment and inequality and increased dependency on male relatives.⁶⁸ This may further reduce women's participation in immunization programmes.

On the supply side, these restrictions raise concerns about the supply of trained female health workers, both now and in the future, thereby causing generational setbacks.⁶⁹ The ban on female education, including pre-existing restrictions on subject choice for female students, will lead directly to a shortage of trained health workers and, in turn, will negatively impact women and girls' access to health. Experts fear that, within a single generation, there will be fewer qualified female service providers in Afghanistan, as women can no longer access medical degrees and training beyond midwifery. In a sociocultural environment which mandates gender segregation, this will be damaging to immunization coverage and vaccine equity.

⁶⁶ UNICEF Internal Polio Programme notes (internal document).

⁶⁷ UN Women, *Gender Alert 3: Out of jobs, into poverty – the impact of the ban on Afghan women working in NGOs*, January 2023, available at: https://asiapacific.unwomen.org/sites/default/files/2023-01/af-Out-of-jobs_Out-of-poverty_Gender-Alert.pdf

⁶⁸ IOM, UNAMA, UN Women, *Afghan Women's Voices- Summary Report of Countrywide Consultations*, March 2023, available at: <https://asiapacific.unwomen.org/en/digital-library/publications/2023/03/afghan-women-voices>

⁶⁹ UN Women, *Gender Alert 4: Back to the 1990s? Women's rights under the Taliban*, March 2023, available at: https://asiapacific.unwomen.org/sites/default/files/2023-03/af-IWD2023_Gender-Alert-4-ss-020323.pdf

KEY FINDINGS

Lower education and limited health literacy

- ❖ Limited literacy and poor access to health information contribute to vaccine hesitancy, particularly among remote and vulnerable communities.
- ❖ Educational restrictions for Afghan women lead to social marginalization, disempowerment and reduced participation in immunization programmes.
- ❖ These restrictions also threaten the availability of trained female health workers, negatively affecting immunization coverage and vaccine equity.

Economic marginalization and poverty

Financial barriers become pronounced in low-resource settings where mothers or female caregivers need to mobilize resources to access immunization-related services.⁷⁰ Research shows that, in contexts where health and immunization-related decision-making is negotiated within the primary household and extended family, mothers may be limited in their bargaining power vis-à-vis the male partner or head of household.⁷¹ This is a particular concern in Afghanistan, especially in the current environment where women's economic empowerment is in jeopardy.

In community consultations, 81 per cent of women participants reported that their household economic situation had worsened over the past three months because of the restrictions imposed on women, and had led to job losses, salary cuts and the closure of women-owned businesses, as well as an overall rise in insecurity for women. The economic situation is particularly dire for households headed by women and for families where women are the primary earners.⁷² Lower economic status and poor financial agency further disempower women at both the household and community level, reducing their ability to play a positive role in improving immunization coverage.

On the supply side, data show that educated, wealthier and urban women are more likely to be permitted to participate in the polio programme than their rural counterparts.⁷³ This

⁷⁰ Merten S, Martin Hilber A, Biaggi C, Secula F, Bosch-Capblanch X, et al., "Gender Determinants of Vaccination Status in Children: Evidence from a meta-ethnographic systematic review". *PLOS ONE*, vol. 10, no. 8, e0135222, 2015, doi:10.1371/journal.pone.0135222

⁷¹ Feletto M, Sharkey A. The influence of gender on immunisation: using an ecological framework to examine intersecting inequities and pathways to change. *BMJ Glob Health*. 2019 Sep 13;4(5):e001711. Doi: 10.1136/bmjgh-2019-001711. PMID: 31565415; PMCID: PMC6747884.

⁷² IOM, UNAMA, UN Women, *Afghan Women's Voices- Summary Report of Countrywide Consultations*, March 2023, available at: <https://asiapacific.unwomen.org/en/digital-library/publications/2023/03/afghan-women-voices>

⁷³ UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report*, 2022, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>

is attributed to lower levels of education, more restrictive gender norms, and poorer economic status of women in rural areas.⁷⁴

KEY FINDINGS

Economic marginalization and poverty

- ❖ In resource-constrained settings like Afghanistan, financial barriers further disempower women and limit the ability of mothers to access immunization services.
- ❖ The recent restrictions have worsened the economic situation of many households, particularly those headed by women or where women are the primary earners, reducing their capacity to enhance immunization coverage.
- ❖ On the supply side, educated, wealthier, urban women are more likely to join immunization programmes, unlike rural women who face more challenges.

B. Community level

Security concerns

Persistent protection and security concerns pose challenges to immunization coverage and equity in Afghanistan. On one hand, mothers and female caregivers are not permitted to travel to the health centres alone due to social norms, recent edicts enforcing the mahram requirement, and lack of dedicated and safe transportation and security. On the other hand, there are reports of hostility against, and fatal attacks on, female health workers.⁷⁵ Female vaccinators and frontline workers report facing hostility and threats while discharging their duties, leading to a high turnover and limited provision of health services. There are reports of GBV, sexual exploitation, abuse and harassment concerns for female frontline workers and female caregivers accessing immunization services.⁷⁶ In a context where women's work is restricted, the visibility and mobility of female health workers and vaccinators, even though permitted within the health sector, raises the risk of retaliation and violence at the community level and work.

⁷⁴ Ibid.

⁷⁵ United Nations News, "UN condemns brutal killing of eight polio workers in Afghanistan", 24 February 2022, <https://news.un.org/en/story/2022/02/1112612>, accessed 24 July 2023

⁷⁶ UNICEF Afghanistan, *GBV Safety Audits in Health and Nutrition Sites in Balkh, Parwan, Badakhshan, Daikundi, Kunduz, Kandahar and Ghazni Provinces*, Afghanistan, 2022.



Concerns about the visibility of polio campaigns also pose security risks for female frontline workers and social mobilizers. In an assessment of women's roles in the polio programme, female frontline workers pointed to public suspicions, even before the DSA takeover, that polio workers were spies for the International Security Assistance

Force and the government.⁷⁷ Such perceptions undermine community trust in the immunization programme and pose significant security threats to polio workers.

KEY FINDINGS

Security concerns

- ❖ Persistent security concerns in Afghanistan negatively impact immunization efforts. Social norms limiting women's mobility and security issues impede the ability of mothers and female caregivers to travel to health facilities.
- ❖ Female health workers face hostility, threats and high turnover, hindering the provision of health services.
- ❖ Suspicion towards the polio campaign exacerbates security risks for female health workers and reduces community trust in immunization programmes, restricting their ability to provide immunization services.

⁷⁷ UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report*, 2022, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>

Gendered spatial risks

Female frontline workers in the polio programme report challenges in defying norms around gendered space while moving from house to house or when interacting with male community members during outreach for vaccine dispensation.⁷⁸ Biases against female health workers, and negative community perceptions of women's work, make it harder for them to reach some communities. Additional spatial challenges include the need to navigate transportation options that may be deemed inappropriate or immodest, such as riding motorbikes across difficult terrain. When travelling long distances, frontline workers may need to stay overnight to avoid night-time travel adding to their difficulties.⁷⁹

KEY FINDINGS

Gendered spatial risk

- ❖ Female frontline workers in the polio programme report biases against female workers and negative societal perceptions of women's work, which hinders their ability to reach certain communities.
- ❖ They encounter logistical obstacles, like needing to use transportation deemed inappropriate or staying overnight in unfamiliar and potentially unsafe locations.

Vaccine hesitancy

Many communities hold deep-seated myths, misinformed religious beliefs and rumours, that deter parents from getting their children vaccinated. While resistance to vaccination typically originates from men or male community leaders (for religious or political reasons), women in these contexts also refrain from vaccinating their children.⁸⁰ This suggests that societal dynamics and power structures can have a substantial impact on health behaviours and decisions including vaccination.

Common misconceptions include claims that the polio vaccine contains pig-derived substances, making it non-halal and therefore forbidden in Islam. Another myth is the association of the vaccine with mental health disorders and impotence.⁸¹ Both of these are ungrounded beliefs that entirely lack scientific backing. In poorer and marginalized

⁷⁸ Kalbarczyk, Anne; Closser, Svea; Hirpa, Selamwit; Cinyamena, Utsamani, et al. "A Light Touch Intervention With a Heavy Lift - Gender, space and risk in a global vaccination programme", *Global Public Health* vol, 17, no. 12, pp. 4087–4100, Dec 2022, doi:10.1080/17441692.2022.2099930

⁷⁹ Ibid.

⁸⁰ Feletto, Marta and Sharkey, Alyssa, "The Influence of Gender on Immunisation: Using an ecological framework to examine intersecting inequities and pathways to change", *BMJ Global Health* 2019, 4:e001711, doi: 10.1136/bmjgh-2019-001711

⁸¹ Habib, Jacky, "Polio in Afghanistan: Everything you need to know", *Global Citizen*, 18 January 2023, <https://www.globalcitizen.org/en/content/polio-eradication-in-afghanistan/>, accessed 24 July 2024

communities, vaccination may not be seen as a priority given more pressing basic needs like food and shelter.⁸²

KEY FINDINGS

Vaccine hesitancy

- ❖ Among poorer and marginalized communities, vaccination is often deprioritized due to more immediate basic needs like food and shelter.
- ❖ Deep-seated myths, misinformed religious beliefs and rumours deter parents, typically influenced by male figures, from vaccinating their children. Misconceptions include claims that the polio vaccine is not halal or is associated with mental disorders and impotence.

C. Health system level

Ban on door-to-door vaccinations

With the transition of power in 2021 came a prohibition on door-to-door vaccination campaigns, which had been an effective way of reaching women, girls and marginalized communities. Although mosque-to-mosque vaccinations are now permitted, the transition has had gendered pitfalls that have led to many children missing vaccinations.⁸³ Women are not permitted to enter mosques, or even to leave their homes without a mahram, and men are typically unavailable during campaign hours due to work. This restricts both women's participation and children's access to immunization services. The change of campaign



Afghan mother with her children in a mobile health clinic.

©UNICEF/UNI403580/Karimi

⁸² UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report, 2022*, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>

⁸³ UNICEF Afghanistan, *Country Office Annual Report 2022: Afghanistan*, available at: <https://www.unicef.org/media/135286/file/Afghanistan-2022-COAR.pdf>

modality from house-to-house to mosque-to-mosque after November 2021 limited the programme's ability to track and follow-up on vaccine refusals and made it difficult to accurately count the number of boys and girls who were vaccinated or missed in each household, leading to potentially unrepresentative data and difficulties in collecting gender-disaggregated data.⁸⁴ Since bans on immunizations such as polio impact female health workers' capacity to discharge their duties, it may lead to attrition in an already limited workforce.

KEY FINDINGS

Ban on door-to-door vaccination

- ❖ The 2021 power transition to the Taliban has led to a ban on door-to-door vaccination campaigns, hindering access for women, girls and marginalized communities. The shift to mosque-based vaccination poses challenges due to gendered restrictions on women entering mosques without a male guardian and the potential unavailability of men during campaign hours.
- ❖ The mosque-to-mosque approach makes it harder to accurately account for the number of vaccinated children and gathers gender-disaggregated data, leading to potentially unrepresentative data and difficulty in tracking vaccination progress.

Challenging working conditions for female health workers

The health-care system in Afghanistan relies on female health workers. In 2022, 24 per cent of front-line workers were women, while men made up 76 per cent.⁸⁵ Women make up nearly half of the CHW programme. Female CHWs face challenges such as lower remuneration, lack of opportunities for career progression, and inadequate support and recognition from the health system. Indeed, most female CHWs are unpaid volunteers. They may receive up to US\$ 2 per month to cover travel expenses, but even this amount is often controlled by male family members (husbands or fathers).⁸⁶

In the recruitment of female frontline workers, the evidence shows the need for better gender representation across all levels of the programme. A gender assessment of the polio programme reveals that women mainly work at the field level, and few occupy

⁸⁴ Afghanistan Polio Eradication Initiative, Annual Report 2021, available at: <https://polioeradication.org/wp-content/uploads/2022/06/Afghanistan-Annual-Report-2021.pdf>

⁸⁵ UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report*, 2022, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>

⁸⁶ UNICEF Regional Office for South Asia (ROSA), Symposium Report on " *Unleash the power of Community Health Workers: The Journey towards 2030* ", 17–18 August 2022 [symposium report], Kathmandu, 2022.

senior positions. Though more women are being hired, their proportion remains far below that mandated by UNICEF's gender parity policy. Most hiring is as external consultants and not on the payroll. This is significant given the security issues faced by health workers in Afghanistan. Security officers working in United Nations agencies are only responsible for staff, consultants and volunteers directly contracted by UNICEF, which does not account for most frontline health workers who are hired by third-party agencies.⁸⁷

KEY FINDINGS

Challenging working conditions for female health workers

- ❖ Afghanistan's health-care system relies heavily on female health workers, who face challenges like lower remuneration, poor career progression and inadequate support. Female community health workers, who make up a significant portion of the workforce, are mostly unpaid volunteers, and any stipends they receive are often controlled by male family members.
- ❖ Despite a substantial presence in field-level roles, women are underrepresented in senior positions in the polio programme. Hiring of female staff falls short of UNICEF's gender parity policy and is usually on a contract basis rather than as regular staff, limiting their access to the security protections offered to employees.

Sub-optimal quality of health service provision

Numerous issues in the health system and facility level affect the quality of services available to women and girls and thus heighten barriers to access and utilization.⁸⁸ The health system is under considerable pressure due to limited funding, which affects both the accessibility and quality of health services. Experts share that the necessity of ensuring a mahram for female health workers can add financial burdens to an already strained system.

Reportedly, many health facilities lack separate admission and waiting areas for women and girls, private consultation/counselling rooms or nutrition services.⁸⁹ Most health facilities are overcrowded, which creates further barriers in a sociocultural context where gender segregation is imperative. Women have shared privacy and safety concerns due to the lack of female guards. Many health facilities lack segregated and gender-responsive toilets which are lockable, equipped with menstrual hygiene product disposal

⁸⁷ UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report*, 2022, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>

⁸⁸ Ibid.

⁸⁹ UNICEF Afghanistan, *GBV Safety Audits in Health and Nutrition Sites in Balkh, Parwan, Badakhshan, Daikundi, Kunduz, Kandahar and Ghazni Provinces*, Afghanistan, 2022.

facilities, and have soap and running water. There have been reports of mistreatment of patients at some facilities, including intimidation by health workers, which negates the image of health facilities as safe spaces and can cause lasting hesitancy in accessing health care in an environment which is already characterized by fear, conflict and instability.⁹⁰

KEY FINDINGS

Sub-optimal quality of health service provision

- ❖ Limited funding strains the health system, and restrictions like the need for a mahram can add to existing costs.
- ❖ Health system issues and challenges within facilities – such as overcrowding, lack of separate areas and private rooms for women, inadequate toilet facilities and safety concerns – intensify access and utilization barriers for women and girls in contexts where gender segregation is crucial.
- ❖ Instances of patient mistreatment and intimidation by health workers damage the perception of health facilities as safe spaces and can lead women to be reluctant to seek health-care services in an already unstable security environment.

Limited technical capacity

An assessment of UNICEF’s polio programming in 2021 has identified supply-side gaps such as limited gender integration in programme design and communication strategies.⁹¹ Of five polio communication strategies (including the national strategy), only two draw explicitly on gender theories or frameworks, and neither of these specifically notes how gender-related norms, attitudes or practices influence vaccination behaviour. The only strategy document that refers to gender-specific norms influencing the advancement of women in Afghanistan is the multisectoral national social and behaviour change strategy.

⁹²

The assessment also highlights a need to invest in context-specific gender training and capacity building for staff. Owing to the prevailing security challenges and environment of gender discrimination, technical capacity falls short in integrating the sociocultural realities and distinct needs of Afghan women.⁹³ A lack of experience and training on protection from sexual exploitation, abuse and harassment (PSEAH), GBV and psychological first aid is also reported among staff working across the health and nutrition

⁹⁰ Ibid.

⁹¹ Ibid.

⁹² Ibid.

⁹³ Ibid.

domains.⁹⁴ Moreover, the effectiveness of gender experts is limited due to disconnect from local communities, stemming from restricted field experience.

KEY FINDINGS

Limited technical capacity

- ❖ A 2021 assessment of polio programming shows that few programme and communication strategies consider how gender-related norms influence vaccination behaviour and point to the need for context-specific gender training and capacity-building for staff.
- ❖ There is reported to be a lack of training among staff on issues such as PSEAH, GBV and psychological first aid.

D. Policy level

Systematic discrimination against women and girls

The effectiveness of public health campaigns relies not only on the women who administer these services but also on the ability of women in the communities to access them. Restrictions on the autonomy of women and girls pose a risk to infectious disease prevention, with potential repercussions on a global scale.⁹⁵ The DFA's restrictions on women's mobility, education and work have caused severe setbacks in progress on gender equality, impeding the crucial role women play in



⁹⁴ Ibid.

⁹⁵ Jung, Laura; Khorsand, Lilly; Afzali, Anita, Dahir, Mariam; Essar, Mohammad Y., and Dhatt, Roopa, "Staring into the Darkness: women health workers in Afghanistan", *The BMJ Opinion*, 6 September 2021, available at: <https://blogs.bmj.com/bmj/2021/09/06/staring-into-the-darkness-women-health-workers-in-afghanistan/>

healthcare delivery, immunization coverage and equity, and greatly limiting their access and participation.⁹⁶

Though the edicts make some exceptions for women working in specific sectors (such as immigration services and health care), the ban on women working for NGOs and international development organizations, including as United Nations staff members, has created significant challenges to the provision of accessible and specialized services to women and girls, especially those belonging to vulnerable groups, and has hampered the expansion of vaccination coverage.

DFA edicts often lack specific details such as definitions, implementation procedures, and punishments for violations and their application and enforcement varies depending on context. This has resulted in a climate of legal ambiguity and fear. This uncertainty leads people to self-censor to evade arbitrary punishment by Taliban officials who interpret restrictions and punishments based on their perceptions. The inconsistent enforcement of these rules, particularly at the local level, exacerbates this situation. While ad hoc solutions have occasionally mitigated the negative effects of the edicts, these are not sustainable long-term strategies.


KEY FINDINGS

Systematic discrimination against women and girls

- ❖ Restrictions on women's autonomy jeopardizes public health campaigns. The limitations imposed by the DFA on women's mobility, education and work prevent women from playing their role in health-care delivery and immunization efforts and severely curtail their access and participation.
- ❖ The ban on women working in NGOs and international development organizations, including on Afghan women working as United Nations staff, challenges the provision of specialized services to vulnerable women and girls and causes regressive trends in vaccination coverage.
- ❖ DFA rules often lack clarity, creating legal ambiguity and fear, which leads to self-censorship to avoid arbitrary punishments. Uneven enforcement, especially at the local level, exacerbates this and temporary fixes have not provided sustainable long-term solutions.

⁹⁶ UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at: <https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>

Edicts issued by DFA targeting women and girls

- ❖ 18 September 2021: restricting education for girls beyond grade six
 - ❖ 23 December 2021: instructing (male) drivers not to accept women passengers without “proper” hijab, or without a mahram for travel more than 78 kilometres
 - ❖ 27 March 2022: limiting access of women and girls to parks; women prohibited from boarding domestic and international flights without a mahram
 - ❖ 7 May 2022: requiring women to observe “proper” hijab, preferably by wearing a chadari (a non-fitted black garment with face covering), and not leaving home without a reason (“the first and best form of observing hijab”)
 - ❖ 21 May 2022: requiring female television presenters to cover their faces
- 
- A mother holds her 2.5-month-old son while at Noor Khoda Clinic in Mazar-e-Sharif for him to receive his vaccinations.*
- ©UNICEF/UN0820032/Bidel
- ❖ 1 June 2022: requiring all girls in fourth to sixth grades to cover their faces while travelling to school
 - ❖ 23 August 2022: asking women government workers to stay home from work
 - ❖ 10 November 2022: prohibiting women from using gyms
 - ❖ 11 November 2022: prohibiting women from entering parks in Kabul; an announcement later published in Faryab banned their access to public baths, gyms, sports clubs and amusement parks
 - ❖ 20 December 2022: right of women to attend university “suspended”
 - ❖ 22 December 2022: prohibiting all forms of education beyond grade six for girls
 - ❖ 24 December 2022: right of women to work with national and international non-government organizations “suspended”

RECOMMENDATIONS

With due recognition of the challenging operating environment in Afghanistan, this section offers recommendations to address the gender-related barriers to immunization identified in earlier sections. The first sub-section highlights opportunities for gender-transformative programming, while the second lists data gaps and avenues for future evidence generation.

Gender-transformative programmatic strategies aim to “address the structural and social root causes of gender inequality and thereby promote more equitable outcomes for children in all their diversity. In so doing, they aim both to change overall structures that underpin gender inequality and to contribute to lasting change in individuals’ lives.”

Source: UNICEF, 2021. *Being intentional about gender-transformative strategies: Reflections and lessons for UNICEF’s Gender and Policy Action Plan (2022-2025)*, Miscellanea, UNICEF Office of Research - Innocenti, Florence

A. Entry points for gender-transformative programming

Mitigating barriers at the individual/household level

Barriers	Entry points and mitigating approaches
<ul style="list-style-type: none"> ▪ Discriminatory norms, roles and relations ▪ Lower education and limited health literacy ▪ Economic marginalization and poverty 	<ul style="list-style-type: none"> ▪ Adopt transformative approaches that promote active demand for vaccines and contribute to gender equality (e.g., engaging female influencers like grandmothers and vaccine champions, recognizing model fathers, targeting male caregivers and allies in outreach and communication efforts). ▪ Utilize well-established and trusted platforms such as Women and Girls’ Safe Spaces to raise health literacy and vaccine awareness among women and girls. ▪ Consider the use of cash-based programmes and cash-plus initiatives to incentivize the utilization of child health services and increase immunization coverage among vulnerable families and marginalized groups. ▪ Foster collaborations and ongoing efforts to enhance women’s economic empowerment to strengthen the ability of women and girls (e.g. through skilling) to express themselves, take charge of their lives and participate in decision-making processes.

Mitigating barriers at the community level

Barriers	Entry points and mitigating approaches
<ul style="list-style-type: none"> ▪ Security concerns ▪ Gendered spatial risks ▪ Vaccine hesitancy 	<ul style="list-style-type: none"> ▪ In collaboration with civil society organizations, establish the position on Islam and Immunization to address gender-related barriers to immunization within an Islamic framework. Use Islamic terminology to situate the importance of immunization and women’s empowerment, aiming to dispel misconceptions related to religion. ▪ Use mobile phone technology and social media platforms to maximize outreach and disseminate health information, promote child health services and raise vaccine awareness. ▪ Consider integrating immunization-related messaging and services with WASH and nutrition initiatives, as these approaches have broader appeal among communities. ▪ Strengthen the integration of gender perspectives into communication materials and programmatic strategies by incorporating gender frameworks, locally relevant indicators and contextual factors. Include social and gender norm change objectives and indicators where relevant.

Mitigating barriers at the health system level

Barriers	Entry points and mitigating approaches
<ul style="list-style-type: none"> ▪ Ban on door-to-door vaccinations ▪ Challenging working conditions for female health-care workers ▪ Suboptimal health service provision ▪ Limited technical capacity 	<ul style="list-style-type: none"> ▪ Expand health services in under-served (“white”) areas, including remote regions and IDP camps, considering both supply and demand factors. ▪ Tailor interventions to country-specific challenges, including the diverse geography and hard-to-reach areas, political conflict, internal displacement and economic crisis; and address unique challenges related to insecurity, war, geography and displacement. ▪ Through affirmative action, prioritize the achievement of a gender-balanced health workforce aligned with gender-parity standards set by humanitarian partners and aim for at least 40 per cent female representation in staff. ▪ Advocate for improved working conditions for frontline health workers in collaboration with humanitarian partners and local authorities. This includes granting more operational decision-making authority, providing strong support teams, incentives specifically designed for female health workers and equitable compensation.

Barriers	Entry points and mitigating approaches
	<ul style="list-style-type: none"> ▪ Recognize and incentivize the valuable contributions of all CHWs, irrespective of gender, social barriers, household responsibilities or competing demands. Provide equal remuneration to prevent CHW roles from being perceived as feminized or being undervalued; enhance the status, significance and acceptance of the CHW role; and promote the economic empowerment of women. ▪ Explore solutions, such as extended working hours for existing health facilities to improve access to health-care services and to enhance service delivery. ▪ Ensure that gender standards for facilities and services are adopted and implemented. This may include, for example, allocating separate waiting and admission areas for men and women, private consultation/ counselling areas for women and girls, gender-responsive, accessible and segregated toilets and deployment of female guards. ▪ Collaborate with humanitarian partners to strengthen capacity at all levels to promote gender-responsive programming that aligns with the specific context of Afghanistan ▪ Provide staff training on GBV, PSEAH, and psychological first aid to mitigate GBV risks and prioritize ongoing training for health-care personnel on ethical standards and professional conduct. ▪ Conduct studies, particularly qualitative assessments, to understand normative barriers to vaccine acceptance and cultural and local sensitivities and dynamics, and to address gaps in knowledge, attitudes and practices, especially among vulnerable groups and marginalized communities. Actively involve women, girls, men, boys, and gender-diverse individuals in research and consultations. Specifically, seek out and engage with groups with intersectional needs, like young mothers and women with disabilities, to understand their unique needs.

Mitigating barriers at the policy level

Barriers	Entry points and mitigating approaches
<ul style="list-style-type: none"> ▪ Systematic discrimination against women and girls 	<ul style="list-style-type: none"> ▪ Collaborate with partners and local authorities regarding continued relaxation of restrictions on female workers in the health and education sectors, as it serves as a gateway for the expansion of immunization and health services. ▪ Partner with the broader humanitarian community to foster dialogue and strengthen advocacy efforts with the DFA, aimed at relaxing restrictive and discriminatory policies that

disproportionately affect women and girls, impacting immunization coverage and equity.

- Advocate for public financing for health, particularly in under-served areas to meet health-care needs, including gender-segregated spaces, toilets and security at health facilities.

B. Data gaps and future evidence generation

- Collect sex- and age-disaggregated data on comprehensive immunization coverage through, or in support of, a national information management system for health, to better understand the vaccination status of different population groups.
- Collect sex- and age-disaggregated data at the subnational level through, or in support of, a national information management system for health, to identify regional and local variations, enabling targeted interventions and informed decision-making for the immunization programme.
- Utilize mixed methods assessments and gather qualitative data to identify missed and vulnerable groups and immunization-related barriers faced by parents and children from these groups to inform programme design and outreach strategies.
- Gather social data with a specific focus on normative factors that influence vaccine uptake, like power dynamics and decision-making, that yields programmatic insights for improved vaccination coverage.
- Until comprehensive information is available through other means, utilize UNICEF's U-report platform, focusing on immunization and the polio programme, to fulfil interim data gaps.

ANNEX: LIST OF DOCUMENTS REVIEWED

- ACAPS, Thematic Report: Afghanistan – Coping with the Crisis: Conversations with Afghan households in Kabul province (16 June 2023), June 2023, available at: <https://reliefweb.int/report/afghanistan/acaps-thematic-report-afghanistan-coping-crisis-conversations-afghan-households-kabul-province-16-june-2023>
- Afghanistan Polio Eradication Initiative, Annual Report 2021, available at: <https://polioeradication.org/wp-content/uploads/2022/06/Afghanistan-Annual-Report-2021.pdf>
- ARTF, UNICEF, *Afghanistan Multiple Indicator Cluster Survey (MICS 2022–2023): Summary Findings Report*, Kabul, 2023, available at: https://www.unicef.org/afghanistan/media/8501/file/MICS_Executive_Summary_Report_2023.pdf
- Essar, Mohammed Yar; Raufi, Nahid; Head, Michael G, Nemat, Arash; Bahez, Ayesha; Blanchet, Karl and Shah, Jaffer, "Afghan women Are Essential to Humanitarian NGO Work", *Lancet Global Health*, vol. 11, no. 4, e497–e498, April 2023, doi: 10.1016/S2214-109X(23)00048-7
- Feletto, Marta and Sharkey, Alyssa, "The Influence of Gender on Immunisation: Using an ecological framework to examine intersecting inequities and pathways to change", *BMJ Global Health* 2019, 4:e001711, doi: 10.1136/bmjgh-2019-001711
- Gavi, the Vaccine Alliance, "Gavi Country Factsheet: Afghanistan", <https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/afghanistan>, accessed 24 July 2023.
- Georgetown Institute for Women, Peace and Security and Peace Research Institute Oslo. *Women, Peace, and Security Index 2021/22: Tracking sustainable peace through inclusion, justice, and security for women*, Washington, DC, 2021.
- Gender in Humanitarian Access Working Group, Afghanistan, "Gender in Humanitarian Action Working Group Meeting" [presentation], 27 March 2023.
- Global Polio Eradication Initiative, "Endemic Countries" <https://polioeradication.org/where-we-work/polio-endemic-countries/>, accessed 2023.
- Goodman, Tracey; Bullock, Olivia; Munro, Jean; Holloway, Megan and Singh Sagri, "Why Does Gender Matter for Immunization?" *Vaccine*, 2022, doi: 10.1016/j.vaccine.2022.11.071.
- Ground Truth Solutions, *Protecting and Improving Healthcare: Community insight from Afghanistan*, June 2022, available at: https://static1.squarespace.com/static/62e895bdf6085938506cc492/t/63a40d94d9b98870aac88e2b/1671695769228/GTS_Afghanistan_Health_June2022_EN.pdf
- Ground Truth Solutions, *Against the Odds: Strengthening accountability to women and girls in Afghanistan*, February 2023, available at: https://static1.squarespace.com/static/62e895bdf6085938506cc492/t/6411ad6f258b0d02a367bd2d/1678880115916/GTS_AFG_R1_March_2023.pdf
- Habib, Jacky, "Polio in Afghanistan: Everything you need to know", *Global Citizen*, 18 January 2023, <https://www.globalcitizen.org/en/content/polio-eradication-in-afghanistan/>, accessed 24 July 2024

- Human Rights Watch, *I Would Like Four Kids — If We Stay Alive*: Women's access to health care in Afghanistan, 2021, available at: <https://www.hrw.org/report/2021/05/06/i-would-four-kids-if-we-stay-alive/womens-access-health-care-afghanistan>.
- Immunization Agenda 2030, "SP3: Coverage & Equity", <https://www.immunizationagenda2030.org/strategic-priorities/coverage-equity>, Strategic Priorities, accessed 24 July 2023.
- IOM, UNAMA, UN Women, *Afghan Women's Voices- Summary report of countrywide consultations*, March 2023, available at: <https://asiapacific.unwomen.org/en/digital-library/publications/2023/03/afghan-women-voices>
- Jung, Laura; Khorsand, Lilly; Afzali, Anita, Dahir, Mariam; Essar, Mohammad Y., and Dhatt, Roopa, "Staring into the Darkness: Women health workers in Afghanistan", *The BMJ Opinion*, 6 September 2021, available at: <https://blogs.bmj.com/bmj/2021/09/06/staring-into-the-darkness-women-health-workers-in-afghanistan/>
- Kalbarczyk, Anne; Closser, Svea; Hirpa, Selamwit; Cintyamena, Utsamani, et al. "A Light Touch Intervention With a Heavy Lift - Gender, space and risk in a global vaccination programme", *Global Public Health* vol, 17, no. 12, pp. 4087–4100, Dec 2022, doi:10.1080/17441692.2022.2099930
- Médecins Sans Frontières, "Women must not be erased from public life in Afghanistan", 29 December 2022, <https://www.msf.org/msf-condemns-ban-women-working-ngos-afghanistan>, accessed 24 July 2023.
- Merten S, Martin Hilber A, Biaggi C, Secula F, Bosch-Capblanch X, et al., "Gender Determinants of Vaccination Status in Children: Evidence from a meta-ethnographic systematic review". *PLOS ONE*, vol. 10, no. 8, e0135222, 2015, doi:10.1371/journal.pone.0135222
- MI Consulting, "UNICEF C4D Strategy Baseline Assessment: Summary findings", Kabul, 2021.
- Parashar, Sangeeta, "Moving Beyond the Mother-Child Dyad: "women's education, child immunisation, and the importance of context in rural India", *Soc Sci Med*, vol. 61, 2005, pp. 989–1000, doi:10.1016/j.socscimed.2004.12.023
- Remy, Vanessa; Zöllner, York and Heckmann, Ulrike. "Vaccination: The cornerstone of an efficient health care system". *J Mark Access Health Policy*, vol 3, 2015, doi: 10.3402/jmahp.v3.27041.
- Sen, Gita; George, Asha and Östlin, Pirooska, "The Case for Gender Equity in Health Research", *Journal of Health Management*: vol. 4, no. 2, 2002, pp. 99-117, doi: 10.1177/09720634020040020
- Gender in Humanitarian Action Afghanistan Working Group and Humanitarian Access Working Group, "Tracking Impact Report on the ban on women working with NGOs, INGOs and UN in Afghanistan – Fifth Snapshot (May 2023)", <https://reliefweb.int/report/afghanistan/tracking-impact-report-ban-women-working-ngos-ingos-and-un-afghanistan-fifth-snapshot-may-2023>, accessed 31 July 2023.
- Gender in Humanitarian Action Afghanistan Working Group and Humanitarian Access Working Group, "Tracking Impact Report on the ban on women working with NGOs, INGOs and UN in Afghanistan (2 - 12 January 2022)", <https://reliefweb.int/report/afghanistan/humanitarian-access-working-group-tracking-impact-report-recent-ban-women-working-ngos-and-ingos-afghanistan-2-12-january-2022>, accessed 31 July 2023.
- Tracking Impact Report on the ban on women working with NGOs, INGOs and UN in Afghanistan #2

- UN OCHA, *Humanitarian Needs Overview (HNO) Afghanistan 2023*, available at: <https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2023-january-2023>
- UN OCHA, *Humanitarian Response Plan (HRP) Afghanistan 2023*, available at: <https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-response-plan-2023-march-2023>
- UN Women, "Press briefing: The situation of women and girls in Afghanistan", <https://www.unwomen.org/en/news-stories/speech/2022/07/press-briefing-the-situation-of-women-and-girls-in-afghanistan>, accessed 24 July 2023.
- UN Women, *Gender Alert 1: Women's rights in Afghanistan – where are we now?*, December 2021, available at: <https://www.unwomen.org/sites/default/files/2021-12/Gender-alert-Womens-rights-in-Afghanistan-en.pdf>
- UN Women, *Gender Alert 2: Women's rights in Afghanistan one year after the Taliban take-over*, August 2022, available at: https://www.unwomen.org/sites/default/files/2022-08/Gender-alert-2-Womens-rights-in-Afghanistan-one-year-after-the-Taliban-take-over-en_0.pdf
- UN Women, *Gender Alert 3: Out of jobs, into poverty – the impact of the ban on Afghan women working in NGOs*, January 2023, available at: https://asiapacific.unwomen.org/sites/default/files/2023-01/af-Out-of-jobs_Out-of-poverty_Gender-Alert.pdf
- UN Women, *Gender Alert 4: Back to the 1990s? Women's rights under the Taliban*, March 2023, available at: https://asiapacific.unwomen.org/sites/default/files/2023-03/af-IWD2023_Gender-Alert-4-ss-020323.pdf
- UNICEF Afghanistan, "Health: Ending preventable maternal, newborn and child deaths", <https://www.unicef.org/afghanistan/health>, accessed 24 July 2023.
- UNICEF Afghanistan, "Vaccinating the children of Afghanistan: Zero-dose" [video], 2023 <https://www.youtube.com/watch?v=stJNC4sdx1o>, accessed 24 July 2023.
- UNICEF Afghanistan, *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline final report*, 2022, available at: <https://polioeradication.org/wp-content/uploads/2022/07/Polio-Gender-Assessment-Afghanistan.pdf>
- UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.1, January 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-no1-31-january-2023>
- UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.2, February 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-february-2023>
- UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.3, March 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-no-3-march-2023>
- UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.4, April 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-no4-april-2023>
- UNICEF Afghanistan, *Afghanistan Humanitarian Situation Report No.5, May 2023*, available at: <https://www.unicef.org/documents/afghanistan-humanitarian-situation-report-no-5-31-may-2023>
- UNICEF Afghanistan, "Antigen Wise Coverage" (internal untitled presentation).
- MI Consulting, *C4D Strategy Baseline Assessment, Paroon District, Nooristan Province* (internal document), n.d.

- UNICEF Afghanistan, *Country Office Annual Report 2022: Afghanistan*, available at: <https://www.unicef.org/media/135286/file/Afghanistan-2022-COAR.pdf>
- UNICEF Afghanistan, *GBV Safety Audits in Health and Nutrition Sites in Balkh, Parwan, Badakhshan, Daikundi, Kunduz, Kandahar and Ghazni Provinces, Afghanistan*, 2022.
- UNICEF Middle East and North Africa Regional Office, *Gender-Related Barriers to Immunization: Zero-dose children in Egypt, Iraq, Sudan, Syria and Yemen*, 2023
- UNICEF Office of Research – Innocenti, *Being Intentional About Gender-Transformative Strategies*, 2021, available at: <https://www.unicef-irc.org/publications/pdf/Gender-Policy-Action-Plan-Compendium.pdf>
- UNICEF Regional Office for South Asia (ROSA), *Immunization Gender Analysis Report: Evaluation of South Asia's current community health worker policies and system support and their readiness for community health workers' expanding roles and responsibilities within post-Astana national health care strengthening plans*, Kathmandu, 2022, available at: <https://www.unicef.org/rosa/media/18151/file/Gender%20Analysis%20Report.pdf>
- UNICEF Regional Office for South Asia (ROSA), *Immunization and Index: A practical guide to integrate a gender lens into immunization programmes*, Kathmandu, 2019, available at: <https://www.unicef.org/rosa/media/12346/file>
- UNICEF Regional Office for South Asia (ROSA), *Symposium Report on "Unleash the power of Community Health Workers: The Journey towards 2030", 17–18 August 2022*, Kathmandu, 2022.
- UNICEF Transparency Portal, "EXPANDED PROGRAMME OF IMMUNIZATION (EPI): Afghanistan", <https://open.unicef.org/country-output?output-id=0060A007881014000>, accessed 24 July 2023.
- UNICEF, "Data: Monitoring the Situation of Women and Girls", <https://data.unicef.org/countdown-2030/country/Afghanistan/2/>, accessed 2023.
- UNICEF, "Immunization and conflict", <https://www.unicef.org/immunization/immunization-and-conflict>, accessed 24 July 2023.
- UNICEF, "Afghanistan's Female Vaccinators Protect Hard-to-Reach Kids From Polio", 21 October 2022, <https://www.unicefusa.org/stories/afghanistans-female-vaccinators-protect-hard-reach-kids-polio>, accessed 24 July 2023
- UNICEF, Polio factsheet, 2021 (internal)
- UNICEF, Polio programme notes (internal)
- UNICEF, Polio social mobilisation worker status, 2023 (internal)
- UNICEF, *UNICEF Immunization Roadmap to 2030*. New York, 2023, available at: [https://www.unicef.org/media/138976/file/UNICEF Immunization Roadmap To 2030.pdf](https://www.unicef.org/media/138976/file/UNICEF%20Immunization%20Roadmap%20To%202030.pdf)
- United Nations Human Rights Council, *Situation of women and girls in Afghanistan - Report of the Special Rapporteur on the situation of human rights in Afghanistan and the Working Group on discrimination against women and girls*, A/HRC/53/21, 15 June 2023, available at: <https://www.ohchr.org/en/documents/country-reports/ahrc5321-situation-women-and-girls-afghanistan-report-special-rapporteur>
- United Nations News, "UN condemns brutal killing of eight polio workers in Afghanistan", 24 February 2022, <https://news.un.org/en/story/2022/02/1112612>, accessed 24 July 2023
- United Nations Population Fund (UNFPA), "Afghanistan: An escalating crisis for women and girls", <https://www.unfpa.org/afghanistan-escalating-crisis-women-and-girls>, accessed 24 July 2023.
- USAID, "Afghan Civil Society Sub-Sector Assessment: Women-focused CSOs", 2023.

- WHO and UNICEF, "Afghanistan: WHO and UNICEF estimates of immunization coverage: 2021 revision", available at: https://cdn.who.int/media/docs/default-source/country-profiles/immunization/2022-country-profiles/immunization_afg_2022.pdf
- World Bank, "Development Projects: Afghanistan Sehatmandi Project P160615", <https://projects.worldbank.org/en/projects-operations/project-detail/P160615>, accessed 24 July 2023.
- World Health Organization (WHO), *Afghanistan Emergency Situation Report 29*, May 2023. Available at: <https://www.emro.who.int/images/stories/afghanistan/emergency-situation-report-may-2023.pdf?ua=1>
- World Health Organization (WHO), "Measles – Afghanistan", Disease Outbreak News, 10 February 2022, <https://www.who.int/emergencies/disease-outbreak-news/item/measles-afghanistan>, accessed 24 July 2023.
- World Health Organization (WHO), *Why Gender Matters: Immunization Agenda 2030*, World Health Organization, Geneva, 2021, available at: <https://www.who.int/publications/i/item/9789240033948>



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